



An independent investigation into the care and treatment of a mental health service user (Mr B) in London

February 2018

Author: Naomi Ibbs, Independent Investigator, Niche Health and Social Care Consulting

First published: February 2018

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

This report was commissioned by NHS England and cannot be used or published without their permission.

Niche Health and Social Care Consulting
One City Approach
Albert Street
Eccles
MANCHESTER
M30 0BG

Telephone: 0161 785 1001
Email: enquiries@nicheconsult.co.uk
Website: www.nichepatientsafety.co.uk

An independent investigation into the care and treatment of a mental health service user (Mr B) in London

Version number: Report WEB7835 V4.11.docx

First published: February 2018

Prepared by: Niche Health and Social Care Consulting

Contents

1	Executive summary	6
	Mental health history	6
	Relationship with the victim	9
	Offence	9
	Sentence	10
	Internal investigation	10
	Independent investigation	11
	Conclusions	12
	Recommendations	12
	Good practice	16
2	Independent investigation.....	17
	Approach to the investigation	17
	Contact with the victim's family	19
	Contact with Miss N.....	22
	Contact with the perpetrator	26
	Contact with the perpetrator's family	28
	Structure of the report	30
3	Background of Mr B.....	31
	Personal history.....	31
	Forensic history	31
4	Care and treatment of Mr B	31
	2011	32
	2012	33
5	Arising issues, comment and analysis.....	53
	Care plans	54
	Risk assessments	57
	Carer's assessment and support.....	60
	Culture and mental health	61
	Child safeguarding	62

Diagnosis.....	64
Psychological support	64
Communication between the Trust and the GP	65
Multiagency working with the Police.....	65
Recording of information	66
Lone working	67
Capacity and capability issues in the Croydon MAP East Team.....	67
6 Complaint made about Mr B's care and treatment.....	69
Summary of the complaint.....	69
Overview of individuals involved in complaint	71
Chronology of actions and communications.....	71
Analysis of response provided by the Trust	75
Summary	79
7 Policy review.....	79
Trust domestic violence policy	79
Adult safeguarding policy	84
Child safeguarding policy	84
8 Internal investigation and action plan	85
9 Overall analysis and recommendations.....	87
Predictability and preventability.....	87
Appendix A – Terms of reference.....	93
Generic terms of reference.....	93
Specific terms of reference.....	93
Appendix B – Documents reviewed.....	94
South London and Maudsley NHS Foundation Trust Documents.....	94
Other Documents	94
Appendix C – Professionals involved	96
Appendix D - Chronology of Mr B's contacts with the Trust, local hospitals, his GP and information gained from the Domestic Homicide Review report	97

1 Executive summary

- 1.1 NHS England, London commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Mr B). Niche is a consultancy company specialising in patient safety investigations and reviews. The terms of reference are at Appendix A.
- 1.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27 on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005; and the NHS England Serious Incident Framework¹ dated March 2015.
- 1.3 The main purpose of an independent investigation is to identify whether there were any aspects of the care that could have altered the outcome or prevented the incident. The investigation process will also identify areas where improvements to services are required, which could help prevent similar incidents occurring.
- 1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.
- 1.5 Mr B killed his wife, Mrs B, at Mrs B's home and in the presence of the couple's child. We would like to express our sincere condolences to the families affected by this tragic event. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr B.

Mental health history

- 1.6 Mr B was in contact with a number of organisations prior to the death of his wife. For ease we have listed those organisations here:
 - Oxleas NHS Foundation Trust – a mental health services provider;
 - St George's Hospital – a general acute hospital provided by St George's University Hospitals NHS Foundation Trust. It delivers a range of services including accident and emergency;
 - Merton Community Mental Health Team – a community team provided by South West London and St George's Mental Health NHS Trust;

¹ NHS England Serious Incident Framework March 2015 <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

- South London and Maudsley NHS Foundation Trust – a mental health services provider (referred to as the Trust hereafter);
 - Croydon Hospital - a general acute hospital provided by Croydon Health Services NHS Trust. It delivers a range of services including accident and emergency.
- 1.7 Mr B presented to his GP in Blackheath in March 2011 complaining of feeling suicidal and describing urges to kill someone from his previous job. A GP made a referral to an Assessment and Shared Care Team for urgent assessment and possible admission. The Domestic Homicide Review report identifies this referral to have been to Oxleas NHS Trust. The report notes that Mr B *“was not taken on for treatment”*.
- 1.8 Mr B first presented to mental health services provided at St George’s Hospital in March 2012 when he was assessed by psychiatric liaison staff. Mr B told the assessor that he had *“no past psychiatric history but has some anger management issues and personality traits”*. At this assessment it was noted that Mr B reported he had *“recently”* been *“referred to Merton CMHT”* but that the team had not yet had opportunity to *“conduct their own assessment”*.
- 1.9 Mr B first presented to the South London and Maudsley NHS Foundation Trust (referred to as “the Trust” hereafter) psychiatric liaison services in October 2012 after he had made attempts to kill himself three weeks previously by turning the gas on and putting his head in the oven. On the day of presentation he had taken 15 vials of cocaine and 150 steroid tablets, and had drunk and injected substances into his arm. Following assessment by the liaison doctor it was recommended that Mr B was admitted to Lewisham Hospital. However when Mr B was informed of this recommendation he said that he did not want to go to hospital. Therefore a Mental Health Act assessment was requested. The assessing doctors felt that the least restrictive care plan would be to consider involvement by the mental health Home Treatment Team. Mr B was agreeable to this and it was decided that Mr B was not detainable as he was consenting to support and treatment. Therefore Mr B was not admitted to Lewisham Hospital and remained in Croydon University Hospital as he had a significant wound on his arm from where he had injected substances.
- 1.10 At the end of October 2012 Mr B’s arm wound had deteriorated badly and the intention was for Mr B to be transferred from Croydon University Hospital to St George’s Hospital so that he could access more specialist treatment. However this did not take place due to the level of self-harm with which Mr B was presenting.
- 1.11 In early November 2012 Mr B remained on the ward at Croydon University Hospital where he presented as unsettled, acting in an aggressive and confrontational manner towards staff. The assessment by the psychiatric liaison staff noted Mr B as high risk and plans were started to transfer Mr B to a psychiatric inpatient ward, however these were halted due to the intervention of liaison psychiatry staff who felt that a transfer to a psychiatric inpatient unit would be detrimental to his physical health. Mr B was eventually discharged

home with support from the home treatment team, during the second week of November.

- 1.12 Mr B was seen by home treatment team staff on nine occasions between 8 and 28 November, when Mrs B reported that Mr B was agitated and suicidal. Mr B was seen at A&E at Croydon Hospital and following liaison psychiatry assessment was admitted overnight to Gresham's 2 ward (a mental health inpatient ward).
- 1.13 Mr B's care was then allocated to a care co-ordinator in a community team. The care co-ordinator recorded four unsuccessful attempts to contact Mr B on 4 December. Contact was established with Mrs B the following day who reported that Mr B had been taken to Croydon Hospital A&E for assessment under Section 136 of the Mental Health Act². Mr B was subsequently admitted under Section 2 of the Mental Health Act to Croydon Triage (a mental health inpatient ward).
- 1.14 Mr B remained an inpatient until 12 December when the section was rescinded and he was discharged home. A seven day follow up appointment was conducted by telephone the same day when Mr B reported that he was still anxious about being at home. Mr B contacted Croydon Triage the following day to say that he had not been seen for a follow up appointment and was informed that the telephone contact had been recorded as such.
- 1.15 On 13 December Mr B was seen by the duty worker for the community team; Mr B reported that he was feeling down and that his mood had deteriorated since discharge from hospital. The duty worker recorded that Mr B was aware of crisis contacts. This entry was not recorded until the duty worker returned from leave in early January 2013.
- 1.16 Mr B was due to be seen by his care co-ordinator on 17 December however Mr B rescheduled this appointment to 20 December.
- 1.17 The following day Mrs B called Mr B's care co-ordinator to say that Mr B had left home that morning taking the family's two mobile telephones and the family car. Mr B was later arrested having assaulted a member of the public.
- 1.18 On 19 December Mr B was still in custody and a mental health act assessment was conducted. The assessment found no evidence of mental illness that required acute treatment and Mr B was therefore not detained.
- 1.19 On 20 December Mr B contacted his care co-ordinator to cancel the appointment scheduled for that afternoon. The care co-ordinator stressed that the appointment should go ahead as he wanted to see Mr B's wife and child and would attend Mr B's address as planned. When the care co-ordinator

² Section 136 of the Mental Health Act. The police can use section 136 of the Mental Health Act to take someone to a place of safety when they are in a public place. They can do this if they think someone has a mental illness and is in need of care. A place of safety can be a hospital or a police station. The police can move you between places of safety. The police can keep you under this section for up to 72 hours.

arrived at Mr B's address the police and ambulance service were present as Mr B had killed Mrs B.

Relationship with the victim

- 1.20 Mr B and Mrs B had been together for about ten years and had been married for about six years at the time of the offence. They met in 2002 when Mr B was about 18 years old and Mrs B was about 15 years old. They married in 2006 and had a child (Child B) together who was born the same year. It should be noted that this information is different from that provided in the Domestic Homicide Review summary. This is because Mr B's family highlighted to us that the Domestic Homicide Review information was inaccurate. In cross checking the feedback, we confirmed that it was indeed accurate and have put the correct details above.
- 1.21 During the relationship there were three incidents of domestic violence reported to police, in 2006, 2007 and the last incident on 18 December 2012, two days prior to Mrs B's death.
- 1.22 There were periods when Mr B and Mrs B lived separately. Mr B had a relationship with another female, Miss N. The exact nature of this relationship is unclear, being variously reported as "*work colleagues*", "*friends*", siblings and "*girlfriend*". It is also reported that Miss N was a friend of Mrs B.

Offence

- 1.23 All information about the offence is taken from Domestic Homicide Review report, which has already been published by Croydon Council.
- 1.24 On 20 December 2012 Child B had been feeling unwell and as a result they did not go to school. Child B was left in the care of their father Mr B whilst Mrs B went to work. It is reported that at this time Mr B and Mrs B were actually separated but they were in regular contact with each other. It is also reported that at this time Mr B had a girlfriend Miss N to whom he sent two text messages on 20 December.
- 1.25 At about 3:00pm on 20 December the police received a call from a neighbour who reported that he could hear sounds of a disturbance at a neighbouring property. The neighbour stated that a female had been heard screaming and there were banging noises coming from the home of Mr B and Mrs B. Police attended the home address ten minutes later to find the flat in darkness with no sounds of disturbance coming from within. Police spoke to another neighbour (not the original caller) who said that they had not heard any disturbance. The police then left.
- 1.26 At about 3:25pm the partner of the original caller rang the police. She asked that they re-attend the address, as she was concerned that something had happened. The caller said that there had been screaming and then it had gone quiet. She further said that nobody had left the address, the blinds were down and she was convinced that something had happened. She repeated

the information shared in the call made by her partner that the male (Mr B) had mental health issues and that there was a young child at the address.

- 1.27 At 3:45pm police re-attended the address and looked through the letterbox. Officers could see a trail of blood through the hallway and immediately tried to force entry to the flat. They found Mrs B lying on the floor of the lounge; she had been fatally stabbed. Officers also found Mr B alive in the main bedroom, lying face down with blood on his legs. He had white froth/vomit around his mouth and was moaning and rocking back and forth. Mr B told police that he had stabbed Mrs B after she had stabbed him in the leg. Mr B also said that he had taken some pills and began to shake and became unresponsive. Ambulance staff attended the scene and administered diazepam intravenously to Mr B. Records indicate that the doctor on the scene had concerns about a possible overdose.

Sentence

- 1.28 In February 2014 Mr B pleaded guilty to the manslaughter of Mrs B. Mr B was sentenced to life imprisonment. In sentencing Judge Nicholas Cooke QC said:

“The circumstances of this offence were extremely grave. You stabbed a defenceless victim to death in a ferocious attack...I am satisfied that you are dangerous and will remain so for an unascertainable period. The combination of an untreatable personality disorder and a propensity to abuse drugs against the background of the explosion of violence dictates as much. I have therefore been driven to the conclusion I must pass a sentence of life imprisonment. It is a life sentence which means you will be released when it is decided it is safe to do so.”³

- 1.29 The court heard evidence from two forensic psychiatrists who agreed that Mr B was suffering from a drug-induced psychosis and a borderline personality disorder. We have not reviewed any reports that formed those assessments because they were not available to us as they were not within the timeframe included in the terms of reference.
- 1.30 The judge ordered that Mr B serve at least ten years and eight months before being considered for parole.

Internal investigation

- 1.31 The Trust undertook an internal investigation that has been reviewed by the investigation team. The internal investigation was completed by a team that included:

- Head of Clinical Pathway (Forensic), Behaviour and Developmental Psychiatry CAG;

³ Standing Together Against Domestic Violence, Domestic Homicide Review Report, The London Borough of Croydon

- Consultant Psychiatrist, Psychiatric Intensive Care Unit and Liaison Team, Psychosis CAG;
 - Trust Investigation Facilitator.
- 1.32 The internal investigation report was scrutinised by a small group of Trust Board members and the Director of Adult Care Commissioning in June 2013. The report made five recommendations:
- *“An improvement in clinical staff awareness of issues relating to violence and abuse, primarily against women, as service users and the partners, carers or members of the family of service user is needed. The revised and reissued Trust Policy on Domestic Violence and Partner Abuse should be publicised widely across all services and used as the vehicle for a concerted awareness raising exercise. Policy standards within the document should be audited periodically.*
 - *The policy and practices around seven day follow up are reviewed to ensure they meet the requirements of the organisation and comply with national guidance.*
 - *In the meantime it is recommended that the Assistant Director of Patient Safety drafts and distributes a Blue Light Bulletin that clearly states the standard expected for seven day follow up.*
 - *Concerns regarding the performance of the care co-ordinator will be brought directly to the attention of the service team by the Nursing Member of the Board Level Inquiry Panel – Deputy Director of Patient Safety and Assurance.*
 - *The investigators have been informed that a further restructuring of Croydon MAP East Team is underway. The investigators recommend that as part of the restructuring there is:*
 - *a review of the duty system and allocations systems;*
 - *a skill mix review to ensure that the team have the skills required to manage a challenging client group.”*
- 1.33 It is our view that there were a number of aspects of Mr B’s care and treatment that were not identified during the internal investigation. These have been drawn out in the recommendations of this investigation.

Independent investigation

- 1.34 This independent investigation has drawn upon the internal process and has studied clinical information, witness statements, interview transcripts and policies. The team has also interviewed Trust staff who had been in contact with Mr B in the two months prior to the incident.

- 1.35 This case has also been the subject of a Domestic Homicide Review report dated April 2015 and published by Croydon Council⁴. It is from this report that we have sourced all information pertaining to the involvement of the police.

Conclusions

- 1.36 It is our view that this tragic homicide could not have been predicted. However we consider that there are actions that should have been taken that could have minimised the likelihood of the death of Mrs B.

Recommendations

- 1.37 The independent investigation supports the recommendations made by the Trust internal investigation team, and has not repeated them. The recommendations from our independent investigation focus on improvements that we consider should be made to record keeping and information sharing across agencies.
- 1.38 The recommendations have been given one of three levels of priority:
- **Priority One:** the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
 - **Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.
 - **Priority Three:** the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Priority One

Recommendation 1

The Trust must ensure that up to date, comprehensive care plans are in place for all patients under the care of liaison psychiatry, home treatment team and Croydon Triage, particularly those who have been detained under the Mental Health Act and who are subject to Care Programme Approach. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.

⁴ Croydon Council Domestic Homicide Reviews <https://www.croydon.gov.uk/community/dabuse/homicide-review>

Recommendation 2a

The Trust must ensure that risk assessments and risk management plans are in place for all patients under the care of liaison psychiatry, home treatment team and Croydon Triage, particularly those who have been detained under the Mental Health Act and who are subject to Care Programme Approach. They must also be reviewed when new information comes to light. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Recommendation 2b

The Trust must ensure when assessments of clients who are in police custody are undertaken, that clinicians obtain a clear history from police staff about the client's forensic history.

Recommendation 3

The Trust must ensure that all staff consider the role of carers and that carers assessments and appropriate support are offered and documented, this includes drawing up an accurate family diagram. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Recommendation 5

The Trust must ensure that when a diagnosis is recorded appropriate plans are put into place for ongoing treatment and support and this is reviewed and amended, if appropriate, when any changes to the diagnosis are made

The Trust must ensure that when changes are made to a patient's diagnosis, the management plan must be revised accordingly and must be consistent with the revised diagnosis and the patients' needs.

Recommendation 8

The Trust and Croydon Health Services Trust must ensure when a patient attends A&E for treatment and is seen by the liaison psychiatry service that appropriate records of that attendance and any interventions are recorded in line with both organisational record keeping policies.

Recommendation 13

The Trust must ensure that prior to discharging a client there should be an appropriate discharge plan and risk assessment in place that are shared with appropriate community staff and other agencies. Where possible this plan should be agreed and supported by the client and (subject to client consent) their carer.

Priority Two

Recommendation 4

The Trust must review the impact of the changes to policy and processes for child safeguarding, including obtaining feedback from staff about how effective the new processes are.

Recommendation 6

The Trust must clarify the care pathway for patients with personality disorder and ensure that staff are aware of the referral criteria for access to psychological services.

Recommendation 7

The Trust must ensure that processes are in place to trace the correct GP for clients when a client record indicates that a client is not registered with a GP; and that this must be undertaken within seven calendar days.

Recommendation 14

The Trust must identify all stakeholders required to be present on the Board Level Inquiry panel at the point that investigations are commissioned, in order to reduce delays in implementing lessons learned.

Recommendation 15

The Trust must manage clinical and organisational commitments appropriately to ensure that they do not cause delays in investigation of serious incidents and implementation of learning.

Recommendation 16

The Trust must review the detail of the actions taken in response to the complaint made by Miss N to assure themselves that the failures in investigating and communicating in a timely fashion cannot be repeated.

Priority Three

Recommendation 9

The Trust must ensure that community staff understand and comply with the lone working policy and that staff read the records and undertake an appropriate risk assessment about the home visit prior to leaving Trust premises.

Recommendation 10

The Trust must make the following amendments to the domestic violence policy so that it is in line with best practice:

- clarify the Trust responsibility and commitment in providing the working environment and comprehensive training required in order that practitioners are able to meet their obligations safely and effectively;
- clarify the Trust response when it is identified that an employee is a perpetrator of domestic violence;
- include more detailed responsibilities for responding when victims or perpetrators of domestic violence are identified within the workplace, including a protocol for reporting concerns about a colleague.
- N.B. This recommendation is based upon our review against best practice and has no direct link with this incident.

Recommendation 11

The Trust must provide a separate handbook on the process for responding to clients or carers affected by domestic violence, to give greater detail to staff outside of the Trust policy.

Recommendation 12

The Trust must review the Adult Safeguarding Policy to ensure that it provides staff with clear direction as to what steps to take to raise concerns about a vulnerable adult, particularly when that person is also a carer.

Good practice

- 1.39 We found that there was evidence of notable good practice, which we wish to highlight in this report.
- 1.40 The Trust's home treatment team staff contacted liaison psychiatry staff when Mr B was on his way to A&E after they had visited Mr B at home and found that he was physically very unwell as his arm wound was infected.
- 1.41 The Trust's home treatment team staff alerted liaison psychiatry staff to Mr B's presentation whilst in Croydon Hospital in October and recommended that liaison psychiatry staff read the relevant entries about how to manage Mr B's presentation.

2 Independent investigation

Approach to the investigation

- 2.1 The independent investigation follows the Department of Health guidance (94) 27⁵, on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.
- 2.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care, which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.
- 2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.
- 2.4 The investigation was carried out by Naomi Ibbs, Senior Independent Investigator for Niche, with expert advice provided by:
 - Dr Afzal Javed, Consultant Psychiatrist;
 - Sue Salas, advisor on culture and mental health;
 - Carol Dudley, advisor on safeguarding;
 - Christopher Gill, lay person and critical friend;
 - John Kelly, retired Detective Chief Superintendent and advisor on interagency communications;
 - Liz Ostrowski, Domestic Violence Intervention Project.
- 2.5 The investigation team will be referred to in the first person in the report.
- 2.6 The report was peer reviewed by Carol Rooney, Senior Investigations Manager, Niche.
- 2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance⁶.

⁵ Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services

⁶ National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

- 2.8 We wrote to Mr B at the start of the investigation, explained the purpose of the investigation and asked to meet him. Mr B did not respond to our letter so we also wrote to the prison governor and to the manager of the prison healthcare service to ask for their assistance in ensuring that Mr B understood the purpose of the investigation. We did not receive any response from Mr B and have therefore not had the opportunity to meet with him.
- 2.9 Mr B did not respond to the request from NHS England for consent to access his records and subsequently indicated to them that he did not wish to participate in the independent investigation.
- 2.10 Access to all records for this investigation was gained through seeking consent from the relevant Caldicott Guardian⁷.
- 2.11 We used information from Mr B's clinical records provided by the Trust, Croydon Health Services NHS Trust, St George's University Hospitals NHS Foundation Trust, and Mr B's GP records from Violet Lane Medical Practice and Blackheath Standard Surgery. There are a number of entries provided by Violet Lane Medical Practice that were included in the records from Mr B's previous GP practice. Mr B registered with Violet Lane Medical Practice in November 2012; all entries accredited to Violet Lane Medical Practice prior to this date relate to information transferred from another GP practice.
- 2.12 We also used information obtained by the Domestic Homicide Review team. We asked Croydon Safer Partnership Board if we could see the Individual Management Reviews from contributing organisations. We were told that individual organisations would need to give their permission for this to happen. Nearly all organisations gave permission for their Individual Management Reviews to be shared with us. Croydon Council told us that the Croydon Police had "*concerns around this inquiry*" and therefore we did not receive a copy of the Individual Management Review completed by the Metropolitan Police. It is therefore important to clarify that all information within this report that refers to contacts that the police had with Mr and Mrs B has been drawn from the Domestic Homicide Review report that has already been published by Croydon Council⁸.
- 2.13 It was not within our remit to pursue the information from the Metropolitan Police. The information within their Individual Management Review had already been provided to the Domestic Homicide Review Panel and their report is in the public domain.
- 2.14 There were significant delays in receiving clinical and documentary information from the Trust. We understand that shortly after this independent

⁷ Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated in 1999 by Health Service Circular HSC 1999/012. Caldicott Guardians were subsequently introduced into social care in 2002, mandated by Local Authority Circular LAC 2002/2.

⁸ Croydon Council Domestic Homicide Reviews <https://www.croydon.gov.uk/community/dabuse/homicide-review>

investigation was commissioned in July 2015 the Trust experienced significant levels of long term unexpected absence within the Quality Team. Three of the four case managers and the administrative support person were unexpectedly absent for extended periods, which resulted in a “*number of issues becoming unacceptably slow*”.

- 2.15 There were also significant delays in receiving clinical information from Croydon Health Services NHS Trust. Records were first requested in early October 2015 and in late October the Caldicott Guardian asked for confirmation from NHS England that they had been unable to obtain Mr B’s consent to access his records. NHS England responded at the beginning of November 2015. Despite numerous follow up letters from NHS England and us, we did not receive the records until early February 2016; some 18 weeks later.
- 2.16 As part of our investigation we interviewed:
- Head of Patient Safety;
 - Director of Nursing;
 - Consultant Psychiatrist, Croydon Triage;
 - Occupational Therapist, Croydon MAP;
 - former Head of Pathway, Croydon MAP (via Skype);
 - a team leader recently trained in Root Cause Analysis investigations.
- 2.17 A full list of all documents we referenced is at Appendix B.
- 2.18 The draft report was shared with NHS England, the Trust, Croydon Health Services NHS Trust, St George’s University Hospitals NHS Foundation Trust, Violet Lane Medical Practice and Blackheath Standard Surgery prior to publication. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with the victim’s family

- 2.19 Contact for the victim’s family was with Mrs B’s mother, father and sister. We wrote to them at a number of points during the investigation to invite them to contribute; however we did not receive a response. We later learned that the families had advised the coroner’s office that all communication with them should go through their relevant legal advisors. Using this route we were successful in meeting with Mrs B’s mother and her legal advisor, and Mrs B’s father and sister with their legal advisor. It should be noted that these meetings took place after all of our investigations and interviews had been concluded and therefore it was not possible to use any information provided to inform our lines of enquiry.

- 2.20 Ms W told us that she had had a violent relationship with Mrs B's father, Mr A, and that Mrs B had witnessed some of this violence when she was a child. Ms W said Mrs B "*always wanted to be with her*" [Ms W] but when Mrs B found Mr B, "*she wanted love and to make her own life*". Mrs B's mother (Ms W) told us that she didn't know very much about her daughter's relationship with Mr B, other than it was "*very up and down*". Ms W did not know that Mr B had left Mrs B or that Mr B was not meant to have been at Mrs B's flat. Ms W clarified that she understood that Mr B's name was not on the tenancy agreement and therefore he had no right to live there.
- 2.21 Ms W described an occasion when she had gone to Mrs B's flat to ask her a favour but Mrs B wouldn't answer the door. Ms W 's grandchild told her that Mr B "*doesn't answer the door to anybody*". Ms W later found out that there had been a warrant out for Mr B's arrest at that time.
- 2.22 Ms W had minimal contact with Mr B's family before he was admitted to hospital in October 2012, after which Mr B's brother stayed with Ms W.
- 2.23 Ms W said that in late November, her daughter had told her that she couldn't cope with, or manage, Mr B and was going to ring the hospital to try to get him admitted.
- 2.24 Ms W told us how, in the week of her daughter's death, she had received a text that she later learned was from Mr B saying "*I have [Mrs B]...I think she's ill and taking cocaine. I want help and advice as to what to do with her*". Ms W did not receive a response to her text message from either Mr B or Mrs B. Mrs W contacted her other daughter Miss A to ask her to contact Mrs B. Mrs W also contacted her grandchild's school to leave a message for Mrs B. Mrs B's neighbour later told Ms W that they had also contacted the child's school to express concern about Mr B and to ask school not to allow him to collect his child. Ms W did not find out that Mr B had been arrested on 18 December until the police told her about this much later on. Ms W also told us that she understood that Miss N had stayed with Mrs B at the flat after Mr B had been arrested for assaulting Mrs B on 18 December.
- 2.25 Ms W's key areas of concern are:
- feeling that Mrs B was invisible and that nobody considered her needs;
 - the presence of references in other reports of "*severe psychological abuse*" and "*some physical abuse*" towards Mrs B;
 - was Mr B's illness correctly diagnosed and managed – was there more that could have been done;
 - sharing of information between authorities, particularly the police and mental health services.

- 2.26 Mrs B's father, Mr A, told us that he knew "*something wasn't right*" with Mr B and he (Mr A) believed that Mrs B thought the same. Mr A said that Mr B would rarely talk to Mrs B's family, when out at meals or at home; Mr B would sit alone and just not speak, unless he was talking to Mrs B when Mr B would speak in Turkish. Mrs B had said to her father "*that's just his way*". Mr A would avoid going to Mrs B's home, as he didn't like Mr B and felt that he wasn't welcome.
- 2.27 Mr A didn't know about Mr B taking cocaine, or Mr B's admission to hospital in October 2012, and never met Mr B's family. The last time Mr A saw Mr B was at Mrs B's home about one month prior to Mrs B death. Mr A said that Mr B was no different on this occasion, although Mr B told Mr A that the wound on his arm was caused by an injury at work. It was only later that Mr A learned this was not true and that the wound had been caused by Mr B injecting himself with substances.
- 2.28 Mr A was not aware of Mr B's relationship with Miss N until after Mrs B's death.
- 2.29 Mr A wanted us to establish what exactly was wrong with Mr B and to explain why Mr B hadn't been diagnosed. We explained that when a patient presents to mental health services for the first time, with a complex presentation (as Mr B had done) it sometimes takes a while for a number of potential diagnoses to be 'tested'. Mr A was keen for us to establish what the assessment of Mr B was after he had been detained at HMP Belmarsh. We explained that this was not within our remit, as the purpose of the investigation was to identify what lessons needed to be learned during Mr B's period of treatment by the Trust.
- 2.30 Miss A, Mrs B's sister, told us that at first she and Mr B "*got on*" but then she wasn't allowed contact with Mrs B. Later on Miss A was "*allowed back*" but by this time Miss A did not like Mr B, although she was never frightened of him.
- 2.31 Miss A described Mr B as a "*show off*" and that he was "*never serious*". Miss A said that Mr B would say sexual things to Miss A in front of Mrs B and this would make Miss A feel uncomfortable.
- 2.32 Miss A reported that Mrs B had told her about Mr B's relationship with Miss N, but Mrs B had said that Miss N had gone back to Australia. At the time, Miss A did not know that Miss N had returned to the UK.
- 2.33 Miss A wanted to know why Mr B was allowed to go home when "*they knew he was violent and that [Mr and Mrs B's child] was at home*".
- 2.34 We offered Ms W and her legal team, and Mr A and Miss A and their legal team the opportunity to meet with us prior to publication of the report.
- 2.35 We met with Ms W and her legal advisor to discuss our findings. Ms W asked us to make some changes to the information we had taken from our earlier meeting with her.

- 2.36 In October 2017 NHS England sent a copy of the draft report to Mr A and Miss A's legal advisor and offered a meeting with them. NHS England did not receive a response until just prior to the publication of this report and consequently we did not have opportunity to meet with Mr A and Miss A prior to the report being published. The offer remains open for a meeting with them to discuss the content of the report after publication.

Contact with Miss N

- 2.37 At the end of the investigation process, NHS England was able to make contact with Miss N, Mr B's girlfriend. Miss N indicated to NHS England that she would welcome the opportunity to meet with us.
- 2.38 Miss N told us that she first met Mr B in September or October 2011 when they were both working for the same gym in Wandsworth. Miss N said that Mr B was quite a private person and that during the first four to six months of dating he was relaxed but didn't talk about his family very much.
- 2.39 After a bit Mr B would sometimes vanish for a few days and wouldn't respond to text messages or phone calls. When Mr B was back in contact, Miss N asked if there was a problem that she could help with. Mr B admitted that there were some days when he didn't want to get out of bed.
- 2.40 Miss N talked to Mr B about depression and how there were services that could help him. Miss N told us that she supported Mr B to see a GP in Tooting, who was "*very good*" and immediately made a referral for Mr B to see someone from a mental health team. Miss N said that Mr B later described the appointment with the mental health team as "*not particularly helpful*". It should be noted that the evidence we have indicates that Mr B never attended the appointment with the mental health team.
- 2.41 Miss N told us that Mr B had weeks that were "*totally fine*", but then there were weeks where his behaviour was very odd. Miss N described that in the middle of 2012 Mr B had "*manic*" days when he was full of energy and continually wanted to do activities.
- 2.42 Miss N described that in August/September 2012 "*things got worse*". Miss N spoke to Mr B's mother and sister and they indicated that Mr B had behaved in this way on at least one previous occasion. This information increased Miss N's concern about him, and she then started to think that his previous periods of employment had ended as a consequence of his behaviour related to poor mental health.
- 2.43 In September 2012 Mr B vanished for at least a week or ten days. Miss N rang Mr B's sister to express her concern. Miss N was concerned that if Mr B was going through a depressive episode he might be considering committing suicide, because this was something that Mr B had spoken of previously.
- 2.44 Miss N told us that she lived in Wandsworth and that Mr B lived in Croydon, but that she had never been to his home. Neither did she know that about Mrs B or the child. However, in September 2012 Mr B did eventually call

Miss N and asked her to go to his house in Croydon. Miss N agreed to go and it was when she arrived that she first met Mrs B and the child. Miss N said from that point, "*it [Mr B's mental health] was a downward spiral*". Miss N described Mr B as being very paranoid from around September or October 2012.

- 2.45 Miss N said that at this point she had wanted to walk away from the relationship but she was concerned about Mr B and wanted to help because Mr B had asked her to do so. Miss N said she felt that nobody could have coped with what happened over the following months, describing Mr B going into a very fast downward spiral into drinking and drug use. Mr B also emptied all of Miss N's bank accounts having acquired her bank cards from her wallet without her knowledge. Miss N told us that Mr B had taken money from Mrs B for drugs and would bring them back to the home that he shared with Mrs B. Mrs B would then try to find the drugs and remove them from the house so that the Mr B couldn't take them and the child wouldn't find them. Miss N described Mr B's drinking as a significant change, because he had never drunk alcohol previously.
- 2.46 Miss N described Mr B and Mrs B as having a very complicated relationship and that although they lived together as far as Mrs B was concerned, they weren't together. Miss N told us that Mrs B had indicated to Miss N that she was seeing someone that she was studying with. Miss N also said that as far as the child was concerned Mr and Mrs B were mum and dad, and that was it. Miss N told us that Mr B and Mrs B's relationship was so complicated that it was difficult for anyone outside of the relationship to understand it, and she wasn't even sure that either Mr B or Mrs B understood it either.
- 2.47 Miss N said that Mrs B knew that Mr B had issues but that she (Mrs B) either didn't know how to deal with them or didn't want to deal with them. Mrs B gave Miss N the sense that Mrs B believed "*it would all be alright in the end*".
- 2.48 Miss N described a time when Mrs B had called an ambulance when she was concerned about Mr B. Mrs B had then called Miss N who arrived at Mrs B's home. Mr B had been reluctant to get into the ambulance but when the ambulance staff were able to persuade him to do so, Miss N went with Mr B and Mrs B followed in the car. Miss N told staff at the hospital that she believed Mr B needed to be admitted and receive treatment because Mr B had talked about killing himself a number of times and his behaviour had been getting increasingly worse. Miss N told us that when the psychiatric nurse saw Mr B she repeated these concerns, but then Mrs B appeared to change her mind and say that Mr B would be fine and she was keen to take him home. This worried Miss N and she urged the psychiatric nurse to heed her concerns, however Miss N felt that she wasn't heard because Mrs B was Mr B's wife and therefore Mrs B's views were more important.
- 2.49 Miss N told us that the psychiatric liaison nurse didn't ask any questions about the detail of the relationship between Mr B and Miss N and Mrs B. Miss N said she remains unsure whether Mrs B would say that she was Mr B's wife in order to get what she wanted, or whether Mr B pushed Mrs B into saying it to

get what he wanted. Miss N said even at this point she knew there were some “*serious problems*” with Mr B.

- 2.50 Miss N told us that every time she was asked to go with Mr B to a doctor or hospital appointment, nobody really sought to understand how quickly or how much Mr B had deteriorated.
- 2.51 When Mr B was admitted to Croydon Hospital following injecting himself with substances, Mr B’s mother and sister had told hospital staff that Mr B had behaved similarly in the past. Miss N also said that Mr B’s mother had told her that Mr B’s mental health problems had been an ongoing but intermittent feature since Mr B had been in his late teens.
- 2.52 Miss N said that she considered that if Mr B had been unwell previously, and was unwell again, he needed to have “*some sort of intervention*”. Miss N told us that each time Mr B “*had an episode*” it was worse than the previous occasion. Miss N said that Mr B’s maternal uncle and grandfather had been diagnosed with schizophrenia and that Mr B’s mother had reported this information to hospital staff. Miss N knew this to be true because she had been present when that information had been shared.
- 2.53 When Mr B was in Croydon Hospital Miss N had told hospital staff that she didn’t think it was good for Mr B to return to Mrs B’s home because she felt he needed medical treatment. Miss N told us that Mr B’s mother and sister felt similarly and therefore Miss N encouraged them to share their views with hospital staff, because she recognised that her own opinion was being discounted. However Mrs B was still of the view that she could manage Mr B at home.
- 2.54 Miss N spoke of her significant concerns at the prospect of Mr B returning to an environment where a child was present, describing it as being “*not acceptable*”. However this concern didn’t appear to be present in the thinking of hospital staff.
- 2.55 Miss N told us that she had never been aware of any form of domestic abuse perpetrated by Mr B. Miss N described to us Mr B’s paranoia with those around him, in particular Mrs B removing his drugs from their home. On one occasion Mr B was convinced that Mrs B had been taking drugs and had grabbed Mrs B’s hair to inspect her nose. Mrs B had called the police and made a complaint and Mr B was arrested. Miss N told us that she was then contacted by police who asked her to act as an Appropriate Adult⁹, but after she arrived the police determined that Mr B wasn’t fit to be interviewed. Miss N told us that a female police officer had said to Miss N that her view was that Mr B needed to be admitted to a psychiatric hospital. Miss N added that she had told one of the staff who had assessed Mr B in the police cells, that she felt that Mr B should be returned to a psychiatric unit for treatment.

⁹ An Appropriate Adult is responsible for protecting (or 'safeguarding') the rights and welfare of a child or 'mentally vulnerable' adult who is either detained by police or is interviewed under caution voluntarily. www.appropriateadult.org.uk

Miss N said that at this time Mr B was on medication for his mental state, and that she had had to return to Mrs B's home to collect the medication and take it to the police station.

- 2.56 Before Mr B was released from police custody Miss N asked Mrs B what she was going to do. Mrs B had responded by saying that she would have to have Mr B home, because he had nowhere else to go. Mrs B asked Miss N to take Mr B out of the house the following day, and Miss N agreed. Miss N said she didn't know if Mrs B was scared or whether there was a different reason for her wanting Mr B out of the house. Miss N described that day being "very *taxing*" because Mr B wanted drugs, he was paranoid, he talked again about killing himself, and kept calling Mrs B asking to return home. Miss N told us that she thought it was unlikely that Mr B would kill himself at that time as he had talked about it a lot but had not done so. Miss N later called Mrs B to express her concern about Mr B's behaviour and suggest that Mrs B contact the mental health team to arrange for Mr B to be detained again. Miss N recognised that Mr B's behaviour towards others did not warrant police intervention, but she felt that the mental health team would listen to Mrs B because she was Mr B's wife.
- 2.57 Miss N talked to us about the home visits that were conducted by Trust staff. Mr B would manipulate those members of staff by saying that he was fine and was taking his medication, but Miss N didn't believe that Mr B always did take his medication. Miss N told us that Mr B had never had a diagnosis of what mental illness he was suffering from. Miss N said that at that point a full assessment had not been done and that the closest Mr B had come to having a full assessment was when he had been in Croydon Hospital receiving treatment for his arm wound. Miss N later learned that Mr B had been diagnosed with personality disorder following assessment by the prison psychiatrist. She told us that she feels that if this had been diagnosed earlier, staff might have recognised that Mr B had been manipulating many situations. Miss N described home treatment staff as undertaking a checklist procedure only and not being interested in any form of assessment of Mr B's mental state.
- 2.58 Miss N told us that she never felt in danger or scared in relation to Mr B's behaviour and that her overriding feelings were of concern.
- 2.59 Miss N said that she now recognises that Mr B manipulated everyone around him, including her and that he did it in a very skilful way. However, she is undecided about whether it was a conscious behaviour or second nature, "*just the way he was*". Miss N described the manipulation as being a very slow process and that it happened without her realising. Mr B also manipulated other people in order to get what he wanted, for example medical staff when he wanted to leave hospital. Miss N said she felt that the only people Mr B was not able to manipulate were the ambulance staff and the police, describing the ambulance staff as "*playing the game, but knew exactly what was happening*".
- 2.60 Miss N said that she would have expected hospital staff to listen to the people caring for someone with mental health problems, because they were able to

provide a different and more realistic perspective. In addition Miss N and Mrs B had told hospital staff the same information, separately, and that this appeared to be discounted. Miss N described Mr B as being very good at telling hospital staff what they wanted to hear so that he was able to get what he wanted.

- 2.61 Miss N said she was vaguely aware of the court case that appeared to be causing Mr B so much stress. Mr B had told Miss N that “*it wasn’t him*” and that the employers were “*out to get him*”. Mrs B had asked Miss N to make a phone call after Mr B had been admitted to hospital on an occasion when he was due in court.
- 2.62 We asked Miss N about Mr B’s claims of being a cage fighter and taking steroids. Miss N told us that clinical staff never asked her about this information. Regarding the steroids, Miss N said it was not inconceivable that Mr B had taken them but she couldn’t say for definite either way, however she did know that Mr B took illegal drugs. Miss N told us that she was concerned that clinical staff attributed all of Mr B’s behaviours to drug taking. Miss N told us that Mr B had attended boxing classes and was a qualified trainer in mixed martial arts (MMA), however she was not aware that he had ever fought in an event.
- 2.63 We asked Miss N if she was aware of Mr B ever using a different name when attending medical appointments. Miss N said that she was not aware that he had ever used anything other than the name she knew him by.
- 2.64 Miss N told us that she saw Mr B on two occasions following the death of Mrs B and that she had done so as part of her own coping mechanism. Miss N described Mr B as still manipulating others, trying to justify or deny things, and being unaccountable for his behaviours.
- 2.65 We met with Miss N again prior to the publication of the report to discuss the findings. Miss N did not ask us to make any amendments.

Contact with the perpetrator

- 2.66 We wrote to Mr B at the start of the investigation, explained the purpose of the investigation and asked to meet him. Mr B did not respond to our letter so we also wrote to the prison governor and to the manager of the prison healthcare service to ask for their assistance in ensuring that Mr B understood the purpose of the investigation. We did not receive any response from Mr B and subsequently learned that he had informed NHS England that he did not wish to have any involvement in the investigation. We therefore did not have the opportunity to meet with him prior to completing this investigation.
- 2.67 NHS England wrote to Mr B in December 2017 to inform him that the report was ready for publication but no response was received until mid January 2018. Mr B’s family had spoken with him about our report and he had asked them to let us know that he would like to talk to us. NHS England and we met with him on 24 January 2018.

- 2.68 We explained to Mr B that we had reviewed his clinical records from the hospitals and GP surgeries where he had been seen in 2012, talked to staff and reviewed policies and procedures in the hospitals and community teams where he had received care and treatment in 2012.
- 2.69 Mr B told us that the only letter he could remember receiving was the most recent one from NHS England and that he didn't receive it until mid January, even though the letter was dated mid December. He said that he was happy to talk to us and help in any way that he could.
- 2.70 Mr B confirmed he was about 17 when he first met Mrs B, but that they didn't start a relationship for a while because she already had a boyfriend at the time.
- 2.71 Mr B told us that he was the second eldest of his siblings and that he had one older sister, one younger sister and four younger brothers.
- 2.72 Mr B explained to us that he didn't live with Mrs B because he didn't feel safe in her neighbourhood. He felt that Mrs B's neighbours were watching him and that his car would not be safe outside Mrs B's home.
- 2.73 Mr B said that he could remember gassing himself, and trying to hang himself and that he had run out of ideas to try and kill himself so he had looked it up on the internet. It was from looking up information on the internet that he got the idea of injecting the white spirit into his arm. When we asked him why he wanted to kill himself he told us that there were voices in his head telling him to do it.
- 2.74 Mr B told us that on one occasion when he had taken an overdose of tablets, that he had managed to take so many because he had been able to alter the prescription for sleeping tablets given to him by the doctor. Mr B said that he had altered the number of tablets to be dispensed and that the pharmacist in a supermarket pharmacy had not questioned the alteration.
- 2.75 Mr B described the mental health appointment he had attended after seeing the GP in Tooting. Mr B said that he left the appointment because the clinician kept answering his phone and Mr B was becoming increasingly anxious.
- 2.76 Mr B admitted that there was information that he did not share with clinical staff. He felt that he had been able to manipulate people's perceptions of how well or unwell he was by telling staff "*what they wanted to hear*", because he knew the questions they were going to ask him.
- 2.77 Mr B feels that he should not have been discharged from hospital (mental health unit) so quickly and that if he had been kept as an inpatient for longer staff would have been able to tell that he wasn't being honest about how he was feeling.

Contact with the perpetrator's family

- 2.78 It took some considerable time to establish any contact details for Mr B's family. In the absence of any information in client records, we would usually establish this information at the meeting with the perpetrator. However, as Mr B did not wish to meet with us at that stage, this avenue was not available.
- 2.79 We identified the details of the legal team that defended Mr B. NHS England contacted the legal team to ask that they be put in touch with Mr B's family in order to share the investigation report prior to publication. NHS England wrote to the legal team on 8 July 2016 but never received a response.
- 2.80 NHS England therefore made contact with the social worker for the child. The social worker agreed to pass the contact details for NHS England to the family of Mr B.
- 2.81 After some discussion with NHS England, Mr B's family agreed to meet with us and said that there was information about Mr B's care and treatment that they wanted to discuss with us.
- 2.82 Mr B's family said that before he became unwell he had been well groomed and had taken pride in his appearance. But that after he became ill he was often unkempt, unshaven and unwashed. A relative of Mr B took him to see a GP in 2011; the GP was very concerned and referred Mr B to Ferry View (another service). We heard that the staff here were very unhelpful and appeared to judge Mr B. Mr B's relative then took Mr B to see their own GP who was also very concerned and referred Mr B to a mental health team, but that Mr B never attended any appointments.
- 2.83 Mr B's family described a number of occasions when Mr B had been displaying behaviour that would indicate that he was unwell. On one occasion Mr B had barricaded himself into a room in the flat he shared with Mrs B, and had tied ropes around his neck. On another occasion Mr B was in a police cell and was hallucinating, saying there were worms on the cell floor. Mr B's family told us that on this occasion the police were unable to get a psychiatric assessment and so called Mrs B to see if he could return home. Mr B would also call his family thinking they were spies. Mr B's family described a time when they visited Mr B at the flat he shared with Mrs B and he was very unkempt. Mr B thought he was a soldier and said he had been shot in his bottom. His family recalled that he had cake all round his mouth and there was cake all over the floor. Mr B told his family that he planned to switch on the gas to try to kill himself, and did actually switch on the gas and try to put his head in the oven. His family said they were very concerned at this time, and that this was when the mental health team was visiting him at home. Mr B's family told us that the mental health team did not see the flat in this state, because they visited the following day by which time the mess had been cleared up.
- 2.84 Mr B's family told us that they had tried to get help for Mr B on a number of occasions and had called social services, MIND and the Samaritans. They were told to ring 999 and ask for the police and an ambulance, but this

concerned them as the presence of the police and ambulance staff made Mr B worse.

- 2.85 Mr B's family told us that they could not understand why Mr B kept being sent home when he was so unwell, and had a six-year-old child at home. They said that various members of their family wanted Mr B to be sectioned (detained under the Mental Health Act) so that he would receive proper treatment. The family had also "*pleaded with the matron*" to get Mr B help because he had deteriorated so badly within a couple of months. They also told us that Mr B was convinced that his aunt and grandmother had died and that he had attended his grandmother's funeral, yet at the time we met with Mr B's family, his grandmother was still alive.
- 2.86 Mr B's family told us that they felt that clinical staff disregarded information and views from both themselves and Miss N, despite both of them providing the same information and expressing the same concerns. His family also said that they had made clinical staff aware of a family history of bi-polar disorder. We were told that two other family members had been diagnosed following a traumatic event and that they recalled that while Mr B was working at the gym, a client had collapsed after having a heart attack and Mr B tried to resuscitate him, but the client had died.
- 2.87 Mr B's family told us that he has very limited memory of family times from his childhood, for example going to the seaside on bank holidays and other regular family outings.
- 2.88 Mr B's family recalled another occasion when Mr B was hallucinating about a bald man and was looking through letter boxes trying to find him. Mr B was later taken to hospital and transferred to Bethlem psychiatric hospital. We heard that the whole family felt that no service would help Mr B or take responsibility for his care, and that nobody listened to his family who were urging staff to "*section*" Mr B.
- 2.89 Mr B's family told us that they and Mr B were very unhappy at the way in which he was cared for when he was first admitted for the wound he had inflicted on his arm. We heard that when Mr B was admitted to Croydon Hospital in October 2012 Mr B asked the surgeon why he had not been operated on sooner and that the surgeon was very rude saying "*the fact of the matter is you did this to yourself*". There were such significant concerns about his physical health treatment that Mr B had written to the PALS office at Croydon Hospital to complain. Mr B first wrote on 7 November 2012 and Miss N followed this up on 25 November 2012. Mr B received a response from Croydon Health Services NHS Trust on 12 December. Croydon Health Services NHS Trust acknowledged that the A&E doctor who had assessed Mr B on 24 October had sent him home because none of the doctors had appreciated the significance and toxicity of the white spirit being injected into his arm. The letter author noted that relevant information is available on the Toxbase website (used by clinical staff for advice on the management of patients who have come into contact with toxic substances) but that the doctors had not access the database on that occasion. The letter stated that

the “Toxbase website clearly states that admission, elevation of the limb and intravenous antibiotics, with early access to surgery is frequently required”.

- 2.90 A letter of complaint was also sent on Mr B’s behalf (by Miss N) to the Trust on 21 November 2012 but the Trust did not respond until 20 August 2013. The reason for the delay stated in the letter is because of the “*subsequent serious incident investigation*”. The Trust apologised for how Mr B had felt following contact with Dr J and advised that Dr J had been asked to “*spend a little more time in obtaining a past history from his patients*” in future.
- 2.91 Following the meeting with Mr B’s family we considered the issue of the delay in the response to the complaint made to the Trust. Following discussion with NHS England we agreed that although the information came to light after completion of the investigation, this should be a further key line of enquiry and therefore we asked the Trust to provide us with more information. Full details of this line of enquiry can be found at Section 6.
- 2.92 We met with Mr B’s family prior to the publication of the report but due to unforeseen circumstances it was not appropriate to discuss the report at that time. Mr B’s family have received a copy of the draft report and the offer remains open for a meeting with them to discuss the content of the report after publication.
- 2.93 Mr B’s family has told us that he is one of seven siblings, all of whom have the same parents. They have also told us that although Mr B’s father is Turkish, none of Mr B’s siblings nor he ever learned Turkish as children and that Mr B can only speak a few words in Turkish.

Structure of the report

- 2.94 Section 4 sets out the details of the care and treatment provided to Mr B. We have included a full chronology of his care at Appendix C in order to provide the context in which he was known to services in London.
- 2.95 Section 5 examines the issues arising from the care and treatment provided to Mr B and includes comment and analysis. Section 6 considers the actions taken following the complaint made the Trust about Mr B’s care and treatment. Section 7 details our review of three policies key to this investigation: domestic violence policy; adult safeguarding policy; child safeguarding policy.
- 2.96 Section 8 provides a review of the Trust’s internal investigation and reports on the progress made in addressing the organisational and operational matters identified.
- 2.97 Section 9 sets out our overall analysis and recommendations.

3 Background of Mr B

Personal history

- 3.1 Mr B is of Turkish heritage and was born and brought up in London. His father is Turkish and his mother English. Mr B has five brothers and two sisters but told clinical staff that he was not in touch with them.
- 3.2 In the clinical documentation Mr B reported that his childhood was “*alright*” and that “*sometimes he thinks his childhood was happy*”, but his mother evicted three older children (of which Mr B was one) and that “*they were a mistake*” and said she wanted to start again. Mr B reported that his mother started a new family when he was 14 years old and said that he felt abandoned. He said that after this time he started experiencing “*mood swings*” and that he had contact with the police from the age of 17 years. Mr B told clinical staff that his parents were still married and living in South London, but that he didn’t see them very often.
- 3.3 In the clinical documentation Mr B reported being bullied at school and said he was “*different from other kids*”. He said that he could not remember how old he was when he left school, although he did leave with qualifications. Mr B reported that he was off school a lot for “*feeling down*” but said that his parents didn’t know he was feeling down.

Forensic history

- 3.4 In December 2012 Mr B reported to a mental health team that at the age of 17 he was convicted of either GBH or ABH (he wasn’t sure which) for throwing a jar of pickles at “*some guy that worked in the supermarket*”. Mr B further reported that at the time he was calm and that he didn’t feel anything for the victim, saying “*it doesn’t bother me if people get hurt*”. Another conviction disclosed by Mr B at the time was that at the age of approximately 23, he had two convictions for theft from an employer for which he received a suspended sentence.
- 3.5 Mr B told clinical staff that in February 2013 he was due to appear in court having been charged with “*theft employee and fraud*”. He had pleaded not guilty and as at 6 December 2012 he was awaiting a further hearing on 14 December 2012.

4 Care and treatment of Mr B

- 4.1 Mr B was in contact with a number of organisations prior to the death of his wife. For ease we have listed those organisations here:
- Oxleas NHS Foundation Trust – a mental health services provider;
 - St George’s Hospital – a general acute hospital provided by St George’s University Hospitals NHS Foundation Trust. It delivers a range of services including accident and emergency;

- Merton Community Mental Health Team – a community team provided by South West London and St George’s Mental Health NHS Trust;
- South London and Maudsley NHS Foundation Trust – a mental health services provider;
- Croydon Hospital - a general acute hospital provided by Croydon Health Services NHS Trust. It delivers a range of services including accident and emergency.

2011

- 4.2 Mr B presented to Blackheath Standard Surgery in March 2011 complaining of mental health problems. Mr B said that his sleep was poor; that he had urges to kill someone from his previous job and that he felt angry and was destroying things. During this consultation Mr B told the GP that he “*had jarred someone*” when he was 17 years old; that he had difficulty staying in one job for long and that his family had a strong history of schizophrenia.
- 4.3 The GP later received a call from a Ms W (it is unclear which organisation this individual was representing or what professional background she was) to say that she “*does not think he is psychotic or manic depressive and he is not actively suicidal now*”. The GP recorded that Ms W had provided Mr B with the telephone number of the anger management team and the number for urgent psychiatric assessment. Ms W reported that Mr B was also advised to book an appointment with his GP and the GP was advised to start Mr B on some anti-depressant medication.
- 4.4 Mr B was seen again by his GP on 25 March when he reported no suicidal thoughts remaining but said that he was due to attend a hearing at work the following day when he would receive a final warning. The GP indicated that he would be “*happy to help him for a few weeks to be off sick*”, but that Mr B needed to contact the anger management team and take his medication.
- 4.5 In late March 2011 Mr B presented at South Street Medical Centre with ongoing depression. The GP who saw him conducted a depression screen and recorded a score of 23/24. [It is not clear which screening tool was used but information provided to the Domestic Homicide Review Team by the Clinical Commissioning Group, noted that this score was high.] Mr B was referred to Ferryview Health Centre.
- 4.6 In July 2011 South Street Medical Centre received a letter from Ferryview Health Centre to indicate that Mr B had not attended his appointment with the Assessment and Shared Care Team. Information provided to the Domestic Homicide Review team did not find any evidence of any follow up. We have not seen any documents to support the information in this paragraph that was provided to the Domestic Homicide Review team.

2012

- 4.7 In March 2012 Violet Lane Surgery records indicate that GP surgery staff where Mr B had previously been registered had a discussion with Mr B's mother who advised that Mr B's girlfriend had reported him missing. Mr B's mother wanted to know when he was last seen at the surgery. Mr B's mother was informed that Mr B was last seen in April 2011. It is not clear whether Mr B had given permission for this information to be shared with his mother.
- 4.8 On 22 March 2012 Mr B presented at St George's Hospital A&E and reported that his GP had advised him to attend. Mr B stated that he wanted to harm his manager and that he had been arrested for throwing a jar at a friend. Mr B also reported an overdose in October 2011. On assessment Mr B admitted that he had used cannabis two weeks' previously and stated that he lived with his girlfriend, Miss N (who was also recorded as his next of kin) and that he had no children. The plan was for him to be discharged home and then to be seen by the mental health community team eight days later. Mr B was prescribed 5mg diazepam for three days and was advised to see his GP if he needed further medication. We have not found any evidence that a report of this attendance was sent to any of the GP practices that Mr B had been in contact with.
- 4.9 On 5 October Mr B was taken to Croydon Hospital A&E by ambulance and accompanied by police following three days of self harm. Mr B reported a three week period of low mood with increasing thoughts of self harm. Over the three days prior to admission he had taken an overdose of diazepam, attempted to hang himself, and taken cocaine with the intention of harming himself. Mr B reported that he was living "*between his partner's home, his ex-wife's home and friends' homes*". Mr B told liaison psychiatry staff that he had a long history of depression and cycling mood and that he had seen a psychiatrist on several occasions. He also said that he had been "*diagnosed with depression and bi-polar disorder having been seen in Tooting and Greenwich*". Trust records note that Mr B "*attends for the first appointment and does not return and does not follow the treatment plan*". Mr B initially denied any alcohol or substance misuse but later disclosed to the AMHP that he had been using steroids for the previous three weeks. His presentation was agitated and aggressive and not wanting to engage in the assessment process, however as the assessment progressed his behaviour became increasingly inappropriate. He poured water on the floor of the room, emptied the paper towels, emptied the gloves, threatened to trigger the fire alarm, tried to pull the wires from the computer and set off the alarm in the room on several occasions. Mr B's mood appeared to fluctuate between being calm, rational and engaging to being verbally aggressive and elated. Mr B was assessed by the psychiatric liaison service but no evidence was found of psychotic symptoms. Liaison psychiatry staff recorded that "*A&E records show*" that Mr B was considered medically fit for discharge. The psychiatric liaison service staff spoke to Mr B's carer who expressed concern about his safety, stating that Mr B's mood was cycling and that he would be at risk again if he left the A&E department. Mr B was offered an assessment by the psychiatrist but refused, stating that he didn't want to stay in the A&E department. He was given information about where he could get help in the

future should he need it. There are no entries relating to this attendance in the records provided by Croydon University Hospitals Trust. We have found no evidence that information was provided to Mr B's GP by either the Trust or Croydon Health Services Trust following this attendance, however on 10 October Trust records show that staff checked Mr B's details using their NHS Smart Card and found "*No GP Registered*".

- 4.10 On 23 October Mr B presented to Croydon Hospital A&E accompanied by his "*wife, mother and father*". Mr B stated he had tried to kill himself three weeks previously and that on that day he had taken cocaine and steroids and had drunk and injected white spirit into his arm. He also reported having tried leaving the gas on and sucking the gas from the cooker. Mrs B reported to liaison psychiatry staff that Mr B had a history of abusing cocaine, and that he had taken cocaine that day. She also reported that Mr B had accused her of having an affair and that they (Mr and Mrs B) had a six year old child living with them. An informal admission to a psychiatric ward was initially agreed with Mr B, however when he was informed about where he would be admitted he changed his mind and said that he didn't want to go to hospital. A Mental Health Act assessment was therefore requested. An AMHP and two Section 12 approved doctors¹⁰ assessed Mr B shortly after midnight. They discussed Mr B's recent behaviour with him and Mr B said that he sometimes felt so low that he acted impulsively and that he had no control over his feelings; Mr B also said that he later felt frightened about his actions. Mr B's wife and child were noted as protective factors. The Section 12 approved doctors felt that the least restrictive treatment plan would be to involve the home treatment team for assessment of his depressive and mood difficulties. Mr B said he would agree to working with the home treatment team staff but that he didn't want to be admitted to hospital. Given Mr B's acceptance of help it was agreed that he couldn't be detained under the Mental Health Act. Mr B was therefore discharged from A&E back to his home address that he shared with Mrs B.
- 4.11 On the afternoon of 24 October Home Treatment Team staff Ms C and Ms S visited Mr B at home. Mr B was in bed when staff arrived and Mrs B informed them that Mr B was in a lot of pain. Ms S recorded that they found Mr B writhing about in bed complaining of severe pain in his arm where he had "*injected white spirit*". On examination of his arm Ms S noted that Mr B's hand was very swollen, almost white in colour, the lower arm was also very swollen, red and discoloured in places. Mr B said that he was unable to move his fingers and was shivery, his forehead was very hot to the touch. Ms C and Ms S were so concerned about Mr B's physical health that they advised him to attend Croydon Hospital A&E immediately. Mrs B agreed to drive him. Ms C and Ms S advised Mr and Mrs B to contact them later to update them and Ms

¹⁰ A doctor who is 'approved' under Section 12 of the Act is approved on behalf of the Secretary of State (or the Welsh Ministers) as having special expertise in the diagnosis and treatment of 'mental disorders'. Doctors who are approved clinicians are automatically also approved under Section 12. Section 12 approved doctors have a role in deciding whether someone should be detained in hospital under Section 2 and Section 3 of the Mental Health Act. www.mentalhealthcare.org.uk

C contacted the psychiatric liaison service at Croydon Hospital to inform them that Mr B would be attending A&E.

- 4.12 On arrival at Croydon Hospital Mr B was seen in A&E and then admitted to an orthopaedic ward. Mr B reported to Trust staff that the previous day he had been feeling suicidal and had *“injected cocaine, fly spray and white spirit”* into his arm in an attempt to end his life. He also said that afterwards he had been annoyed that he hadn’t been successful. Following assessment by the orthopaedic team, it was agreed that Mr B required surgery to remove unhealthy tissue in order to encourage the wound to heal.
- 4.13 On 25 October Croydon Health Services NHS Trust staff informed Mr B that the operation would need to be repeated 48 hours later for a further assessment of the injury as there remained a gap in the skin of Mr B’s arm of 4-5cm width, by 10cm length. Shortly after Mr B was given this information in late evening, psychiatric liaison staff were called to the ward as it was reported that Mr B had been presenting with several management problems. Several members of Mr B’s family were present when Ms M, Senior Clinical Charge Nurse from psychiatric liaison arrived on the ward. It was reported that Mr B’s relatives had acted in a confrontational and accusatory manner towards ward nursing staff about ignoring Mr B and allegedly *“telling him that it was his own fault why he was in the situation”*. (Mr B’s family has told us that they did not consider their behaviour to be confrontational. They shared their concerns about Mr B’s mental state and pleaded with staff to get the help that Mr B needed, even if it meant detaining him under the Mental Health Act). Mr B told Ms M that he had repeatedly asked ward staff to give him something to help calm him, but he believed he was being ignored. Mr B also spoke of his fear and vulnerability being on the ward and his worry of possible amputation of his arm or total loss of use, and the effect this would have on his physical self-image. Ms M spoke with Mr B’s mother, brother, father and *“ex-wife”* whom she understood had been visiting throughout most of the day. Ms M suggested that the family members go home so that Mr B could get some rest - they agreed and left the ward. Ms M spoke at length to Mr B and reinforced which behaviours were and were not acceptable on the ward. Mr B agreed to *“tone down”* his irritability. The agreed plan at this point was for further review of both physical and psychotropic medications; assess Mr B’s mental state and toleration of current pain management; observe for signs relating to possible opiate withdrawal; consider whether a one-to-one psychiatric nurse was required; and review the progress of the current treatment plan.
- 4.14 The same day Home Treatment Team staff were informed by liaison psychiatry staff that Mr B had been admitted to an orthopaedic ward at Croydon Hospital and that he would remain on the caseload for the psychiatric liaison service. Mr B was therefore discharged from the Home Treatment Team caseload with advice that, if appropriate, Mr B should be re-referred on discharge from Croydon Hospital.

- 4.15 On 26 October the orthopaedic doctor explained to Mr B that necrotic tissue had been removed and that he had compartment syndrome¹¹. The doctor said that it was not possible to predict how much muscle function would return and explained *"it would be difficult and he had to be patient"*. Later Mr A, Psychiatric Liaison Nurse reviewed Mr B who could not recall the events of the previous evening. Mr B presented as calm and rational during interview, reported a history of low mood, suicidal ideation and *"giving up in life"*. Mr B stated he was happy to remain in hospital for further medical treatment and follow up by mental health services upon discharge from Croydon University Hospital. Mr B requested that his wife be allowed to stay with him overnight as it made him feel less *"paranoid and trapped"*. Mr A noted that if this were not possible, a one-to-one psychiatric nurse for overnight should be considered. The agreed plan was that if Mr B tried to discharge himself against medical advice, detention under Section 5(2) of the Mental Health Act¹² should be considered.
- 4.16 On 27 October Mr B was seen by Ms O, liaison psychiatry nurse, both independently and then with his wife. When seen independently Mr B was standing in an upright position visibly distressed by physical pain. Mr B said that his pain was not well managed and became anxious, as he believed that Ms O was there to arrange for him to be moved to another ward. Mr B explained that during the night he had had a nightmare and had responded in an aggressive manner, which had disturbed other patients. Mr B said that he had apologised to those patients that morning. When seen with his wife, the general opinion appeared to be that Mr B continued to be irritable and impulsive. Mr B believed that Croydon University Hospital staff on the ward were unsympathetic to him and that staff attributed his current situation to his own making and said that this view upset him. Mr B's wife remarked that his behaviour had improved during the three days he had been on the ward - Mr B said that his wife had a positive influence in controlling his agitation on the ward. Ms O recorded that although Mr B was calm during assessment, she was not certain that his agitation and challenging behaviour was being well managed in terms of medication therapy. The plan was to discuss Mr B's medication management with the on-call psychiatrist the following day.
- 4.17 On 28 October Ms O reviewed Mr B again. There was no change in Mr B's presentation compared with the previous day, his pain was not managed by the medication, he was unable to sleep during the night, and continued to experience fleeting thoughts of self harm. Ms O assessed Mr B's risk to self and others as moderate and noted that his risk was managed at that time by the presence of his wife. Ms O suggested to Croydon University Hospital ward staff that they consider using antihistamine to manage his anxiety.

¹¹ Compartment syndrome is a painful and potentially serious condition caused by bleeding or swelling within an enclosed bundle of muscles (a muscle 'compartment').

¹² Section 5 (2) is a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act 1983. This ensures their immediate safety whilst the assessment is arranged.

- 4.18 On 29 October Dr S, from the liaison psychiatry team came to assess Mr B, but Mr B was recovering from surgery and in a deep sleep. An entry in the Croydon University Hospital records indicates that Dr S discussed a plan with Mr B's wife: to use regular diazepam and to be reviewed again the same day if possible. We found no corresponding entry in the Trust records.
- 4.19 On 30 October Mr B was seen on the ward and his case was discussed with the Trust and Croydon University Hospital medical staff. Mr B gave a history of many attempts to self harm and end his life and described the attempts as being triggered by various changes in his circumstances, some may be minor/trivial such as an argument with his wife. Mr B denied being a regular user of alcohol or illicit drugs, but admitted occasional usage when his mind was disturbed and having unpleasant moods, when he would use anything available to harm himself. Mr B said he was happy to still be alive after his last attempt to kill himself and wanted to make positive changes in his life. The plan was to refer him to talking therapy, gradually reduce the diazepam, start sertraline 50mg and to be reviewed by the liaison team the following week or earlier if necessary.
- 4.20 On 4 November a nurse transfer letter was completed by Croydon University Hospital staff, however it was unclear to where Mr B was being transferred. Risk issues were noted as self harm and "*needs wife to be there at all times or special*". It is unclear from the Trust and Croydon Health Services NHS Trust records what resolution was in place at this point. However we believe this was intended to accompany Mr B on transfer to St George's Hospital; a transfer that did not take place.
- 4.21 On 5 November Ms L, liaison psychiatry, assessed Mr B as an emergency. Mr B had not been sent to St George's Hospital as according to the notes there were no beds, however the Croydon University Hospital ward sister had said his referral had not been accepted due to the history of self harm. The ward sister advised that the "*plastics team would see Mr B in his current ward*". When Ms L went to see Mr B, he was being treated by the tissue viability nurse, so Ms L was unable to assess his mental state properly. Ms L recorded that her impression was that Mr B was not currently suicidal and the plan was to complete the assessment the following day or later in the week.
- 4.22 At 10:45 on 6 November Mr B was seen by Dr M, staff grade psychiatry doctor and the ward sister. The ward sister informed Dr M that Mr B had been very unsettled, getting angry with staff and had threatened the security guard with a knife. He had become fixated on a ward nurse who used to be a neighbour and said he wanted to murder her. Mr B had also described suicidal thoughts. Dr M noted that Mr B had three female visitors staying by his bed 24/7 which had been agreed by the ward nursing staff; Mr B stated they were his "*life-line*" in hospital. Mr B described that he felt he "*wanted to murder the nurse who used to be his neighbour and that he felt suicidal as if was going to kill himself she would deserve to go as well*". Mr B said that he heard voices that had a negative content but denied that they directly instructed him to harm others, although Dr M felt that may be some potential association. Mr B said he saw a little man at the end of his bed with a "*screwed up face*". He was aware that nobody else had seen the man and said that this had concerned him, as he

was *"unable to tell reality"*. Mr B expressed concern about being taken to a psychiatric unit and being locked away against his will but accepted that he needed help to talk about his issues. The plan was for an urgent psychiatric assessment to be completed and for transfer to inpatient care to be arranged. Dr M clarified that if Mr B would not agree to informal admission a Mental Health Act assessment should be undertaken, given the risks and threats of harm to others. Surgical staff agreed to the transfer to psychiatry and indicated they would provide a surgical handover for Mr B's ongoing physical care. Dr M noted that ongoing risk assessment was needed as well as psychiatric assessment to determine the appropriate management. A bed was identified at The Dene Hospital in Hassocks however, Dr V, the liaison psychiatry specialist registrar was of the opinion that a transfer to The Dene would not be in Mr B's best interest as it was *"clear that his surgical situation is NOT stable and he requires close ongoing care"*. Dr V noted *"clear narcissistic and antisocial personality traits that complicated the picture"*. Dr V noted ongoing risks of *"IMPULSIVE self harm and, because of his nature, these are likely to be violent and extreme. There are also risks of violence towards others, but I am not convinced these are driven by mental illness"*. Dr V considered that Mr B's surgical situation was not sufficiently stable for a move to a psychiatric bed to be successful and recorded his opinion that a transfer to the bed in Hassocks was not in Mr B's best interest. Dr V noted that Mr B was accepting psychiatric medication, and was consenting to informal psychiatric admission when required. It was therefore decided that there would be no requirement for further assessment under the Mental Health Act and that Mr B would remain at Croydon Hospital. Mr B was advised that if his behaviour became unmanageable again, staff would call the police. Dr V continued to prescribe sertraline and diazepam with haloperidol as required to manage Mr B's agitation and zopiclone at night to help him sleep.

- 4.23 On 7 November Dr I, SHO from liaison psychiatry assessed Mr B who stated he wished to be discharged home with input from the Home Treatment Team and 24 hour telephone helpline access. Dr I noted his wife supported Mr B at home and that Mr B felt that his wife was the only person who stopped him from harming himself. Dr I recorded that Mr B had a six-year-old child and that he denied harming himself when his wife or child were around. Mr B reported that his wife would be taking time off work to care for him and that Mrs B did not want Mr B to be admitted to a psychiatric unit, as this would *"unsettle him"*. Dr I noted that Mrs B confirmed that prior to being admitted to hospital three weeks' previously Mr B experienced hallucinations. Mrs B reported that he seemed possessed and like he was being controlled by something. Mr B had reported that he thought his wife was pregnant but now did not believe this. The surgical team from Croydon University Hospital informed the liaison psychiatry team that Mr B would be discharged home that day. Therefore it was agreed that Mr B would be referred to the home treatment team, consideration should be given as to whether the Mood and Anxiety CAG may be appropriate, and an IAPT referral form was given to Mr B. Dr I reduced the diazepam to 5mg bd and to continue sertraline. Liaison psychiatry staff checked Mr B's registered GP information using the Smart Card system after a discharge letter was returned from Waterfall House noting that Mr B *"was no longer registered"*. The check confirmed that Mr B

was not registered at any GP surgery at that time. This information was entered into a Single Assessment Process contact assessment completed by a staff nurse at Croydon University Hospital; the document also recorded Mrs B's name as her maiden name.

- 4.24 On 8 November Ms S, from the home treatment team visited Mr B at home with a colleague. Mr B's speech was hard to follow and difficult to interpret at times; Mr B informed staff that he was "*feeling very 'horny'*" and that "*he and his wife had intercourse six times overnight but he was unable to ejaculate*". Mr B said that his time in CUH had been very stressful and was adamant that the nurse that had been his neighbour had been "*winding him up*". Mr B told staff that as long as his wife was with him "*he would be fine*". Mrs B told staff that Mr B would never usually discuss personal issues with anyone and that he had experienced mood swings and hallucinations since childhood, but his presentation at that time was unusual and she felt it had worsened since he started taking the antidepressant a week previously. It was noted that Mr B was not registered with a GP but that he intended to sort this out. Mr B registered with Violet Lane Medical Practice later that day.
- 4.25 On 9 November home treatment team staff received a call from Mr B stating that the wounds on his arm were infected and he had been told by walk-in clinic staff to go straight to A&E as his arms were leaking puss. Mr B said that he would therefore be unable to attend the medication review with the doctor that day. Home treatment team staff called liaison psychiatry at A&E to inform them Mr B was on his way and recommended that liaison psychiatry staff read the previous entries regarding Mr B's inappropriate behaviour.
- 4.26 On 11 November Mr C, a STAR worker and Mr T, an AMHP (both from the home treatment team) visited Mr B at home. Mr B was at home with Mrs B and their child. Mr B was calm and able to converse coherently. His main concern was the injury to his arm and the difficulties getting it dressed - he described being anxious when having to wait and becoming frustrated that the wound was infected. Staff assured Mr B that a home treatment team doctor would see him early the following week when he would be able to discuss his concerns. Mr B's care plan was recorded as daily home visits to monitor his mental state and risks to self and others; encourage concordance with his medication; regular medical reviews with team doctors; offer education regarding illicit drug use; and facilitate handover to the appropriate team in due course. It was recommended that staff did not visit Mr B unaccompanied due to this risk profile.
- 4.27 On 12 November Mr C and Mr G, a Crisis Resolution Practitioner from the home treatment team visited Mr B at home. Initially he was seen with his wife and child present, but as staff were discussing his mental health and risks they "*agreed that we would see him on his own*". Mr B engaged well but at times seemed distracted or perplexed; Mr B described times when he felt he was not there and that things were not real. Staff discussed Mr B's work and recent events, Mr B explained that he hadn't disclosed his previous criminal record so that he could secure the job but was later told he may need to do some work at Buckingham Palace so then chose to disclose his criminal record. Mr B was particularly concerned as the judge had told him to expect one year in

prison. Mr B said he *"would rather be dead than go to prison"*. Staff noted the statement was at odds with a typical criminal who would not be bothered by a small sentence. Mr G was happy that Mr B's guarantee of maintaining his own safety and protective factors of wife and child would be sufficient to keep him safe. Mr B denied thoughts or plans to self harm. It was agreed that Mr B needed an urgent medical review and that daily contact should be maintained. Mr C completed a child needs and risk document and noted that Mr B's mental health was likely to impact on his capacity to meet the needs of his child. Mr C considered that further information about Mr B's child was required and that this should be followed up with liaison psychiatry staff at A&E. Mr C noted that he had *"handed this over to the team to gain further information on 30/10/12"*. Mrs B was recorded as an alternative carer for their child.

- 4.28 On 13 November the home treatment team discussed Mr B's case during their ward round meeting. Mr B's history was noted, as was the fact that a psychiatric medical review had been planned for 9 November but Mr B had been unable to attend as his arm wound needed medical attention. Staff considered that the risks to Mr B's child needed to be assessed further; it was noted that staff had asked that the liaison psychiatry team followed this up. This was noted as *"PLEASE ACTION"*. (We have looked at this information in detail and it is very difficult to determine which incident this refers to because the paperwork provided does not make this clear). Staff discussed Mrs B's views about Mr B's mental state historically and currently. The view of the team was that Mr B was likely to have personality traits, compounded by abuse of prescribed and non-prescribed drugs. They considered the possibility of a functional illness, and that the recent hypo-manic presentation may be secondary to stimulant use or possibly caused by his current medication. A number of risk issues were discussed: staff were considerably concerned about Mr B's six year old child who was living at the address, risk to himself and others (partially mitigated by involvement by the team). The agreed plan was to offer a medical review two days' hence (Thursday); the team to make an urgent referral to child to social services; ask Mr B to provide a urine sample for testing for illicit drugs at the next visit; continue visits in pairs; and to maintain a low threshold for admission given potential risks to himself and others. Following the ward round Ms R, an AMHP, called Mr B to offer him an appointment that evening. Mr B said that he was fine and more settled in his mental state and therefore did not require a visit that evening but *"would appreciate one tomorrow"* morning. Mr B said that he continued to attend A&E to have his wound dressings changed. Ms R informed Mr B of his medical review with Dr J on 15 November, Mr B said that he had another appointment with the muscular specialist that day so *"would appreciate another appointment"*. Ms R noted that Mr B's risks continued through an unstable mental state in the context of stress he was experiencing at that time.
- 4.29 On 14 November W and D, home treatment team staff, saw Mr B at home. Mr B was noted as being welcoming, with no hostility or aggression shown. His mental state was stable and he denied hallucinations but reported that he easily forgot things. Mr B reported he was taking his medication and that he had some left. Staff informed Mr B of the medical review on 16 November and that his child had been referred to Children & Family social services noting *"he was okay with that"*. A urine sample was collected and sent for screening.

- 4.30 On 15 November home treatment team staff contacted Croydon children and family social services to see if they had already received a child in need form. Social services confirmed that they had received a form from A&E on 6 October. This statement was confirmed in the review of information provided to the Domestic Homicide Review team by Children's Social Care. Mr R and Ms S visited Mr B in the evening; he was at home with his wife and child. Mr B reported that his mood was a little low in the morning and evening but said he had been sleeping well. Mr B denied taking any illicit substances since his admission to Croydon Hospital and informed staff that a skin graft would be required for his arm. Staff reminded Mr B of his medical review the following morning. No risks were identified.
- 4.31 On 18 November Ms G, a STAR worker and Mr T visited Mr B at home. Mr B appeared bright but his speech was rapid and he informed staff "*he was getting worse*". Mr B stated that when waking at 4:00 – 5:00 am he was experiencing increased thoughts to self harm. He stated they went during the day and he was "*fine all day*" but then his mood became low before going to bed. Mr B was concerned that his medication could be wearing off. Mr B reported that he kept himself distracted during the day by going out, playing computer games etc. He told staff he was "*never left alone and gestured to a female whom he called his carer. She stated that she used to be his boss.*" Staff suggested he discuss the issue of medication with the home treatment team medic at his review the following day. Staff noted that Mrs B was out with their child for the day but that Mr B had to ask his carer where his wife was. No immediate risks were identified at time of meeting.
- 4.32 On 19 November at 4:10pm Mr B attended a psychiatric medical review with Dr J. Mr B reported that he felt supported by his wife stating: "*I'm not going to kill myself while I'm supported by my wife*". Dr J discussed Mr B's long history of affective instability without triggers but Mr B was unclear and inconsistent when Dr J tried to clarify numerous statements from earlier entries in Mr B's records. Dr J noted no evidence of mental illness that day and suggested to Mr B that his anxiety could be related to his court hearing and that the anxiety may reduce once he had attended. Mr B appeared surprised, saying that he "*thought you would be writing to the courts to say I could not go*" and that home treatment team staff had indicated that "*being under HTT was like being in hospital so I wouldn't need to go*". Dr J described the support that could be provided to Mr B and he responded: "*I'm not worried about going, it's just that I was told I didn't need to go*". Dr J's impression was that Mr B had mixed personality traits (both antisocial and emotionally unstable) and recorded Mr B's risk of impulsive suicide as moderate to high. Dr J made no changes to Mr B's treatment regime. The agreed plan was to continue daily visits by the home treatment team to closely monitor Mr B; and for home treatment team staff to obtain some history from Mr B's family (following consent) regarding the inconsistencies in Mr B's presentation. At 5:40pm home treatment team staff received a call from Mr B's friend, Miss N, who was concerned about Mr B following his appointment with Dr J earlier. Mr B had called Miss N because "*he was told that his anti-depressant was going to be stopped and he was losing hope for the future*". Miss N said she was as unsure why Mr B's medication was being stopped. Home treatment team staff told Miss N that there were no immediate plans to discharge Mr B and he would be seen again

the following day but that Mr B could ring the team if he wanted to discuss aspects of his care in the meantime. At 8:30pm Miss N left a message on the home treatment team answerphone, as she was more concerned about Mr B's risk of suicide. Staff rang Mr B and spoke with "*both him and his wife*". Mr B said he was not happy with how the meeting with Dr J had gone and said he felt the doctor didn't listen to him. Mr B also said that staff had told him that he wouldn't have to attend court because of his involvement with the service and that he had subsequently been told by Dr J that he should attend. Home treatment team staff advised Mr B and his wife that if they were concerned about his safety overnight to call an ambulance and go to Croydon Hospital for assessment by psychiatric liaison. Mr B talked about going to the hospital the following day to have further treatment on his arm. Staff reinforced that Mr B had not been discharged from the service and that he would continue to be supported and assessed during the court case.

- 4.33 Also on 19 November Mr B attended a new patient health check at Violet Lane Medical Practice. Basic observations were completed and recorded. On the same day Violet Lane Medical Practice received a copy of a letter dated 14 November from Croydon IAPT to Mr B advising that a referral had been received and that the waiting time was approximately seven weeks. The letter included a form that Mr B needed to return within 28 days in order to remain on the waiting list.
- 4.34 On 20 November Ms S received a call from a woman who stated she was Mrs B and asked Dr J to call her. Ms S noted that the woman had an Australian accent, that she had met Mrs B several times and noted that the voice was different. Ms S reflected this information to the caller but the caller insisted she was Mrs B. Later a call was received from Mrs B advising that she and Mr B were at the vascular clinic that day and would not be at home for the scheduled home visit.
- 4.35 On 21 November the home treatment team received a call from Mr B advising that he was going to have further surgery that day and that he had run out of medication. Staff recorded that Mr B had no thoughts of suicide or harm to self or others reported. Mr B repeated that he was not happy with the Trust doctor who had seen him and wanted to complain. The staff member advised Mr B how to complain and arranged for a prescription for further medication for Mr B to collect. Later home treatment team staff discussed Mr B in ward round. It was noted that Mr B had informed staff that his court case was the following day and that Croydon Hospital staff had advised that Mr B was being admitted for day surgery only and would be discharged by the end of the day. It was agreed that the liaison psychiatry team should be given this information in order to undertake a risk assessment before surgeons discharged Mr B that afternoon, given the concerns about Mr B's increased risk of self harm in relation to the court case. Home treatment team staff also noted Mr B had told them that his wife didn't understand his psychiatric condition but that his friend (Miss N) did. At 11:10am the liaison psychiatry team recorded that they had received a call from the home treatment team advising that Mr B was awaiting day surgery and that it was expected he would leave hospital by 6:00pm that evening. At 5:00pm home treatment team staff received a call from Mr B to say that he was still in hospital following his operation. Mr B admitted that he

had left the ward earlier in the day *“as things were taking too long, however a doctor from CUH had called him and advised him to return which he did”*.

Mr B appeared animated and did not mention feeling low or suicidal. Staff agreed to speak to Mr B again once he had left the hospital, to arrange next contact. At 8:55pm Mr B called the home treatment team and spoke to Mr G to ask if he would be visiting, as Mr B had just returned from CUH. Mr B was advised that visits were not undertaken late in the evening but that Mr G was happy to chat to him on the phone. Mr G asked Mr B if he would be attending court the following day, Mr B said not as the surgeon had given him a letter to excuse him as he had an open wound and would be risking infection. Mr G asked if Mr B was feeling suicidal; he said not.

- 4.36 On 22 November Ms C called Mr B as he had requested a visit before 6:00pm that evening. Ms C apologised that she was already committed and offered a later appointment or an appointment the following day. Ms C advised Mr B that she wanted to discuss onward referral to psychological services, which would be able to provide support to him in the longer term. Mr B was happy with this and confirmed the court date had been delayed due to his physical health. Ms C noted that originally the home treatment team would support Mr B during the court case but that had been postponed. Ms C said that the home treatment team would visit Mr B the following day to assess his mental state and risk, and that if he was no longer in crisis, the team would consider discharging him to his GP with a suggestion for onward referral to CIPTS for psychological assessment and intervention. Ms C also noted that home treatment team staff *“should assure [Mr B] that we will be making an onward referral to CIPTS for psychological assessment and intervention”*.
- 4.37 Also on 22 November Mr B attended an appointment with his GP at Violet Lane Medical Practice. The GP noted that Mr B had debridement and necrotic tissue excision on his right forearm where there was a gaping wound. The GP also noted that Mr B was on treatment for bipolar disorder and that the home treatment team psychiatrist thought that Mr B might need further assessment. Medication was noted as metronidazole 400mg and flucloxacillin 500mg. Mr B was given a medical certificate for the period 31 October 2012 until 1 January 2013.
- 4.38 On 23 November Ms C and Ms S visited Mr B at home, he appeared to have been sleeping prior to the visit. Staff discussed the call where discharge plans had been mentioned but Mr B appeared unsure about what was happening. Staff reiterated that the referral to CIPTS was for psychological therapy and this was considered the best way for Mr B to move forward. Mr B said he was still unhappy about the medical review and felt the doctor had judged him. Mr B admitted that he put on a brave face when staff visited, so he was reminded of the importance of being honest and reassurance was given that staff were not there to judge him. Mr B spoke about the court case and said if he went to prison he would *“kill himself as he wouldn’t be able to cope with being locked up”*, although Mr B confirmed that he had no thoughts of harming himself at that time. Mr B was provided with one week’s supply of medication and was encouraged to make a GP appointment before his medication ran out. He was also encouraged to keep a mood diary and to allow his family to have input. Mr B was then discharged from the home treatment team

caseload, noting that a discharge letter would be sent to his GP and a referral to CIPTS needed to be made.

- 4.39 On 26 November there was an email exchange between Miss N and a secretary at Croydon Hospital. Miss N emailed advising that she was caring for Mr B and that Mr B wanted a second opinion and something in writing from Miss V, vascular surgeon, regarding the treatment of his arm. Miss N advised that Mr B's view was that he should not have been sent home from hospital when he first presented at A&E. Miss N also advised that she and Mr B were making a complaint against A&E for sending him home, a decision which they believed made his arm worse and resulted in Mr B requiring surgery and a long recovery. Miss N indicated that Miss V had agreed with Mr B and that Miss V had said she would be able to give a second opinion agreeing that Mr B should have been treated and not sent home on the first day. The secretary advised that she would pass the email on to Miss V.
- 4.40 On 27 November Dr J wrote to Mr B following his medical review on 19 November. Dr J enclosed a self referral form for the IAPT service and advised Mr B that should he require further psychological intervention his GP would be able to refer directly to CIPTS. The Trust has told us that when the home treatment team discharged Mr B, staff asked Mr B's GP to refer him on to CIPTS and that according to Trust records CIPTS received no such referral. We have not found any evidence of this request to Mr B's GP in either Trust or GP records.
- 4.41 On 28 November Mrs B called home treatment team staff seeking advice as Mr B was agitated and suicidal. Staff advised that Mr B should visit his GP or attend A&E for assessment. Ms J discussed the issue with the team manager who explained there was no further intervention from the home treatment team that would be helpful in the short term. At 4:45pm Ms A, liaison psychiatry team, assessed Mr B at the request of A&E staff. Mr B had presented to A&E accompanied by his wife. Mr B reported that he had taken an overdose of one box of ibuprofen (unclear whether this was 12 or 24 tablets) at 12 noon. Mr B said that his wife did not see him take the overdose and didn't know about it until she found him with lots of tablets around him and stopped him taking more. Mr B said he felt suicidal and had the intention of killing himself and made reference to the court case on 29 November. Mr B reported that he had an episode of being manic (query bipolar disorder) and that during the episode he felt suicidal and believed he would try again to kill himself. Ms A sought confirmation from the A&E medical team that Mr B was physically okay and contacted on call psychiatrist for further assessment. At 7:40pm the CT1 liaison psychiatry doctor assessed Mr B who was now accompanied by his wife and his friend Miss N. Mr B reported that the previous day he had received a letter from the courts reminding him of his appearance the following day. This had triggered a sudden increase in his thoughts of ending his life. Mr B reported he had taken ibuprofen in secret but had been interrupted by his wife. Mrs B reported that she had tried to persuade Mr B to go to A&E but he refused so Mrs B called an ambulance. An informal admission was planned and Mr B was advised that the admission will be short and staff would have no influence over court appearance. Mr B would be expected to attend court the following morning and this would be organised by the ward. The CT1 liaison

psychiatry doctor noted that assessment was required for clarification of a diagnosis (query personality issues, query depression). The CT1 liaison psychiatry doctor increased the prescription of sertraline to 100mg OD with plans to increase further later. One to one observations were recommended as Mr B's risk of self harm was likely to increase prior to his court appearance. Liaison psychiatry staff completed a child needs and risk form; the primary carer first name was recorded incorrectly as "*Ruth*" but all remaining entries were the same as the previous child needs and risk document.

- 4.42 On 29 November at 12:05am Mr B was admitted as an informal patient to Gresham's 2 ward (a mental health inpatient ward), "*escorted by his girlfriends*". He was admitted with an intravenous cannula in his left arm. One girlfriend asked staff if she could stay with him on the ward for the whole night; this wasn't possible and staff explained why (Mr B was on a male ward). Mr B became agitated and angry due to this decision and started kicking the door and tried to pull out the cannula, which resulted in blood splashing over the corridor. Staff "*quickly de-escalated*" the incident and accompanied Mr B to his room. The duty doctor attended and removed the cannula. Mr B initially refused any nursing intervention but eventually allowed his physical observations to be done; all were in a normal range. Staff noted "*family dynamics unclear*". Later that day Mr B was discussed in Gresham's 2 ward round; his diagnosis was noted as "*mixed traits of dissocial and emotionally unstable personality disorder*". Staff reported that Mrs B had no concerns for their child's safety at home and that Mr B had denied thoughts of harm towards his child or his wife. Mr B had admitted he could be impulsive at times, using an example of spending £100 on lottery tickets on one occasion. Mr B reported feeling paranoid and having hallucinations and said that others had told him that he had previously thought people had kidnapped his wife. Staff had discussed talking therapy with Mr B, which would provide long term help, Mr B had responded by saying he thought he needed medication for short term therapy. Staff views were that the suicide attempt was an impulsive act and found no evidence of a depressive disorder. Mr B had indicated he was willing to make contact with the Sun Project¹³ and comply with additional medication. The agreed plan was for: additional sodium valproate to be prescribed; information about the SUN Project to be provided; and the community team to be informed in order to arrange for seven day follow up meeting. At the end of the day staff recorded that Mr B was prompted several times for his breakfast and medication; but said he had little sleep overnight and was feeling tired. Mr B also initially refused lunch and eventually attended after lots of encouragement but then said he "*didn't eat that type of food*" and started kicking the main door. Staff activated the panic alarm and Mr B became increasingly agitated as more staff arrived to assist, and again Mr B kicked the door but denied any wrongdoing. Shortly after this incident the Patient Advice and Liaison Services officer arrived to say that Mr B had called

¹³ "The SUN Project is for people who have longstanding emotional and behavioural problems (personality disorder), and who may feel they do not get adequate support from mainstream services. It has been designed for service users and in consultation with them. The SUN aims to reduce the common experiences of isolation and being overwhelmed by feeling stuck in a pattern of behaviour". <http://www.hear-us.org/the-sun-project/>

him to report that he “*had not eaten all day and nobody had offered him anything to eat*”. One to one observations were removed following the ward review and Mr B was discharged. Mr B’s wife arrived with their child to collect him; staff explained that children were not allowed on the ward and Mrs B and their child were shown to the family room. Mr B left the inpatient ward at 8:30pm.

- 4.43 On 30 November Mr B had an appointment with his GP and requested a prescription for his medication. The GP had not received a discharge letter at that time so was unable to arrange this. Mr B was asked to collect his medication boxes from home so that a medication review could be done. The same day the community team discussed Mr B’s case in the multi-disciplinary team meeting and noted that a care co-ordinator was required. The case was allocated to Mr Y.
- 4.44 On 4 December a member of staff from the Trust recorded a “working diagnosis” as “F60.3 emotionally unstable personality disorder”.
- 4.45 On 5 December Mr Y noted that he had called Mr B more than four times the previous day but nobody picked up the phone. Mr Y then called Mr B’s GP to ask for alternative numbers and was provided with Mrs B’s (but under her maiden name) number as “*partner of*” Mr B. Mr Y spoke with Mrs B who advised that the police had just taken Mr B to Bethlem Hospital because he had been kicking and shouting so she had called the ambulance who in turn had called the police. Mr Y asked Mrs B to call him when she heard something from the police. Mr B was taken to Croydon Hospital A&E for assessment under Section 136¹⁴ of the Mental Health Act. Advice was sought from the liaison psychiatry team as the police were told that the Section 136 suite at Bethlem Royal Hospital was full. A&E staff informed police that A&E was not an appropriate place for assessment and that it was not a place of safety. Mr B informed the liaison doctor that he didn’t want to go to a psychiatric hospital and wanted to remain in Croydon Hospital. Mr B was given an explanation about Section 136 place of safety which it appeared he did not understand; he became agitated and started threatening that if he went to a psychiatric hospital he would harm himself and others and it would be the doctor’s fault. The liaison psychiatry doctor attempted to find an alternative place of safety and eventually Lambeth was identified as an alternative. Mr B attempted to leave A&E as this was being arranged and had to be brought back by police. During this time Mr B re-opened his wound by picking at it.
- 4.46 Mr B was moved to the Section 136 suite in Lambeth where it was reported that police had picked Mr B up after he had tried to jump out of a second floor window at his flat, this followed a call to police by Mr B’s “*partner*” as he was shouting and screaming. The duty doctor (psychiatry), Dr T arrived 50

¹⁴ Section 136 of the Mental Health Act. The police can use section 136 of the Mental Health Act to take someone to a place of safety when they are in a public place. They can do this if they think someone has a mental illness and is in need of care. A place of safety can be a hospital or a police station. The police can move you between places of safety. The police can keep you under this section for up to 72 hours.

minutes after Mr B had arrived; he appeared to be drowsy and hard to arouse but stated he hadn't taken any medication other than his prescribed medications. The recent history provided was that Mrs B had called police stating Mr B was armed with a weapon (metal bar). When police arrived Mr and Mrs B were in the street. Police persuaded Mr B to hand over the metal bar but when he did so, Mr B started running inside the flats shouting *"I'm going to try and kill myself"* and attempted to jump from the second floor window. Mr B said that certain triggers made him distressed such as the court hearing on 14 December. Dr T spoke to Mrs B who said that Mr B had been getting worse since discharge from hospital on 29 November. Mrs B said that Mr B was behaving impulsively and had almost no control over his behaviours; following events he would have no recollection of what happened. Mrs B reported that Mr B had increasing memory problems and that he had not slept for the previous 48 hours, being convinced that there was someone in his car. Mrs B and neighbours had tried to get him back inside the house many times. Mrs B said that Mr B was paranoid that people would try to break into his house and kidnap his wife but said that she wasn't sure if Mr B wanted to see her as she had called the ambulance that had put him in hospital. Mrs B reported that their child had heard the noises and had asked Mrs B what was going on but hadn't visually witnessed anything. Mrs B told staff that when she worked Mr B would usually look after their child but that recently she had made other arrangements, as she wasn't sure how Mr B would be. Dr T identified a bed for Mr B at Croydon Triage mental health inpatient ward, and noted the diagnosis as personality disorder. The on call specialist registrar then assessed Mr B and recorded that although Mr B had personality disorder it was possible he was experiencing *"transient psychotic symptoms sometimes seen in such patients, which are a more vivid nature than usual"*. Mr B subsequently refused informal admission. The specialist registrar then spoke to Mrs B and it became apparent that Mr B was not stating the full facts so a decision made to admit Mr B on Section 2 of the Mental Health Act.

4.47 On 6 December Mr B was assessed for detention under the Mental Health Act and was detained on Section 2. The paperwork recorded that Mr B had a diagnosis of personality disorder and that police had picked him up after he was found on the street carrying a metal rod. Mr B's wife reported that she was concerned about his behaviour as he was smashing property and that the previous night he had been *"preparing a cocktail of spirit to inject himself with, with the intention of ending his life"*. The clinical record noted that Mr B had presented bizarrely over the preceding few days and had been quite paranoid. It was recorded that he was a risk to himself and that he had refused informal admission, therefore the decision was taken to detain under Section 2 for his health and safety. Mr B was discussed in the ward round later that day when information about his background was noted including self-reported previous contact with mental health services. Mr B reported that he had been *"trying to kill himself for several years"* and told staff that his fear the previous week was about going to court. It was agreed that Mr B should remain on 1:1 within eye sight observations until review by a doctor. These were reduced to general observations the following day.

4.48 Mr B was discussed again at ward round on 7 December when Mrs B was seen alone. Mrs B told staff that Mr B had started getting disorientated at the

age of about 21 years and that he had had help in the past, but he was embarrassed and “often” had not told the truth about his “breakdowns”. Mrs B said that Mr B had been “back and forth” between herself and Miss N for the previous few years and that Miss N had taken Mr B to St George’s Hospital because of his behaviour at work (Miss N was also a work colleague of Mr B). Mrs B said that she had never seen Mr B doing martial arts or cage fighting, despite his claims that he did so. Mrs B confirmed to staff that Mr B had been using cocaine and steroids as well as “household substances” to overdose. Mrs B gave staff an account of the events on the day that Mr B was admitted and said that Mr B had not been sleeping at home (although staff noted he had slept since arriving on the ward) and that she was scared of him as she believed he would “bluff” his way out of hospital. When Mr B was seen by staff in the presence of Mrs B he told staff that he had not taken his medication on the day of his arrest as Mrs B “forgot to give it to him” however staff informed him that it would take days for any effects of not taking medication to show. Mr B told staff that he did not want to spend any time with his wife and left the ward round shortly afterwards. Mrs B told staff that Mr B was not very talkative and had told her on the telephone that “if you don’t bring me home then there’s no point in living”. Staff noted that Mr B appeared “very keen to explain away and minimise his behaviour”. Staff recognised that Mrs B had provided new information regarding the decline in Mr B’s mental health and recorded that she had been subjected to physical and “severe psychological” abuse by Mr B. It was agreed that nursing staff would conduct a urine drug screen and that Mr B should remain on the ward over the weekend. Nursing staff would monitor Mr B for symptoms of psychosis and Mr Y should undertake a carer’s assessment for Mrs B.

- 4.49 On 8 December a urine drug screen for Mr B was conducted; this was positive for benzodiazapine and cocaine. Mrs B arrived with their child and Mr B’s parents to visit Mr B later that day. Staff informed them that a supervised visit could not be facilitated, as the ward was busy. Mr B then became more agitated, as he was unhappy about this. Staff successfully de-escalated Mr B’s behaviour, and a brief visit from his parents was supervised by staff.
- 4.50 On 9 December Ward staff noted that Mr B had been visited by a female friend, then later his wife, child and a male family member. Later that day the duty senior house officer reviewed Mr B’s arm as Mr B was worried it was infected. Mr B told the senior house officer that he had been seen regularly in the vascular clinic, but that he not been reviewed there for about a week. The senior house officer noted that Mr B looked physically well and all physical observations were within a normal range. It was decided to continue with antibiotics and Mr B was told to inform staff if he felt any pain.
- 4.51 On 10 December the night shift staff reported that Mr B had been sleeping on the floor and had told staff that he was concerned about people coming into his room. Despite reassurance from staff Mr B continued to sleep there until the early hours of the morning when he moved to his bed. Mr B said that he had enjoyed seeing his family and wanted to be discharged. A medical review took place with Dr D and Dr J when Mr B reported that he was keen to go home. Dr D explained the result of urine drug screen to Mr B; Mr B said he didn’t know whether he used cocaine prior to admission. Mr B said he had

been hearing voices since he was 14 years old, that he heard them every day and couldn't identify whose voices they were; sometimes the voices tried to influence him to cut himself or get out of hospital. Mr B also said he saw people who commanded him but that he had not told his family about this hallucination. The plan was to keep Mr B under review with the aim of rescinding the Section 2 detention, pending progress of agreed leave, later that day. Dr J called Mrs B to inform her that Mr B was likely to be discharged the following day with support to follow from the community team. Dr J noted that Mrs B was pleased to hear that Mr B would receive further support in the community.

- 4.52 Also on 10 December Ms T, welfare advisor, met with Mr B for a welfare benefits check. Mr B said he had recently applied for employment support allowance and was in receipt of housing benefit, he had also recently applied for disability living allowance. Mr B said he had recently started living with his wife again as they had been separated but he moved back in when his mental health became poor. Ms T contacted the Child Tax Credit helpline to seek advice and was advised that Mr B needed to submit both his and Mrs B's P60 for the previous year so that correct income figures could be recorded.
- 4.53 During the day it was reported that Mr B had become more open with staff and was doing small things to aid his peers such as handing out cups during mealtimes. Mr B said that he felt better for having been in hospital but that he didn't feel that he needed to be there any longer. Staff noted that he was compliant with antibiotics and that he had asked staff to change the dressings on his arm. Mr B said that the wound was stinging and staff noted that it looked worse than previously. Mr B had used his leave appropriately, with Mrs B present.
- 4.54 On 11 December Mr B was seen during ward round when he reported that his leave the previous day had gone well. Staff advised him that they wanted take him off his section that day to allow him to go home; Mr B said things "*should be alright*" at home but that he had "*not really*" spoken to Mrs B about it. Mr B said that Mrs B was "*being very vague about things, she says she doesn't know what is happening*". Staff advised Mr B not to use cocaine and asked how he would manage things differently on discharge; Mr B said that he hoped he would have some support. Mr B said that he got very anxious on the day prior to a court hearing and staff explained that he would need to anticipate this anxiety and deal with it differently. The opinion of staff was that there was a "*vast improvement*" in Mr B's mental state and that he was ready for discharge from the section and inpatient services.
- 4.55 On 12 December Mr B was discharged home having been compliant with his medication, had adequate food and fluid. The records state that "*Mrs B was informed of the plan to be discharged*", however another entry states that Dr J called Mrs B to inform her of Mr B's discharge but that she wasn't available and a message was left for her to contact the ward "*if any concerns arose during the period between discharge and care co-ordinator follow up*". Dr J also recorded that he informed Mrs B that he would call again the following day to check on progress. We can find no record of ward staff actually speaking to Mrs B to inform her of Mr B's discharge arrangements.

- 4.56 Around the time that Mr B left the hospital at 12:30 pm Dr D, consultant psychiatrist, Croydon Triage, emailed Mr Y, care co-ordinator, and Mr P, team leader Croydon MAP East, to advise that Mr B had been admitted on 5 December under Section 2. Dr D noted that Mr B's mental health and conduct had settled and there were no concerns about his safety. He had been compliant with prescribed medications and the previous day had begun unescorted leave without problem. Dr D stated that Mr B was keen to return home and as continued admission was not indicated Dr D had rescinded the Section 2 and was planning to discharge Mr B later that day. It was noted that Mr B planned to return home with his wife "*who was aware of the discharge plans*". Mr B would require ongoing contact with CMHT services and Dr D suggested that arrangements were made for initial contact in the following couple of days. Dr D noted that nobody from the CMHT was able to attend a ward round during Mr B's stay and informed Mr Y and Mr P that ward rounds took place at 9:30am daily.
- 4.57 The same day Mr B's GP received a discharge summary report from the Trust. This gave information about the overdose, his attendance at A&E and his subsequent admission to and discharge from Croydon Triage. Mr B's diagnosis was recorded as "*traits of emotionally unstable personality disorder*" and medication noted as "*sodium valproate chorno 200mg od added*".
- 4.58 On 12 December Ms T advised benefits agencies that Mr B had been discharged from hospital. Ms T also wrote to Mr B to remind him that he needed to call the Child Tax Credit number with both his and his wife's P60 to enable records to be changed and more tax credit to be paid if appropriate.
- 4.59 At 3:30pm on 12 December Mr Y called Mr B who said he was "*still anxious about being at home*". Mr Y reassured him and advised him to continue to use his medication. Mr B said that his sertraline tablets had been reduced to 50mg from 100mg and Mr Y encouraged Mr B to keep using medication as prescribed. Mr Y asked about the "*vascular wound*" [the wound on Mr B's arm], which Mr B reported was infected and that he was taking antibiotics. Mr B also expressed anxiety about his next court appearance. Mr Y noted that the telephone conversation was seen as a seven-day follow up appointment.
- 4.60 At 5:15pm Dr D had telephone contact with Mr B, speaking to him twice at the family home. Dr D confirmed the arrangement for Mr B to attend Tamworth Road the following day in order to see his care co-ordinator or duty worker (MAP East Team¹⁵). Dr D also spoke with Mr B's solicitor at Mr B's request; the solicitor reported that he was waiting for authorisation of legal aid in order to represent Mr B and advised that Mr B needed to attend the scheduled hearing on 14 December. Dr D then called Mr B to convey this information to him.

¹⁵ Mood, Anxiety & Personality (MAP) East

- 4.61 Also on 12 December Croydon Hospital records show a letter from the specialist registrar to Mr B's GP advising that Mr B had been seen in clinic for review of his wound. Mr B had reported that he was "*feeling much better as he was on medication for bipolar disorder*"; he was being looked after by his family and had someone with him 24 hours a day. Mr B said he was keen to let the wound heal itself and it was agreed that dressings would be done twice weekly by Tissue Viability Nurse. Only then, if the wound was still not healing, would grafting be considered.
- 4.62 On 13 December Mr B contacted the Triage ward to inform them that he had not been seen for his discharge follow up as arranged. Triage ward staff informed Mr B that the telephone call with his care co-ordinator on 12 December had been noted as his seven day discharge follow up. Triage ward staff informed Mr B that he needed to see his vascular nurse in the community to have his wound dressing changed, as he was no longer a patient on the ward. Staff recorded that "*care co-ordinator to be sent an email*".
- 4.63 Also on 13 December at 10:00am Ms D, duty worker MAP East Team saw Mr B. This entry was not recorded until Ms D returned from leave on 3 January after a Christmas break. Mr B had explained that he was unable to shake hands with her due to the injury to his wrist/lower arm. Mr B's newly allocated care co-ordinator (with whom the client had previously had telephone contact only) called into the meeting briefly to introduce himself prior to a scheduled meeting the following Monday. Mr B said that he was feeling down and that his mood had deteriorated since initially feeling positive on discharge from hospital. Mr B gave a history of 10-12 suicide attempts during his life. He talked about the recent episode where he had injected himself and reported that he had been diagnosed with bipolar disorder. Mr B said he had no current thoughts of suicide and that he would be at home with his wife prior to the court appearance the following day. Ms D advised Mr B to attend Croydon Hospital regarding his arm injury and recorded that Mr B was "*aware of crisis contacts*".
- 4.64 On 15 December Trust staff received a telephone call from a lady requesting information about Mr B. The caller gave her name as Miss N and claimed to be Mr B's sister and asked whether Mr B had been admitted to hospital. The member of staff identified that the last known ward was Croydon Triage and spoke to Triage staff, who advised that the caller had already contacted Triage and was not given any information about the patient as there were concerns about her identity.
- 4.65 On 17 December Mr Y called Mr B several times in order to change the appointment time from 2:00pm to 3:00pm. Eventually Mrs B called back to say that they would be going out and wouldn't be at home for an appointment. The appointment was therefore rescheduled to Thursday 20 December at 3:30pm.
- 4.66 On 18 December Mr B did not attend a scheduled appointment with his GP and no reason was given.

- 4.67 Also on 18 December at 2:00pm Mr Y received a call from Mrs B to say that Mr B had left home that morning and she had not heard from him since. Mrs B said that Mr B had taken the family's two mobile phones with him and the family car. Mr Y noted that Mrs B had reported this information to the police in view of Mr B's mental state. Mr Y called both mobile phone numbers and left messages for Mr B to contact him immediately. At 3:45pm Mr Y received a call from the duty nurse at Croydon police custody about Mr B having been taken into custody that morning for "*pulling someone's hair at Croydon Tram Station*". There is some confusion as to the nature of this offence and whether it is connected to the domestic assault on Mrs B. The Trust records are different from the Domestic Homicide Review, which indicates that Mr B had been arrested for assaulting Mrs B. The Trust records indicate that the duty nurse said that Mr B was behaving oddly saying that he was seeing faces in the newspapers and that he didn't want to be contaminated. Mr Y noted that Mr B had admitted taking cocaine the previous day. The duty nurse told Mr Y that she wanted Mr B to be seen for a Mental Health Act assessment. Mr Y then phoned Mrs B to inform her that Mr B was in police custody.
- 4.68 On 19 December Croydon IAPT team made a referral to Croydon MAP East Team. The referrer noted that Mr B had returned a registration form on 11 December that had been screened on 19 December. The result of the screening was that Mr B reported experiencing visual hallucinations and was considered to be in urgent need of help to prevent him harming himself. The referrer requested an assessment by Croydon MAP Team. Mr B's GP also received a letter informing him of this information.
- 4.69 Also on 19 December a Mental Health Act assessment was completed on Mr B who was still in Croydon Police Custody. The assessors were Ms J AMHP, Dr N, specialist registrar, and Dr A, Section 12 doctor. It was noted that Mr B had recently been discharged from Croydon Triage ward and the previous day Mr B had been arrested after reports that he had assaulted his wife by pulling her hair and hitting her. Mr B told assessors that he knew his wife had been using cocaine as he had noted a sudden change in her behaviour and that he had seen her using it. Mr B said he was worried about the fact that she was using it in front of his six year old child and had called the police himself, due to these worries. Mr B said that Mrs B did not want him to call the police and said she would lie about him hitting her and get him sectioned.
- 4.70 Assessors then took a history about Mr B from Mrs B over the telephone. Mrs B said that she thought that Mr B had been hallucinating. She said had known him for about 10 years and said that he did have outbursts sometimes. Mrs B reported that Mr B had taken the keys so she was locked in the house at that point and that Mr B had taken her mobile phone so she had no contact with anybody. Mrs B said that Mr B had never hurt their child and agreed to him returning home that night. Ms J noted that Miss N had been to see Mr B in the cells that day, and that Miss N had commented that Mr B played them (Mrs B and Miss N) off against each other.

- 4.71 Mr B denied having thoughts of self harm or suicide, denied having hurt anyone that day and said that he was no longer angry with his wife. He said that he would go home and sleep on the sofa. Ms J noted that Mrs B was willing to have him home and Mr B agreed to accept further support from services through his care co-ordinator.
- 4.72 The assessing team found no evidence of mental illness that required acute treatment, and found that Mr B was not detainable at the time of assessment. The assessors agreed that there appeared to be ongoing interpersonal issues within his relationships and noted that previous assessments had suggested narcissistic and antisocial personality traits. Previous recommendations to “*consider psychotherapy input (eg Touchstone¹⁶)*” were also noted by the assessing team. Ms J recorded that she had emailed the care co-ordinator (Mr Y) regarding making a referral to Child and Families due to the concerns about Mr B’s aggression and drug use in the home.
- 4.73 At 9:40am on 20 December Mr Y received a call from Mr B cancelling the planned appointment at 3:30pm. Mr Y told Mr B that the meeting should go ahead as he wanted to see Mr B’s child as well. Mr B said that his child would be at school and that they were six years old. Mr B also said that Mrs B would be at work, that she worked at ASDA and that he didn’t know when she would be home. Mr Y said he would be coming anyway and that he would wait for Mrs B to return from work. Mr B again told Mr Y not to visit as he would not be at home, and neither would Mrs B. Mr Y said he would be visiting anyway and then Mr B put the phone down.
- 4.74 That afternoon Mr Y left the office to visit Mr and Mrs B as arranged. Mr Y got lost on the way but called the landline and mobile numbers to inform Mr and Mrs B that he was on his way and to wait for him to arrive. Mr Y arrived at the family home address to find police cars and police officers preventing access to the flat. Police informed Mr Y that Mr B had killed Mrs B. Mr Y asked about Mr and Mrs B’s child and was informed that police had taken them and they were in the care of social services.

5 Arising issues, comment and analysis

- 5.1 Mr B was in the care of Trust services for eleven weeks. We have found no evidence of any Care Programme Approach paperwork, despite the fact that Mr B was detained for assessment under Section 2 of the Mental Health Act. In addition there were many missed opportunities for risk assessments to be completed or reviewed. There were further missed opportunities for carer’s assessments and assessments of the risks to Mr B’s wife and child.
- 5.2 Mr B was first diagnosed with emotionally unstable personality disorder on 29 November. Shortly after this point Trust staff also had evidence to support

¹⁶ The Croydon Adult Personality Disorder Service operates from the **Touchstone Centre** where the service provides outpatient assessment, treatment and rehabilitation for people, aged 18-65, who have personality disorders.

Mrs B's statement that Mr B was using cocaine, as he had a urine drug screen on 6 December that on 8 December confirmed the presence of cocaine.

- 5.3 Annex 2 of the 2009 Department of Health document "*Recognising complexity: commissioning guidance for Personality Disorders*"¹⁷ provides professionals with a clear table to aid the identification of the level of severity of personality disorder that a patient presents with. It is our view that Mr B was presenting as someone with a moderate to severe personality disorder, at times tipping into severe and complex. Add to this Mr B's propensity to take illicit drugs and the picture is further complicated.
- 5.4 Annex 4 of the same document sets out the services needed for people with personality disorder presenting in different ways. The profile below fits with Mr B's presentation, but it wasn't until 12 December that the Mood, Anxiety and Personality (MAP) team became involved with his care, following discharge from a Section 2 detention the previous day. This was just eight days before Mr B killed his wife.

Profile	Description	Services needed
Those at high risk of self-harm or suicide	Adults, sometimes young adults, with severe and complex PD, most commonly BPD and associated co-morbidities, who are experiencing a period of acute and severe self-harm or suicide risk. Where the client lives in a family group, or with a parent, there may be risk of severe impact on family or children.	A period of acute care followed by intensive community-based treatment.

Care plans

- 5.5 We found only evidence of basic care plans being completed whilst Mr B was an inpatient in December. We have found no Care Programme Approach paperwork despite Mr B being detained under Section 2 of the Mental Health Act on 5 December. We have found no evidence that Mr B was considered for Care Programme Approach. The Trust has stated "*the decision to place someone on Care Programme Approach is multifactorial based largely on the complexity of presentation and severity of mental disorder. A person would not be placed on Care Programme Approach simply because they have been detained, especially for such a short period of assessment under the Mental Health Act as described in the report*".
- 5.6 Good practice guidance "Refocusing the Care Programme Approach: Policy and Positive Practice Guidance" (Department of Health 2008) states that Care Programme Approach is for those with:

¹⁷ *Recognising complexity: commissioning guidance for Personality Disorders*, Department of Health 2009, http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101788

- Severe mental disorder (including personality disorder) with high degree of clinical complexity
- Current or potential risk(s), including:
 - Suicide, self harm, harm to others (including history of offending)
 - Relapse history requiring urgent response
 - Self neglect/non concordance with treatment plan
- Vulnerable adult; adult/child protection e.g. – exploitation e.g. financial/sexual – financial difficulties related to mental illness – disinhibition – physical/emotional abuse – cognitive impairment – child protection issues
- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team
- Significant reliance on carer(s) or has own significant caring responsibilities
- Experiencing disadvantage or difficulty as a result of:
 - Parenting responsibilities
 - Physical health problems/disability
 - Unsettled accommodation/housing issues
 - Employment issues when mentally ill
 - Significant impairment of function due to mental illness
- Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues

5.7 This good practice is present in the Trust Care Programme Approach Policy in place at the time, which sets out when service users should be considered for Care Programme Approach. Paragraph 5.2 states:

“Some service users have sufficiently complex needs to require being on CPA. There are clear guidelines as to what these criteria are, and they broadly equate to the previous category of Enhanced CPA. They are individuals with complex characteristics whose needs are met from a number of services or

who are most at risk and who need a higher level of engagement, co-ordination and support. ”

“Key groups of service users who must be assessed for [new] CPA include those with parenting responsibilities ...the decision and reasons not to include individuals from these groups should be clearly documented in the care records.”

- 5.8 Paragraph 5.3 of the policy provides the criteria for Care Programme Approach; this includes:

“Current or potential risks including...self harm...self neglect...”

“Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse...”

“Currently/recently detained under Mental Health Act or referred to crisis/home treatment team”

- 5.9 Additionally we found no documented reasons for a decision not to place Mr B on Care Programme Approach.

- 5.10 It is our view that Mr B should have been considered for Care Programme Approach for the following reasons:

- he had been detained under Section 2 of the Mental Health Act;
- he had made several serious self harm attempts
- he was paranoid
- he had admitted misusing substances;
- he had parenting responsibilities;
- he had a history of being psychologically and physically abusive to his wife;
- he presented with physical health problems in addition to his mental health problems;
- he presented to mental health services numerous times over a short time frame;
- he had recently been under the care of the Crisis Team

- 5.11 There were no comprehensive care plans in Mr B's records and nothing to indicate that any care plans had been shared with Mr B or his carer Mrs B. The Trust has stated: *“it would have required at least three hours of patient engagement to complete the preliminary assessment for the community care plan/recovery and support plan. Mr B's allocated care co-ordinator from Croydon MAP East did not have the opportunity to engage him to develop this plan due to Mr B's reluctance to engage”*. However, as the Trust stated in the

internal investigation Mr B had 12 episodes of care during an 11-week period. It is our opinion that planned interventions and responses were focussed too much on responding to managing Mr B's presentation in the 'here and now' rather than planning for the longer term. It is recognised that caring for Mr B was challenging due to the nature of his physical health problems in addition to his mental health problems. This resulted in him being cared for by a number of different mental health and physical health care teams.

Risk assessments

- 5.12 There were nine occasions when Trust staff had information that should have led to a risk assessment or review of an existing risk assessment. A risk assessment was completed on only three of those occasions.
- 5.13 On 6 November liaison psychiatry staff were informed that Mr B had threatened the Croydon Hospital security guard with a knife and that he had become fixated on a nurse who used to be a neighbour and had said he wanted to murder her. We have not found any evidence of a risk assessment being completed or reviewed following this information. Yet the following day Mr B was discharged home to be with his wife and six year old child.
- 5.14 On 8 November Mr B presented with unusual behaviour when home treatment team staff visited. Mrs B told staff that the very personal information Mr B had shared was out of character and that she felt his presentation had worsened since he started taking antidepressants a week previously. Again we have not found any evidence of a risk assessment being completed or reviewed following this information.
- 5.15 On 11 November home treatment team staff recommended that staff did not visit Mr B unaccompanied due to his "*risk profile*". However we can find no evidence of a formal assessment of his risk to others nor management or mitigating actions.
- 5.16 On 22 November the home treatment team informed Mr B that the team were considering discharging him to his GP with the possibility of onward referral to the Croydon psychology service. There is no evidence of any review of risk assessments being completed to inform this decision.
- 5.17 On 23 November when discussing the court case, Mr B told staff that if he went to prison he would "*kill himself as he wouldn't be able to cope with being locked up*". There was no risk assessment after this information was shared and staff informed Mr B on the same day that he was being discharged from the home treatment team caseload to the care of his GP.
- 5.18 On 28 November a Brief Risk Screen was completed by liaison psychiatry staff. This noted Mr B's attempted overdose that day, the previous history of self harm and identified that further investigations or referral was required. There is no information about Mr B's, Mrs B's or other professionals' views about Mr B's risks.

- 5.19 On 29 November a Brief Risk Screen was completed by inpatient staff. This noted Mr B's history of self harm, the loss of his job and pending court case. It also notes that the family dynamics remained unclear, but again there was no information about Mr B's, Mrs B's or other professionals' views about Mr B's risks.
- 5.20 On 6 December a Brief Risk Screen was completed by inpatient staff. This document provided significantly more information about Mr B's risks to himself, his wife and his child. Risk reduction actions were noted as admission under Section 2 of the Mental Health Act. A Full Risk Assessment was subsequently completed.
- 5.21 On 19 December after Mr B had been arrested for assaulting his wife the previous day, he was assessed under the Mental Health Act, the only risk assessment was a few lines noted in the record made by Dr N, the specialist registrar on call.
- 5.22 The document published in March 2009 by the Department of Health, Best Practice in Managing Risk¹⁸ identifies 16 best practice points for effective risk management. Professor Louis Appleby's foreword states, "*A good therapeutic relationship must include both sympathetic support and objective assessment of risk.... We know that an unacceptable number of patients who die by suicide or commit homicide have not been subject to enhanced CPA, despite indications of risk.*"
- 5.23 Best practice indicates that where a carer is involved and it is felt that the carer is at risk they should be seen individually, so that risks can be explored and actions agreed.
- 5.24 Concerning the recording of information, all significant risk-related decisions should be recorded, signed and dated and the service user and those involved in their care should have opportunity to contribute to the document and receive copies.
- 5.25 There are a number of different risk assessment tools listed in the best practice guide, covering five areas of risk:
- Violence;
 - Sexual violence;
 - Antisocial and offending behaviour;

¹⁸ *Best Practice in Managing Risk*, Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services, updated March 2009, Department of Health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

- Self-harm/suicide;
 - Self-neglect/vulnerability.
- 5.26 Mr B was presenting with significant self-harm issues and violence. It would therefore have been appropriate to use risk assessment tools that are recommended as best practice for such presentations:
- CRMT – Clinical Risk Management Tool/Working with Risk;
 - FACE – Functional Analysis of Care Environments;
 - GRiST – Galatean Risk Screening Tool;
 - RAMAS – Risk Assessment Management and Audit Systems;
 - START – Short-term Assessment of Risk and Treatability.
- 5.27 We can find no evidence that any of these assessment tools were used by Trust staff when assessing Mr B.
- 5.28 This document also refers to best practice in managing risk in patients who self-harm and directs readers towards the NICE Guidance Self-harm in over 8s: short term management and prevention of recurrence (CG16)¹⁹. Also relevant is the NICE Guidance Self-harm in over 8s: long-term management (CG133). In this context, short-term management means in the first 48 hours following self-harm and long-term management, thereafter.
- 5.29 Although the CG16 guidance was first published in 2004, and the CG133 guidance first published in 2011 NICE reviewed the evidence in for both guidance documents in September 2016 and identified no major studies that would affect their recommendations. Therefore both sets of guidance remain current and relevant.
- 5.30 Best practice in risk assessments for long-term management states:
- “A risk management plan should be a clearly identifiable part of the care plan and should:*
- *address each of the long-term and more immediate risks identified in the risk assessment*
 - *address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide*

¹⁹ NICE Guidance Self-harm in over 8s: short term management and prevention of recurrence, National Institute for Health and Care Excellence, July 2004.

- *include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail*
- *ensure that the risk management plan is consistent with the long-term treatment strategy.”*

5.31 Whilst staff completed elements of this best practice list, it is our view that the risk management plan was not sufficiently robust, given Mr B’s escalating self-harm and the risks he posed to his wife and child that were recognised and documented by staff.

Carer’s assessment and support

5.32 When staff assessed Mr B on 5 October they spoke to his “*partner*” (it is unclear whether this was Mrs B or Miss N) who reported that she was concerned about his safety “*Mr B’s mood was cycling and that he would be at risk again if he left the A&E department*”. Although Mr B was provided with information about how he could get help in the future, no information was provided to his partner.

5.33 When Mr B presented at A&E on 23 October staff noted the presence of his wife and child as “*protective factors*”. There was no discussion with Mrs B about what support she needed to function as a “*protective factor*” nor consideration of the risks of Mr B’s impulsivity that resulted in him having no control over his feelings and actions.

5.34 On 28 October a liaison psychiatry nurse noted that Mr B’s moderate risk was being managed by the presence of his wife on the ward. No discussion was had with Mrs B about what support she needed.

5.35 Home treatment team staff visited Mr B at home on eight occasions between 23 October and 23 November. On at least five of those occasions Mrs B was also present. We can find no evidence that any discussion took place with Mrs B to discuss her role as a carer, nor what support she might need.

5.36 On 18 November when home treatment team staff visited Mr B at home they found that he was being cared for by Miss N as his wife was out. Mr B told staff that he was “*never left alone*”. Despite this information no action was taken to arrange for a carer’s assessment for Mrs B.

5.37 Dr D told us that he didn’t think that there were any conversations about a carer’s assessment for Mrs B whilst Mr B was on the ward, but that he couldn’t remember as it was a long time ago. On 7 December at the ward round meeting a number of actions were noted; one of which was for a carer’s assessment to be done for Mrs B and noting that this should be done by the care co-ordinator. We have seen no evidence that the care co-ordinator, Mr Y, was subsequently informed of this action, given he was not present at the meeting. This was a missed opportunity as Mr B remained in hospital for a further four days thereby offering the chance for Mrs B to speak more openly with staff.

- 5.38 No carer's assessment was undertaken for Mrs B. We found no evidence that staff considered any safeguarding needs in relation to Mrs B. When we spoke to staff who provided care and treatment to Mr B they did not consider Mrs B to have been a vulnerable adult.
- 5.39 On 10 December Dr J called Mrs B to inform her that Mr B would be discharged home the following day. There was no discussion with Mrs B about what support she would need, neither was there discussion within the team on this matter. Two days later Mr J recorded that he had called Mrs B and she was informed of the plan to discharge Mr B, however there appears to have been no information shared about Mr B's care plan other than the fact that he would be followed up by community staff.
- 5.40 Some staff that we wanted to interview to discuss this issue had left the Trust. We therefore asked the Trust to identify appropriate members of staff for us to interview to enable us to gain more understanding about why a carer's assessment was not undertaken. We had to escalate the request, as initially no information was forthcoming. We were then told that there were no other "*clinicians who were in contact with the patient at the time of the incident*" who were still working within the Trust.
- 5.41 We asked the Trust to provide information about training requirements and compliance with carers' assessments. However despite escalating this issue to the Director of Nursing the information was not forthcoming.

Culture and mental health

- 5.42 During the course of Mr B's repeated presentations, there is evidence from the clinical notes that there were many attempts to take a personal history from Mr B. During this process clinicians obtained some information about his cultural background. It was established that he was of Turkish heritage, born and raised in South London and is Muslim. It was also established that he was married and had a six-year-old child. He also had a girlfriend. It was established that his mother is British and his father Turkish and there were differing reports about his relationship with his parents. Mr B reported that he had five brothers and two sisters with whom he also no longer had contact.
- 5.43 Clinical staff recorded that Mr B's parents separated when he was a teenager and he described his mother as having a new family when he was 14 years old. (We know this not to be true because Mr B's family has told us that his parents are still married and that he has six siblings, all of whom have the same parents as he does). It is recorded that he grew up in Greenwich until the age of 14 and then moved to Croydon at 15 years of age. It is unclear what connections Mr B had with Turkey (or if any) whilst growing up or subsequently as an adult. It is also unclear when, how or why his father came to the UK, and his father's degree of connection with Turkey subsequently. It is unclear whether or not his mother had or has any connection with Turkey.
- 5.44 In the clinical records it states that Mr B was bullied at school. The notes state: "*He says he was bullied at school as he was different to the others*". Mr B reported to clinical staff that he was bullied at school due to his weight. It is

unclear whether being of mixed heritage made him the target of racism at any time whilst growing up or subsequently.

- 5.45 In the Domestic Homicide Review report it is reported that Mr and Mrs B conversed with one another in Turkish. Mrs B's father Mr A told us that Mr B was quiet and withdrawn and only really spoke to his daughter in Turkish when Mr A was present. The Domestic Homicide Review report states that this might have been one way in which Mr B could socially isolate Mrs B. It is unclear which language/s Mr and Mrs B routinely used in the family home to one another and with their child.
- 5.46 Although the fact that Mr B is Muslim is recorded in the clinical records, this element does not seem to have been explored with him. This may have provided a further opportunity for staff to develop a closer therapeutic relationship with him and to establish what being Muslim meant to him. Mrs B at one point in the notes, describing her husband states that it was as though he was "*possessed*". It does not appear that clinicians explored this comment by Mrs B further with her or with Mr B, and it is unclear whether or not Mr B thought he was possessed by spirits. It would have been helpful if the clinicians had explored with Mr B not only his understanding of his health and mental health problems, but also what he thought had caused him to be ill and his views on how to best help him.
- 5.47 Mr and Mrs B's child was of mixed heritage. Their experience as parents of bringing up a child together of mixed heritage does not appear to have been explored.

Child safeguarding

- 5.48 On 26 October Mr B requested that his wife be allowed to stay with him overnight as made him feel less "*paranoid and trapped*". The liaison psychiatry nurse did not advise against this but noted that "*if this were not possible, a one-to-one psychiatric nurse for overnight*" should be considered. There appears to have been no consideration about the welfare of the couple's child should Mrs B have stayed overnight.
- 5.49 On 12 November home treatment team staff completed a Child Needs and Risk document. This noted that Mr B's mental health was likely to impact upon his ability to meet the needs of his child and although an alternative parent was identified, the member of staff completing the form indicated they were unsure about whether there were concerns that the child's needs were being met. The document also indicates that information was "*handed over*" to the liaison psychiatry team on 31 October to gain more information. However there is no evidence that this action was taken by liaison psychiatry staff. This was highlighted at the home treatment team meeting on 13 November and staff were asked to complete the outstanding action. On 15 November home treatment team staff received confirmation from children's social care that they had received a referral from Croydon Hospital A&E on 6 October. There is no record to indicate what the outcome of this referral was.

- 5.50 On 28 November liaison psychiatry staff completed a Child Needs and Risk form. The contents were the same as those on the entry described above with the exception of providing the child's name and the name of the primary carer which was incorrectly noted as "*Ruth*". It remains unclear what action, if any, staff took as a result of completing this document.
- 5.51 Throughout all the records, despite the presence of some entries referring to Mr B's risk of violence and staff noting concerns about potential harm to his child, there were no entries in the relevant safeguarding children section of the Event screen.
- 5.52 Trust staff were aware that Mr B's child was six years old and therefore would have been at school; in addition, it is likely that they would have had contact with their GP and health visitor, all of whom may have had concerns for their physical safety or emotional health. In addition it is recorded that the child stayed with a friend of their mother's so that they were not left alone with Mr B; this is another adult who may have had concerns. There is no evidence that domestic violence had been considered, nor a referral to MARAC²⁰.
- 5.53 It is our opinion that Trust staff appear to have been complacent in their actions of:
- believing Mr B when he said that he would not harm either his wife or child;
 - the information from Mrs B that their child did not "*see anything*" at home.
- 5.54 There are at least seven occasions when staff noted issues that identified that the child could have been at risk. On at least one occasion a child needs and risk assessment was noted as being required, however this was not completed.
- 5.55 Mr B gave assurances to staff that he would not harm his child, Mrs B also gave those assurances and there is no evidence that staff made enquiries to support or reject this point of view.
- 5.56 It is our view that there was plenty of evidence available to staff that the child was in need of protection and that actions to safeguard the welfare of the child should have been taken. Experienced, well-trained, supervised staff should have identified this family to be in need of support to protect Mrs B and their child. Any professional could have initiated the Common Assessment Framework to seek the child's view about what they were actually seeing or hearing at home. It is recorded that Mr B's child visited him whilst in hospital and one must consider the appropriateness of such an interaction. There were numerous occasions where opportunities were missed to properly understand the risks to the child.

²⁰ A MARAC (Multi Agency Risk Assessment Conference) is a regular local meeting to discuss how to help victims at high risk of serious harm.

Diagnosis

- 5.57 There were a number of diagnoses made during the eleven weeks that Mr B was involved with the Trust:
- a) 28 November: F99 mental disorder not otherwise specified;
 - b) 29 November: F60.3 emotionally unstable personality disorder;
 - c) 4 December: F60.3 emotionally unstable personality disorder (noted as a working diagnosis);
 - d) 12 December: F60.3 emotionally unstable personality disorder.
- 5.58 It is common practice for a diagnosis to be noted in several places in clinical records and letters. However it appears that even when a decision was reached about diagnosis this did not lead to the development or implementation of a care plan.

Psychological support

- 5.59 After Mr B had injected himself with the cocktail of substances he was told of the possibility of the total loss of use or amputation of his arm. Trust staff recorded that Mr B “*spoke of his fear and vulnerability*” and the effect that losing the use of his arm would have on his body image. There is no evidence that there was any discussion to reassure Mr B or to provide him with support.
- 5.60 Referral to two different psychological therapy services were discussed with Mr B:
- Croydon Improving Access to Psychological Therapy (Croydon IAPT): a primary care service that accepts self-referrals.
- Croydon Integrated Psychological Therapy Service (CIPTS): a secondary care psychological therapy service.
- 5.61 The Trust has told us that when the Home Treatment Team discharged Mr B, they asked the GP to refer him on to CIPTS and that according to Trust records no such referral was received. We have re-reviewed the Trust records and the GP records and have found no evidence of a letter to Mr B’s GP to this effect. There were two occasions when Mr B was discharged from the home treatment team:
- 24 October: a discharge summary was sent by the home treatment team to Waterfall House Surgery, stating that the follow up plan was for mental health liaison to “*continue with mental health assessment and feedback further to GP*”;
 - 23 November: the entry in Trust records notes that a referral would be sent to CIPS and a letter would be sent to Mr B’s GP. We have found no evidence of either action being taken.

- 5.62 On 30 October the liaison psychiatry team provided Mr B with an information leaflet and application form for talking therapy.
- 5.63 On 7 November Mr B was given a form to self-refer to the IAPT (Improving Access to Psychological Therapies) service. The IAPT service wrote to Mr B acknowledging receipt of his referral and sending him a registration form to complete.
- 5.64 On 22 November the home treatment team noted the plan to be “*discuss onward referral to psychological services and make referral prior to discharge*”. The following day Mr B was discharged from the home treatment team. Staff noted “*referral to be done to CIPs, letter to be sent to GP*”.
- 5.65 On 27 November Dr J wrote to Mr B enclosing a further copy of a self-referral form for the IAPT service and advising that if Mr B required further psychological intervention, his GP would be able to refer him directly to the Croydon Integrated Psychological Therapies Service (CIPTS).
- 5.66 The IAPT service received Mr B’s registration form on 7 December. On 19 December they wrote to the Croydon MAP East Team to request that someone from the team made contact with Mr B. as they (the IAPT service), “*did not have the resources to meet his presenting needs*”.
- 5.67 There was an inconsistent response from teams to address Mr B’s psychological needs. A referral to “*CIPs*” (we take this to be CIPTS) was never sent by Trust staff and there was no request to Mr B’s GP to make the referral either.

Communication between the Trust and the GP

- 5.68 On 22 November the GP at Violet Lane Medical Practice saw Mr B and noted that he was on treatment for bipolar disorder and that the psychiatrist from the home treatment team thought that Mr B required further assessment. Note that this was the same date that the home treatment team discussed the possibility of Mr B being discharged back to the care of his GP.

Multiagency working with the Police

- 5.69 We have found three occasions when the police had contact with Trust staff:
- 5 October, when the police and ambulance service took Mr B to A&E. It is unclear whether the police were still present when Trust staff arrived to assess Mr B, however we consider that this was unlikely. The police created a Merlin²¹ report that was subsequently shared with Children’s

²¹ A Police Merlin report is created in all instances when a child or young person who comes to the attention of a Police officer where it is believed there are concerns about the child’s well-being or safety and one or more of the Every Child Matters outcomes are not met, must be recorded onto a MERLIN PAC form, as soon as reasonably practicable and within that tour of duty. The child does not need to be present, only knowledge that a child exists. Standing Together Domestic Homicide Report. April 2015.

Social Care on 16 October – this highlighted concern that the child “*should not have unsupervised contact*” with its father until the full extent of Mr B’s mental health issues were known;

- 5/6 December, when Mr B was arrested and was subsequently detained by the police on Section 136 of the Mental Health Act. He was subsequently assessed and detained under Section 2 of the Mental Health Act. The only discussion recorded in Mr B’s notes is that of the respective responsibility of Trust staff and the police to identify an appropriate place of safety;
- 18/19 December, when Mr B was arrested and taken to the police station for questioning. He was subsequently assessed under the Mental Health Act but not detained.

5.70 We have not found any evidence in Trust records that discussions took place with police staff to establish more detail about Mr B’s risk to Mrs B, despite there being two opportunities to do so in December 2012. If this had been done it would have helped inform Trust staff in assessing the risk that Mr B posed to others, especially Mrs B.

5.71 In the records for the assessment that took place on 19 December, there is no evidence that Trust staff properly considered the risk to Mrs B who “*was happy to have him come home*”, despite the fact that:

- Mr B had assaulted her;
- Mrs B described Mr B’s moods and behaviours as unpredictable;
- Trust staff noted that there seemed to be “*interpersonal issues within his relationship*”;
- previous assessments have “*suggested narcissistic and antisocial personality traits*”.

5.72 It is possible that greater information sharing between the police and mental health services might have assisted in identifying the risk that Mr B posed to others, in particular Mrs B, and facilitated a multi-agency plan to keep Mrs B and her child safe.

Recording of information

5.73 When Mr B attended Croydon Hospital on 5 October he was assessed by medical staff in A&E and liaison psychiatry staff. We have only found entries relating to these assessments in the Trust records. There are no entries in Croydon Health Services Trust records that were provided to us.

5.74 On 29 October there is an entry in Croydon Health Services Trust records made by liaison psychiatry staff regarding a discussion with Mr B’s wife about “*a plan*”. We found no corresponding entry in the Trust records.

Lone working

- 5.75 On 20 December Mr Y attempted to visit Mr and Mrs B alone despite the clear message from home treatment team staff made on 11 November that staff should visit in pairs. As previously mentioned, this information never led to a formal risk assessment or management plan.
- 5.76 We have found no evidence that Mr Y conducted his own risk assessment prior to visiting Mr B at home alone. As Mr Y indicated to the internal investigation team, had his timing been different, he may have been caught up in Mr B's attack.

Capacity and capability issues in the Croydon MAP East Team

- 5.77 The internal report identified that there were questions about the effectiveness of the team leader and that there were concerns about the implementation of key processes within the team.
- 5.78 We note that performance management of the team leader had been instigated prior to the internal investigation interviews taking place. The internal investigation team was unable to interview the team leader, as he had been unexpectedly absent for an extended period of time. We had hoped to interview him but this was not possible, as he had not returned to the Trust following his period of unexpected absence, because his contract had been terminated.
- 5.79 In our interview with the Head of Pathway, we learned that the team manager role for Croydon MAP was a band 7 role and that this was different for Croydon compared with Southwark, Lewisham and Lambeth. We understand that funding issues meant that there were fewer layers of management support in Croydon. The Head of Pathway was responsible for the strategic and operational management of the Croydon MAP services, which included two MAP community teams, the personality disorder day treatment service and also the Croydon Integrated Psychological Therapy Service.
- 5.80 The Head of Pathway told us that she had kept supervision and performance management records for the team manager from the time she took over management responsibility for the team in April/May 2012. The Head of Pathway told us that the performance management records would have been kept in the relevant disciplinary case file, and that she stored supervision records on her computer and in the team manager's disciplinary case.
- 5.81 We asked the Trust for copies of the supervision records but they were not available. We understand that the team manager's (supervisee) contract was terminated about a year prior to the Head of Pathway (supervisor) leaving the Trust and therefore there was no reason for her to hand the records on to another manager. The Head of Pathway told us that areas of concern relating to the team manager's performance were communication; completion of Care Programme Approach reviews within specific time periods (this team was the only team in the Trust not achieving the required standard); and appropriate escalation of issues.

- 5.82 The Head of Pathway told us that the Croydon MAP East team was “*completely overwhelmed*” with the huge caseload they had, at one point this caseload was over 1,000 clients. We understand that there were large numbers of referrals and that it was the view of the Head of Pathway that the capability of the team was weighted towards psychosis (rather than balanced between psychosis and mood, anxiety and personality) and that this was because of the prevalence of psychosis in the area. The Head of Pathway told us that she didn’t believe that the large numbers of referrals or the consequential workload for staff had been anticipated. We understand from the Head of Pathway that a full time care co-ordinator would have had a caseload of between 30 and 35 clients at the time and the occupational therapist (duty worker on 13 December) told us that this has now reduced to between 25 and 30 clients. The occupational therapist told the internal investigation team that although she only worked 18 hours per week, at the time of the incident her caseload was as high as 30 clients.
- 5.83 We understand that the expectation of the Head of Pathway was that it was the responsibility of the team lead to ensure that:
- care co-ordinators were aware of which clients had been allocated to them;
 - appropriate supervision and oversight was provided to care co-ordinators so that all clients were followed up and that Care Programme Approach reviews were completed on time.
- 5.84 We understand there were concerns about the team manager’s communication with his team and this was an issue that formed part of his performance management and subsequent termination of contract.
- 5.85 Concerning the issues of new assessments, case management and duty. We understand at the time staff were expected to:
- attend ward rounds for newly allocated, or existing clients whilst they were an inpatient;
 - assess new referrals coming from the community, inpatients or the home treatment team;
 - provide care co-ordination to existing clients;
 - provide treatment for existing clients;
 - participate in duty sessions.
- 5.86 It is clear that a care co-ordinator attending a ward round would not have been a priority, given the other pressures on staff. The occupational therapist told us that workload pressures have improved significantly since 2012. Responsibility for assessments and ongoing treatment has been split into separate teams; the occupational therapist now has a workable caseload and opportunity to do a specified number of occupational therapy assessments per month. She also told us that duty responsibility has improved and she is

required to do two duty days per month. The occupational therapist told us that previously it was very difficult to find time to complete relevant paperwork due to time spent in face-to-face work. She gave this as the reason she didn't complete her entry following the appointment with Mr B on 13 December until 3 January, as she finished her duty that day, was on duty again twice the following week and then went on leave. We understand at the time there were a number of different roles expected from the person covering duty that are not present now. There remains, on average, one occasion per week when the occupational therapist has contact with a client that she is unable to write up that day.

- 5.87 The duty worker told us that she was the only part time worker in the team, and that there was a high turnover of a number of agency staff. We were told that as a part time worker, it was difficult for her to access a reflective practice group as it was held on one of her non-working days. We learned that the issue was being discussed and that this position was expected to change. We also understand that the number of agency staff in post now has significantly reduced and that the staff team is more stable.
- 5.88 The Trust has told us that the functions of the team have now been split into two teams: an assessment and liaison team, and a treatment team, and that management functions have also been separated. Patients with a diagnosis of psychosis are now supported through the Psychosis CAG Promoting Recovery Teams.
- 5.89 In order to help us understand the capability issues within the team, we asked the Trust to provide us with information about requirements and compliance for attendance at staff training for domestic abuse awareness and safeguarding (adults and children). However despite escalating this request to the Director of Nursing the information was not forthcoming.

6 Complaint made about Mr B's care and treatment

- 6.1 As we have indicated earlier in this report, when we met with Mr B's family they provided us with information about a complaint that had been made to the Trust. This section provides:
- A summary of the complaint;
 - An overview of Trust staff involved in managing the complaint;
 - A chronology of actions and communications that followed receipt of the complaint by the Trust;
 - An analysis of the response provided by the Trust.

Summary of the complaint

- 6.2 On Wednesday 21 November 2012 Miss N sent a letter of complaint on behalf of Mr B to the PALS (Patient Advice and Liaison Service) officer at the Trust. Although Miss N sent the letter it appears from the clinical records that she did

not actually attend the meeting with Dr J and therefore everything she reports is what Mr B reported to her.

- 6.3 The letter described the expectation and outcome of an appointment Mr B had had with Dr J on Monday 19 November. At this appointment Dr J had told Mr B that there was nothing wrong with him and that he only had anger issues. Miss N pointed out that this was *“despite a number of psychiatrists at the hospital giving a diagnosis of bi-polar”*. During the appointment Mr B recalled that Dr J only asked questions about anger management and at no point did Dr J ask why Mr B had tried to commit suicide on a number of occasions or what issues in his past had led to the diagnosis of bi-polar. When Mr B tried to say that there were other issues he wanted to discuss, Dr J said that they *“would come to that later”* but this never happened despite Mr B asking a number of times during the consultation.
- 6.4 Dr J had said to Mr B that he *“was not the type of guy that should have issues like this”*. When Dr J asked about Mr B’s court case and prison Mr B explained that when he thought about it and other issues in his life he felt suicidal, however the issue of suicide was not discussed. Dr J just said to Mr B that he *“didn’t want to go to prison and that he wouldn’t kill himself as they wouldn’t let him”*. Miss N quoted Dr J as having said *“you just feel angry because you don’t want to be associated with people like that”*. Mr B felt that Dr J was judging him and that he was being accused of faking symptoms to get out of going to prison.
- 6.5 Mr B had tried to explain that he had experienced continual cycles of deep depression, being suicidal, paranoid and having delusions and hallucinations. At the end of the appointment Dr J asked if there was anything else Mr B wanted to discuss. Mr B again said he felt depressed and suicidal and tried to discuss this but Dr J simply said *“sorry about that”*. Mr B left the appointment feeling *“depressed, let down and suicidal”* and wanted to give up completely. Miss N reported that it took two carers and a telephone call from the home treatment team to relieve Mr B of his anxiety and feelings of hopelessness. (This is recorded in paragraph 4.32).
- 6.6 Miss N said that Mr B felt that the appointment had taken him backwards again, rather than helping him in his recovery and that he had experienced ongoing mental health issues from a young age. Miss N reported that Mr B had finally agreed to get help and was on track with a team of carers and the home treatment team. However the appointment with Dr J had knocked his confidence and Mr B now doubted if he would be able to “make inroads into his mental illness”.
- 6.7 Miss N said that for the last three days one of Mr B’s carers had left four messages for Dr J to call her (one of Mr B’s carers) so that she could discuss Mr B’s mental health issues from the previous few years to try and explain his situation from a different point of view. At the time that Miss N sent the letter (10:48 pm), the carer had not yet had a return call.
- 6.8 Earlier on 21 November Mr B had gone to collect the medication that the home treatment team had prescribed for him. When he arrived Dr J *“wanted*

to speak to him” because he had heard that Mr B wanted to complain about him. Dr J told Mr B that he had not advised him to stop taking the medication and that he had only said to wean off the diazepam. Miss N pointed out that Dr J should have been clear to which medication he was referring because he did state “all medication should be stopped when he got home”.

- 6.9 Miss N provided Mr B’s name and mobile telephone number at the bottom of the letter and attached it to the email to the PALS Officer.

Overview of individuals involved in complaint

- 6.10 There were a number of Trust staff involved in managing Miss N’s complaint and we have provided an overview of those individuals below:

- Ms L2 – Complaints Coordinator Assistant
- Mr M – Business Manager, Mood Anxiety and Personality Services
- Mr D – Service Director
- Dr R – Clinical Director, Psychiatric Medicine
- Dr B – Consultant Psychiatrist, Psychiatric Medicine and second complaint investigation manager for this case
- Ms J2 – Service Manager, Croydon Home Treatment Team
- Dr S2 – Consultant Psychiatrist, Psychiatric Medicine and first complaint investigation manager for this case
- Mr H – Complaints Coordinator
- Ms C2 – CSL Croydon Liaison and Home Treatment Team
- Ms M2 – Assistant Director, Complaints and Patient Advice and Liaison Services
- Dr L – Consultant Psychiatrist, Medium Secure Psychiatric Hospital

Chronology of actions and communications

- 6.11 The PALS officer forwarded this email to the complaints team the following day.
- 6.12 On 23 November the complaints team graded the complaint as moderate and Ms L2, a member of the complaints team forwarded the complaint to two members of staff, Mr M (a business manager for the mood, anxiety and personality service) and Mr D, for an investigation to commence. Ms L2 also sent an email to Miss N in which she acknowledged Miss N’s letter and advised that the PALS Officer had forwarded the letter to the complaints team. Ms L2 indicated it would be helpful to discuss the concerns in more detail and to understand what Miss N would like the complaints team to do in response

to the letter. Ms L2 advised that as Miss N had provided her telephone number the complaints team would contact her shortly. Ms L2 further advised that as Miss N's complaint related to care and treatment provided to somebody else, written consent from Mr B would be required before any information could be disclosed to her about his health. Ms L2 stated that an authorisation form had been sent to Mr B for him to indicate whether he would give such consent. Ms L2 indicated that if Mr B did not give his consent the Trust could only address the concerns Miss N had raised in relation to non-clinical issues. The letter and accompanying authorisation form were sent to Mr B the same day.

- 6.13 On 27 November Miss N emailed Ms L2 to advise that Mr B had completed the form and returned it. Miss N said she hoped to hear from Ms L2 soon so that the issues with Mr B's treatment could be discussed.
- 6.14 On 3 December Miss N emailed Ms L2 again to say that she had not heard anything regarding the complaint. She again advised that Mr B had signed and returned the form and wanted to know when she would be contacted. Later that day Ms L2 forwarded Miss N's email to Mr M and Mr D highlighting that Miss N had not yet been contacted. Ms L2 also noted that Miss N had advised that Mr B had signed the consent form but that it had not been received at that time.
- 6.15 On 4 December Mr D emailed Dr R and requested advice about who the investigation should be allocated to. Mr D noted that the response was due by 21 December and that as of yet they had not made contact with the complainant. On 7 December Dr R's personal assistant emailed Dr B and advised that the investigation had been allocated to him.
- 6.16 In the meantime, on 5 December Ms L2 forwarded a copy of a patient authorisation form to Mr M.
- 6.17 On Wednesday 12 December Mr M emailed Ms J2, the team manager for the Croydon home treatment team, and Dr S2 to ask whether they were investigating the complaint. Ms J2 responded almost immediately to advise that she was not aware of any complaint and asked for more information. Ms J2 stated that if Dr S2 was meant to be investigating the matter, he was unexpectedly absent at that time. Mr M provided more information and advised that he didn't know whether Dr S2 had started the investigation because he (Mr M) had been away from the office when the complaint had been received.
- 6.18 On Wednesday 12 December Dr B emailed Ms L2 to advise that the investigation had been allocated to him and that he was planning to see Dr J that Friday. Dr B sought advice from Ms L2 as to whether he should:
- Meet with the complainant alone;
 - Meet with the complainant with Dr J;
 - Arrange for Dr J to meet with the complainant.

- 6.19 On the same day, Ms L2 forwarded this request to a more senior member of staff, Mr H, and asked him to give Dr B some advice.
- 6.20 The following day (13 December) Mr M emailed Dr R to ask that the investigation be allocated to another consultant because Dr S2 was unexpectedly absent from work. Dr R advised that it was the same investigation that had been discussed with Mr M by Dr R's personal assistant, that the investigation had been allocated to Dr B and an extension had been requested. Mr M then contacted the complaints department to clarify whether an extension had indeed been requested and if so, for how long.
- 6.21 On the same day Ms L2 received a further email from Miss N who advised that she had received no follow up communication. She also advised that she had contacted ICAS²² who had no record of the complaint and asked that somebody let her know what was happening. The following day (14 December) Ms L2 responded to Miss N to apologise for the delay in providing a response and cited the reason being that the investigating officer, Dr B, was on leave. Ms L2 reassured Miss N that Dr B would be in touch shortly. Ms L2 clarified that ICAS would only become aware of the complaint if Miss N provided the information to ICAS and asked for their support in making the complaint.
- 6.22 Ms L2 responded to Mr M on 14 December and advised that Dr B had spoken with Mr H the previous day and that a two-week extension had been requested. Dr B later responded indicating he thought Mr H had agreed to an extension to the week of 14 January 2013. Also on 14 December Ms L2 forwarded Miss N's email of the previous day to Dr B, Mr M and Mr D to ask that Dr B contact Miss N to discuss her concerns. Dr B advised that he had emailed Miss N that week but had not received a response from her and that he was meeting Dr J that day.
- 6.23 Later the same day (14 December) Dr B emailed Ms L2 again after his meeting with Dr J. Dr B reported that Dr J had told him that Miss N had been *"posing as various members of [Mr B's] family in recent weeks - including posing as his wife over the phone to Croydon HTT, and posing as his sister when she visited him on Croydon Triage last week. She has also written the complaint letter 'on his behalf' and signed it from him"*. Mr B sought confirmation from Ms L2 that the Trust had seen evidence that Miss N had gained Mr B's consent to proceed with the complaint. Mr B also sought advice about what view should be taken of *"the above circumstances in terms of how [Miss N] is going about things"*.
- 6.24 Ms L2 responded to Dr B on 17 December and included a copy of the authorisation form. She asked that he contact Mr B directly to see if he would provide authorisation. Dr B noted that the authorisation form appeared to have been signed by Mr B's wife or carer and that he would contact Mr B.

²² Independent Complaints Advocacy Service was a free service that helped individuals in making a complaint to an NHS organisation. According to the NHS England website, the service ended on 31 March 2013.

However he felt that he could not proceed with the investigation until he had secured Mr B's consent.

- 6.25 There is no other information on the file until 16 January 2013, which is a letter from the Chief Executive to Mr B. The letter was attached to an email that Dr B sent in which he asked for clarification about whether a copy of the letter should be placed on the client's electronic patient record. The letter refers to a response being provided by Mr J, in response to the complaint. We have not received a copy of this. The letter was subsequently reviewed by the Chief Executive who asked that changes be made to the draft letter and that the Trust's apology should be clearer. These comments were sent back to Dr B via the complaints team on 24 January.
- 6.26 On 25 January a Ms C2 (role unknown) advised Mr H that Mr B was at that time in prison and was unlikely to be released for some time due to a "very serious charge". She advised that Mr B's case was the subject of a serious incident investigation and asked therefore that Mr H seek advice about what should happen with the complaint. Mr H responded within an hour to advise that the complaints team had discussed the issue and could not see a reason why the "current circumstances" would be relevant to the historic concerns. Mr H advised that a complaint response still needed to be re-drafted in light of Chief Executive's comments.
- 6.27 On 12 February Mr H forwarded the email exchange with Ms C2 to Mr M and advised that the complaints team was still waiting for a revised copy of the letter. Mr M forwarded the exchange to Dr B to ask for a timescale for the revised letter. Dr B responded the following day with a revised letter, noting that he had provided a more robust response.
- 6.28 On 8 March a Ms M2 (role unknown) sent an email to Dr B, copied to a number of other members of staff. Ms M2 advised that the response had to be put on hold until the serious incident investigation had been completed. Ms M2 advised that "We will notify the complainant/ patient accordingly" and asked that Dr B confirm the date of his telephone call with Mr B as this information was not clear in the draft letter. There is no indication that Ms M2 received a response to this request.
- 6.29 On 2 May Mr M emailed Mr H to ask why the complaint remained "open" on the system because a response appeared to have been sent on 13 February.
- 6.30 On 27 June Mr M emailed Ms M2 to advise that following a discussion with a senior manager, they could see no reason why the letter could not be sent as the Board Level Inquiry had almost concluded. There is no indication of a response to this query.
- 6.31 On 9 July Mr M emailed Dr L, a consultant forensic psychiatrist who had recently assessed Mr B. Mr M sought Dr L's advice about how the complaint response might be received by Mr B. Dr L indicated that he thought the letter should be placed on file but would seek the views of the team in the medium secure hospital that was being considered for Mr B.

- 6.32 Also on 9 July Ms M2 sought confirmation from one of the senior managers involved in the serious incident investigation that the contents of the draft letter did not contradict the findings of the investigation. This confirmation was received but it was noted that Mr B was no longer at the home address cited at the top of the letter.
- 6.33 On 11 July Dr L advised that the chair of the team meeting did not feel it was an appropriate decision for them. Mr M then sought advice from Ms M2.
- 6.34 The following day Mr M asked the medium secure psychiatric hospital to clarify an expected date of admission for Mr B. Mr M chased this query on 24 July and received a response the following day. The medium secure psychiatric hospital had not agreed to admit Mr B. Mr M therefore contacted Ms M2 to suggest that the letter be placed on Mr B's file as it was felt unwise to send the letter to him in prison. Ms M2 disagreed with this view.
- 6.35 On 26 July the Assistant Director for Patient Safety advised that Mr B's trial was scheduled to start within a couple of weeks and reminded key staff that it was likely to generate publicity and media interest.
- 6.36 On 6 August Ms M2 emailed the complaints team to ask that the letter be sent to Mr B and the investigation closed.
- 6.37 The letter was finally sent to Mr B in the medium secure psychiatric hospital on 20 August.

Analysis of response provided by the Trust

- 6.38 In considering the response of the Trust to the complaint raised by Miss N we have made reference to the Trust's Complaints Policy dated October 2010.

Acknowledgement and initial contact

- 6.39 The Trust provided a timely acknowledgement of the complaint to Miss N and allocated the investigation to two managers. The Policy states that the complaint should be acknowledged within three working days, and this was done within two working days.
- 6.40 The complaint investigation was sent to two members of staff with instructions to "*investigate or delegate as appropriate*". No action at all was taken until on 4 December when Ms L2 forwarded Miss N's email of 3 December advising that she had not been contacted. At this point Mr D simply asked to whom the complaint should be allocated. The complaint was not actually allocated to Dr B until 7 December, ten days after the acknowledgement letter was sent. The Trust has advised us that the complaint was originally allocated to Dr S2 but that this doctor was unexpectedly absent from work shortly after being nominated. We have not seen the evidence trail of this nomination, nor of any actions taken to source an alternative complaint manager until after Miss N chased progress of the investigation on 3 December.

- 6.41 Appendix 4 of the Complaints Policy states that initial contact by the allocated complaints investigator should be made with the complainant within five working days of the acknowledgement.

Service user consent

- 6.42 The complaints team was right to seek Mr B's consent to discuss aspects of his care with Miss N, but this should not have prevented the investigating manager from seeking more information from Miss N in the meantime. At section 3.1 of that policy it states:

"If the complainant is not the service user, the consent of the service user, should be requested of the complainant. If a complaint from a carer or relative relates to the care of a service user, care must be taken not to disclose personal health information without the express consent of the service user."

- 6.43 Trust staff had the opportunity to obtain more information from Miss N without disclosing any personal health information about Mr B. Miss N made contact on three occasions after emailing the initial complaint letter:

- On 27 November advising that the form had been returned and that she hoped to hear soon;
- On 3 December to advise that she had received no communication from the investigators;
- On 13 December to advise that she had still received no communication from the investigators.

- 6.44 Had the Trust staff been proactive, they would have identified that Mr B had been an inpatient for 13 days during the initial three weeks following receipt of the complaint. This provided plenty of opportunity for consent to have been sought.

Allocation of complaint investigator

- 6.45 There is no clear evidence that the complaint was allocated to anyone after it was sent to Mr D and Mr M on 23 November. It is unclear why Mr D should seek advice from the Clinical Director in order to allocate an investigating officer but it is only after this advice was sought that on 7 December Dr B was allocated the investigation.
- 6.46 There is an inference in email communication on 12 December from Mr M to Ms J2 that a Dr S2 may have been asked to investigate, but the manager of Dr S2's service appeared to have no knowledge of this. Dr S2's manager advised that she was not aware of any complaint and asked *"was Dr S2 investigating the matter and if so what is the complaint?"*. It is very unclear how Dr S2 would have been allocated the role of investigating manager because Mr M advised he had been out of the office when the complaint was received.

- 6.47 There was a lack of clarity about who was responsible for allocating an investigating manager and whether an investigating manager had actually been identified, until two weeks after the complaint was received. This significantly reduced the time available to complete the investigation by the initial deadline.

Contact with the complainant or service user

- 6.48 On 14 December Ms L2 sent an email to Miss N apologising for the delay in providing a written response and advised that the reason was that the investigating manager Dr B had been on annual leave. We have seen no evidence to indicate that this was true. In addition as we have stated above, the investigation had not been allocated to Dr B until five working days prior to this email.
- 6.49 Also on Friday 14 December Dr B advised Ms L2 that he had emailed Miss N that week but had not received a response. We have not seen a copy of that email.
- 6.50 Following Dr B's meeting with Dr J, Dr B raised concerns about reports that Miss N had been posing as various members of Mr B's family. Dr B sought advice about the view that the Trust should take and was advised to contact Mr B directly to see if he would give consent. Dr B then said he could not proceed with the investigation until Mr B's consent had been secured.
- 6.51 In the time between Miss N submitting the complaint and this exchange between members of staff Mr B had been admitted as an informal patient and discharged (29 November) and admitted on Section 2 and discharged (6 December to 12 December). Had assertive action been taken to investigate the concerns raised staff would have realised that Mr B was an inpatient and would have had easy opportunity to establish his views about his treatment and ask about consent to share information with Miss N.
- 6.52 There were multiple missed opportunities to progress the complaint investigation during this period of time.

Extension of investigation deadline

- 6.53 The original deadline of 21 December was set by the complaints team when the complaint was sent to Mr M and Mr D for investigation or delegation.
- 6.54 On 13 December Ms L2 advised that a two week extension to the investigation deadline had been agreed. This therefore moved the deadline from 21 November to 4 January. However there is an email from Dr B indicating that Mr H had agreed to an extension to the week of 14 January 2013. We have not seen any correspondence that corrected this statement, nor any indicating of why the deadline had been further extended.
- 6.55 The Trust policy states:

"If due to the complexity of some complaints an extension of the agreed time limit is sought. the Complaints Team should contact the complainant and invite

their agreement, explaining the reasons for the request. No pressure must be placed on the complainant to agree to the extension but the Complaints Manager may, in suitable cases, consider it appropriate to explain that a comprehensive response may not be possible to achieve within the original agreed timeframe. All reasons for such a delay must be well documented and record any details surrounding discussions concerning agreed/disagreed extensions.”

- 6.56 At the time the request for an extension was discussed, the complaint had not been identified as complex and Miss N was not given the opportunity to choose to agree or otherwise. Miss N was also not give the true reason for the delay.

Simultaneous complaint and serious incident investigation

- 6.57 At section 3.8 the Complaints Policy also sets out the process to follow if a complaint is received during the course of an investigation under the serious incident procedure:

“The procedure for investigation of Serious Untoward Incidents is separate from the complaints procedure.

If a complaint has been received by the Trust during the course of an investigation under the Serious Untoward Incident procedure the latter procedure will take precedent.

The complaint should be acknowledged and complainant kept informed throughout the process with a final response explaining the outcome of the investigation when completed.

When a complaint alleges serious misconduct or a criminal offence including:

- *Physical abuse*
- *Sexual abuse*
- *Financial misconduct*

This will be a formal complaint. It should also be reported as an incident and investigated in accordance with the Trust’s SUI procedure.”

- 6.58 At no time was any correspondence sent to Mr B, Miss N or Mr B’s family after the serious incident investigation was commissioned. The view of the complaints team on 25 January was that despite the “current circumstances” a letter should still be sent to Mr B.
- 6.59 We have seen evidence of questions or email discussions regarding whether or not Mr B should receive a letter in May, June and July. However, with the exception of one occasion, at no point have we seen evidence that any member of staff involved in those exchanges considered the impact of the delay in responding from the service user’s perspective.

Deadline for Trust response

- 6.60 The Trust policy provides no parameters for the timeframe for complainants to receive a response to their complaint. Appendix 2 simply states that a full response will be provided within the timescale agreed with the complainant. As no follow up contact was made with Miss N this timeframe was never agreed.
- 6.61 In addition, no evidence has been provided to indicate that anybody actually spoke to Mr B about the complaints raised on his behalf. The final resolution letter was eventually sent almost 39 weeks after the complaint was made. No other communication was sent to Mr B or Miss N in the intervening period.

Summary

- 6.62 Our review has identified that the Trust failed to practice their own policy in initially contacting the complainant and providing a formal response following investigation within a suitable time frame.
- 6.63 We have made a recommendation (Recommendation 16) so that the Trust can ensure that similar failings cannot happen in future.

7 Policy review

Trust domestic violence policy

- 7.1 We have reviewed the Trust domestic violence policy and in doing so have drawn upon the following documents:
- Department of Health's publication: *"Responding to Domestic Abuse: A handbook for health professionals"*. This document is available online and although it was published in 2005 it remains relevant and a very helpful resource for all health practitioners, Trust managers and policy makers. It references a sample domestic violence policy, which is likely to be a useful template, but this is only available via an accompanying CD ROM which we have not accessed.
 - *NICE Quality Standard (QS116) Domestic Violence and Abuse – February 2016*. <https://www.nice.org.uk/guidance/QS116/chapter/Introduction>
- 7.2 Overall the content of the policy provides a comprehensive and constructive overview for Trust staff in domestic violence awareness that relates to their direct work with patients. It gives helpful and clear processes and pathways for frontline staff to follow regarding the identification and response to disclosures of domestic violence by patients. However, there is insufficient clarity regarding what the Trust management's responsibility or commitment is in providing the working environment and the comprehensive domestic violence training required in order that practitioners can carry out their obligations safely and effectively.

- 7.3 There is reference to a related human resources policy on workplace violence for situations where a Trust employee is experiencing domestic violence. This is not extended to the Trust's policy on how it will respond where an employee is identified as using domestic violence. It is our view that the Trust domestic violence policy should clearly include more detailed processes for responding to both perpetrators and victims identified within the workforce, including a protocol for reporting concerns about a colleague.
- 7.4 The bulk of the document takes the form of a practitioner handbook rather than a policy, and as such duplicates similar documents such as the Department of Health 2005 handbook. A more useful format for a domestic violence policy would comprise a shorter, clear policy focussed on obligations and tasks to be carried out by each grade of staff within the Trust in various situations where domestic violence is an issue. This should also include specifically what training and clinical supervision or support should be provided and what senior managers will commit to do to ensure the policy is achievable. It is our view that there should also be a separate handbook accompanying the training which can then be used as an ongoing guide to good practice and professional development.
- 7.5 Within the above Department of Health 2005 handbook, there is useful guidance for policy makers and Trust managers, including the following in relation to writing a domestic violence policy.

“What should be included in domestic abuse policy? As a bare minimum, policy should include:

- a) a description of the principles underpinning the policy;*
 - b) a definition of domestic abuse;*
 - c) information on the national and local context;*
 - d) an outline of expectations of policy;*
 - e) the Authority's or Trust's approach – to include reference to who has responsibility for asking a woman about domestic abuse. By saying that everybody needs to take responsibility for asking about domestic abuse, you might risk nobody doing so. The main responsibility should lie with the person with primary responsibility for a woman's care. It is of paramount importance that your policy is underpinned with education and training, supervision and support for staff.”*
- 7.6 We know that a third of domestic violence victims are men²³, and therefore where the handbook specifically references female victims, the Trust should not make a gender differentiation.

²³ The Home Office Statistical Bulletin of 2009/10 estimates that among adults (aged between 16 and 59) 15.8% of men and 29.4% of women have been victims of domestic violence since the age of 16. It estimates that this represents around 2.6 million men and around 4.8 million women. Looking at the numbers of victims in the last year, 4.2% of men and 7.5% of women

- 7.7 The Trust domestic violence policy reflects the minimum inclusions reference in the Department of Health 2005 handbook in the following ways:
- a) Section 4.4 states the principles underpinning interventions around domestic violence, which incorporate those given in the handbook. The principle stating that practitioners should not attempt specialist interventions themselves but refer to local agencies is missing from the Trust's stated underpinning principles, however there is considerable reference in the body of the policy to the need to refer to other services where appropriate and a good list of local and national domestic violence services.
 - b) There is a comprehensive section on the definition of domestic violence in Sec 4.3.1. Whilst there is interesting and helpful information here, a shorter clearer summary of what the Trust intends to use as its definition, would have been preferable, with the additional external links and research findings included in a separate training handbook.
 - c) Sections 4.5 – 4.9 outline issues around the prevalence of domestic violence and its effects, including links to mental health issues. Whether this can be viewed as a summary of the national and local context, within which the Trust policy has been written, is arguable. As with much of this Policy, this section contains a lot of interesting and useful information around domestic violence, which would be better contained within a separate handbook.
 - d) Section 4.3.2 gives a good list of the aims of the Trust policy, and these points do reflect what the document goes on to deliver. It is also clear to whom the policy is targeted and whom it affects.
 - e) Section 4.3.3 states all Trust staff *"have a role in identifying and responding to disclosures of domestic violence."* The explicit direction that the main responsibility should lie with the person with primary responsibility for the relevant patient's care is missing from this policy. There is therefore a risk in situations where practitioners are covering for absences, or dealing with high caseloads, that the lack of an explicit policy instruction on responsibility for this task, could lead to oversights or misunderstandings over responsibilities. There is also a very clear expectation that this work requires a good level of training, to which we make reference later.
- 7.8 The NICE Quality Standard (QS116) Domestic Violence and Abuse document has recently been published and contains four key quality statements:
- Statement 1 People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.
-

are estimated to have experienced domestic violence equating to around 677,000 men and 1,207,000 women. So on both of these measures about one third of victims are men.

Statement 2 People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff.

Statement 3 People experiencing domestic violence or abuse are offered referral to specialist support services.

Statement 4 People who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.

7.9 Each of the above comprises details of what the statement means for service providers, practitioners and service users. There is therefore an expectation that the Trust has a responsibility to ensure that its frontline staff are equipped to undertake their stated tasks. The Trust policy reflects these four statements in the following ways:

Statement 1 There are clear references in Section 5.2 regarding the need for the practitioner to find a private space where they can interview the patient alone about any potential experiences of domestic violence. There is also reference to the need to allow time for disclosure to be made. Furthermore, there is detailed guidance within the policy to assist practitioners in identifying and asking patients about potential domestic violence.

The onus for creating and finding this space and time appears to sit with the practitioner; there is no reference to Trust responsibilities in ensuring that on a strategic level they plan for suitable space to be created and available at all reasonable times for this purpose, or that workloads are within manageable limits to enable time to be spent by practitioners in gathering disclosure in a safe and sensitive way with patients.

Similarly, in relation to how effectively staff are trained in identifying and asking questions around domestic violence, there is a strong assumption that the staff members will absorb the learning within this document and seek out further locally provided training or online learning and guidance tools. Only basic reference is made in Section 14.3 to the responsibility of senior managers and clinicians in ensuring staff members are aware of the Policy document and have access to local training events.

Statement 2 This follows on from Statement 1 in that it requires training to be provided for practitioners that can enable them to safely and effectively identify and ask questions around domestic violence.

We would strongly advise against reliance solely upon written information (such as the handbook-style guidance within this policy), or the standard local Safeguarding Board DV training events. These will be insufficient for staff who are tasked with directly questioning and responding to patient disclosure from either victims or perpetrators. Local Safeguarding Board training events are usually basic generic awareness courses and rarely

tailored to the specific service delivery issues experienced by mental health professionals. This policy does not give any indication of what depth and quality of training is required for SLAM practitioners in this context.

Handbook-style guidance which makes up the bulk of the policy document, is an excellent resource but only when accompanied with specialist, tailored training that includes plenty of: experiential components; skills practice and reflective discussions around victims' experience of domestic violence; the additional complexities and risk factors linked to mental health issues; and a patient's potential experiences of further powerlessness in carrying a "mental illness" label, as well as strategies for professionals to adopt around their own self-care.

There is very little reference in the policy to what constitutes adequate and effective training, clinical supervision or ongoing professional development in domestic violence for mental health workers, and no reference to the Trust's obligation under the policy to provide this training or ensure the time and budget is provided to enable it to be obtained externally. There is no reference in the policy to the level 1 and 2 training requirements that are explicitly mentioned in the NICE Standards.

Statement 3 This relates to the referral pathways into local specialist services when domestic violence has been identified. The Trust care pathway flowchart in Section 6 is useful and easy to follow, with reference to a range of local support agencies and further services detailed in a later Appendix.

Section 14.2 states the responsibility of senior clinicians and managers to make visible in the workplace the contact details of local support services, which is positive.

Statement 4 This relates to the referral pathways into appropriate interventions for people disclosing or identified as being the perpetrator of domestic violence. Section 9 of the policy responds to this reasonably well, outlining a process of identification and risk assessment, as well as giving the national Respect Phone-line details. However it does not recognise the significant level of anxiety that this process can create for practitioners who are generally not trained or confident in engaging with domestic violence perpetrators directly around their use of violence or abuse.

The lack of referrals of abusers into local domestic violence perpetrator services by general health or mental health practitioners (less than 1% of DVIP's annual perpetrator referrals are via health professionals) reflects the reality of how hard and potentially intimidating it feels for frontline staff to approach potential perpetrators regarding their behaviours.

Adult safeguarding policy

- 7.10 We have reviewed the Pan London Policy and the Trust Safeguarding Adults Policy.
- 7.11 In our opinion the Pan London Policy would have been fit for purpose at the time of use in relation to this case. However best practice would be to include the safeguarding adults training requirements of staff.
- 7.12 The most recent Trust Safeguarding Adults Policy was ratified in 2015, however it should be noted that in the version control section it is evidenced that the policy was initially agreed in 2008 by the Governance Executive and then not reviewed again until December 2013. This review took place a year after the incident and the Trust Safeguarding Adults Committee approved the revised policy.
- 7.13 The revised policy references Section 59 of the Safeguarding Vulnerable Groups Act 2006, describing how an adult person can be vulnerable in the context of different settings. There are references to domestic violence and the Trust policy in place; however there are no references to referrals to MARAC.
- 7.14 It is our opinion that the Trust Safeguarding Adults Policy is not fit for purpose. It does not give the reader clear direction as to what steps to take to raise concerns about a vulnerable adult and it does not lead the reader to consider that a carer could be at risk. There are numerous links to other policies rather than referencing them in the appendices therefore a member of staff would be unable to use this policy in 'hard copy' needing a computer to follow links, which would put staff working in community teams at a disadvantage. The policy concentrates on the management and governance of safeguarding locally, and whilst this is required it takes the focus away from the patient and frontline staff.

Child safeguarding policy

- 7.15 We have reviewed the Pan London Safeguarding Children Policy, the Trust Safeguarding Children Policy 2015 and the Trust Safeguarding Children Policy and Procedures 2008.
- 7.16 It is our view that the Pan London policy is comprehensive and covers all aspects of safeguarding children for all agencies.
- 7.17 The Trust Safeguarding Children Policy 2015 has good links to relevant other policies and gives staff clear expectations of child protection conferencing and working with children on child protection plans. This is a very comprehensive policy with sufficient information to give the professional clear direction of safeguarding children.

8 Internal investigation and action plan

8.1 The internal investigation team comprised:

- the head of clinical pathway (forensic);
- a consultant psychiatrist, PICU and liaison team;
- the Trust investigation facilitator.

8.2 The internal investigation was not commissioned until January 2013; this was outside of the timeline stated in the Trust Policy for the Investigation of Incidents, Claims and Complaints version 2.2 dated September 2011. Section 5.1 of the policy details timescales to be met for incidents of varying severity. For incidents with a severity classed as A or B the policy states:

“Investigation commissioned outside CAG/s involved at Level 2 as soon as possible but in any event 10 working days of the notification of the incident.”

“Structured investigation completed within 60 working days from date of notification to completion of the investigation, report and Trust BLI. Investigation to be completed by the Team Leader or other senior manager not directly involved in the event.”*

“ A structured investigation incorporates a root cause analysis.”*

8.3 In waiting until January 2013 to commission the investigation the Trust was immediately acting outside of its own policy. However, we have been told that the initial delay was as a result of Police Gold Command instructions that no members of staff should be interviewed prior to police interviews with staff taking place. It is not our view that the Trust could or should have challenged this statement. However there were further delays *“due to clinical and organisation commitments”* that meant the investigation team were unable to meet until the end of January 2013, five weeks after the homicide.

8.4 The final report was originally scheduled to be discussed at a Board Level Inquiry meeting on 25 April 2013, however this was postponed at the request of the Service Director for MAP Clinical Academic Group so that a senior representative from the local authority could attend. The Board Level Inquiry eventually took place on 14 June 2013 when the Director of Adult Care Commissioning was present.

8.5 The internal investigation report identifies that some recommendations put forward by the investigation team were amended at the Board Level Inquiry. We asked the Director of Nursing why amendments would be made and were told recommendations are sometimes amended during the *“fit for purpose”* check.

8.6 The final recommendations were:

“R1 An improvement in clinical staff awareness of issues relating to violence and abuse, primarily against women, as service users and the partners, carers or members of the family of service user is needed. The revised and reissued Trust Policy on Domestic Violence and Partner Abuse should be publicised widely across all services and used as the vehicle for a concerted awareness raising exercise. Policy standards within the document should be audited periodically.

R2 The policy and practices around seven day follow up are reviewed to ensure they meet the requirements of the organisation and comply with national guidance.

R2a In the meantime it is recommended that the Assistant Director of Patient Safety drafts and distributes a Blue Light Bulletin that clearly states the standard expected for seven day follow up.

R3 Concerns regarding the performance of the care co-ordinator will be brought directly to the attention of the service team by the Nursing Member of the Board Level Inquiry Panel – Deputy Director of Patient Safety and Assurance.

R4 The investigators have been informed that a further restructuring of Croydon MAP East Team is underway. The investigators recommend that as part of the restructuring there is:

- a review of the duty system and allocations systems;*
- a skill mix review to ensure that the team have the skills required to manage a challenging client group.”*

8.7 The Trust produced an action plan to respond to the recommendations above. We have reviewed the progress made against the action plan and note that the Trust has indicated that all the required actions have been completed.

R1 An increase in focus of domestic violence within risk assessments, training and policy has been implemented to strengthen practice. We have seen a screen shot from the e-learning safeguarding training, however the focus of this is on child safeguarding. The Trust Domestic Violence Policy was updated in March 2013. Whilst this was a risk that was not given proper attention, there was also the issue of the risk of domestic violence towards Mrs B. It is our view that there has been insufficient focus on raising awareness of the impact of domestic violence on partners or carers of service users.

We have reviewed this policy and our comments can be found at Section 7 above.

There has been a revision to the Child Need and Risk Screen to include a section on domestic violence. We have seen a screenshot of this and can see that it prompts staff to consider whether a MAPPA²⁴ referral is required. It is our view that staff should also be prompted to consider whether a MARAC referral could be appropriate.

- R2 Automated emails have been introduced that are sent to both the assigned care co-ordinator and the sending clinician that lists the date for the seven day follow appointment as six days after discharge.
- R2a A bulletin was sent to all staff highlighting the increased risks at the point of discharge from hospital. The document reminded staff of the responsibility to follow up on all patients and that those arrangements should be documented on ePJS.
- R3 We have seen a copy of the email sent to Ms L regarding action to be taken in relation to the performance of the care coordinator. The email advises that the view of the Board Level Inquiry panel was that service line management should decide upon the management action to be taken. The care co-ordinator was employed by an agency and therefore a management referral was made to that agency regarding his conduct. We do not know the outcome of that management referral.
- R4 A review of the service has taken place and the team has been restructured into separate assessment and treatment teams. The assessment team hold the duty function for the team. We understand that the restructure has allowed for a *“consistent approach to new assessments as well as ensuring that the teams are more focussed and have the time to reflect on the clients they are working with”*. We heard from a team member that the work balance between duty, care co-ordination and specialist assessments is much improved.

- 8.8 The recommendations identified by the internal investigation team responded sufficiently to the issues that the investigation identified. However, the internal investigation failed to identify the lack of carer's assessments and support, or the absence of risk assessments and care plans.

9 Overall analysis and recommendations

Predictability and preventability

- 9.1 Predictability is *‘the quality of being regarded as likely to happen, as behaviour or an event’*.²⁵ An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been

²⁴ Multi-agency public protection arrangements (MAPPA) are in place to ensure the successful management of violent and sexual offenders. This guidance sets out the responsibilities of the police, probation trusts and prison service. It also touches on how other agencies may become involved, for example the Youth Justice Board will be responsible for the care of young offenders.

²⁵ <http://dictionary.reference.com/browse/predictability>

predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.²⁶

- 9.2 Prevention²⁷ means to ‘*stop or hinder something from happening, especially by advance planning or action*’ and implies ‘*anticipatory counteraction*’; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.
- 9.3 In considering the issue of preventability we have made our assessment based upon the information known to health services only. The Domestic Homicide Review report stated:
- “Had the agencies involved with [Mr B], [Mrs B] and [their child] worked more effectively and as part of a functioning coordinated community response to domestic violence, they would have been better able to identify and manage the risks [Mr B] posed to [Mrs B] and [their child], and [Mrs B] may not have died.”*
- 9.4 We share the sentiments in this statement and it is our opinion that the Trust contribution to this information sharing had the opportunity to be significant. Despite being in contact with Trust services for only 11 weeks, there were a significant number of contacts with a range of staff, most of whom received reports of, or were witness to Mr B’s outbursts.
- 9.5 The assessments submitted to the court by the two forensic psychiatrists indicated that Mr B had an “*untreatable personality disorder*”. However this does not appear to be the view of Trust staff as Mr B had been referred to one of the Mood, Anxiety and Personality teams.
- 9.6 Given these facts it is our view that further violent episodes from Mr B were predictable, and indeed occurred during the 11 weeks he was in contact with the Trust. However there was no intelligence to suggest that an episode of as severe as the attack on Mrs B could have been predicted.
- 9.7 It is **possible** that Mrs B’s death could have been prevented if the following actions had taken place:
- a more robust and assertive response was provided by the Trust following Mr B’s presentation at A&E on either 5 or 23 October;
 - more attention was given to developing an assessment and treatment programme on discharge from Greshams 2 on 29 November or Croydon Triage on 11 December;

²⁶ Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

²⁷ <http://www.thefreedictionary.com/prevent>

- the referral to CIPTS, identified by home treatment team staff as being required, was actually made and Mr B had engaged with such therapy;
- a more intensive response was provided following Mr B's arrest and assessment under the Mental Health Act on 18 and 19 December.

9.8 The recommendations have been given one of three levels of priority:

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

Priority One

Recommendation 1

The Trust must ensure that up to date, comprehensive care plans are in place for all patients under the care of liaison psychiatry, home treatment team and Croydon Triage, particularly those who have been detained under the Mental Health Act and who are subject to Care Programme Approach. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Recommendation 2a

The Trust must ensure that risk assessments and risk management plans are in place for all patients under the care of liaison psychiatry, home treatment team and Croydon Triage, particularly those who have been detained under the Mental Health Act and who are subject to Care Programme Approach. They must also be reviewed when new information comes to light. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Recommendation 2b

The Trust must ensure when assessments of clients who are in police custody are undertaken, that clinicians obtain a clear history from police staff about the client's forensic history.

Recommendation 3

The Trust must ensure that all staff consider the role of carers and that carers assessments and appropriate support are offered and documented, this includes drawing up an accurate family diagram. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Recommendation 5

The Trust must ensure that when a diagnosis is recorded appropriate plans are put into place for ongoing treatment and support and this is reviewed and amended, if appropriate, when any changes to the diagnosis are made.

The Trust must ensure that when changes are made to a patient's diagnosis, the management plan must be revised accordingly and must be consistent with the revised diagnosis and the patients' needs.

Recommendation 8

The Trust and Croydon Health Services Trust must ensure when a patient attends A&E for treatment and is seen by the liaison psychiatry service that appropriate records of that attendance and any interventions are recorded in line with both organisational record keeping policies.

Recommendation 13

The Trust must ensure that prior to discharging a client there should be an appropriate discharge plan and risk assessment in place that are shared with appropriate community staff and other agencies. Where possible this plan should be agreed and supported by the client and (subject to client consent) their carer.

Priority Two

Recommendation 4

The Trust must review the impact of the changes to policy and processes for child safeguarding, including obtaining feedback from staff about how effective the new processes are.

Recommendation 6

The Trust must clarify the care pathway for patients with personality disorder and ensure that staff are aware of the referral criteria for access to psychological services.

Recommendation 7

The Trust must ensure that processes are in place to trace the correct GP for clients when a client record indicates that a client is not registered with a GP; and that this must be undertaken within seven calendar days.

Recommendation 14

The Trust must identify all stakeholders required to be present on the Board Level Inquiry panel at the point that investigations are commissioned, in order to reduce delays in implementing lessons learned.

Recommendation 15

The Trust must manage clinical and organisational commitments appropriately to ensure that they do not cause delays in investigation of serious incidents and implementation of learning.

Recommendation 16

The Trust must review the detail of the actions taken in response to the complaint made by Miss N to assure themselves that the failures in investigating and communicating in a timely fashion cannot be repeated.

Priority Three

Recommendation 9

The Trust must ensure that community staff understand and comply with the lone working policy and that staff read the records and undertake an appropriate risk assessment about the home visit prior to leaving Trust premises.

Recommendation 10

The Trust must make the following amendments to the domestic violence policy so that it is in line with best practice:

- clarify the Trust responsibility and commitment in providing the working environment and comprehensive training required in order that practitioners are able to meet their obligations safely and effectively;
- clarify the Trust response when it is identified that an employee is a perpetrator of domestic violence;
- include more detailed responsibilities for responding when victims or perpetrators of domestic violence are identified within the workplace, including a protocol for reporting concerns about a colleague.

N.B. This recommendation is based upon our review against best practice and has no direct link with this incident.

Recommendation 11

The Trust must provide a separate handbook on the process for responding to clients or carers affected by domestic violence, to give greater detail to staff outside of the Trust policy.

Recommendation 12

The Trust must review the Adult Safeguarding Policy to ensure that it provides staff with clear direction as to what steps to take to raise concerns about a vulnerable adult, particularly when that person is also a carer.

Appendix A – Terms of reference

Generic terms of reference

- 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 Mr B's first contact with services to the time of his offence.
- Review the appropriateness of the treatment of Mr B 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 Mr B harming himself or others.
- Examine the effectiveness of Mr B'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

Specific terms of reference

- Review why there was a delay in starting the internal investigation
- Establish if there was a carer's assessment undertaken, if not then why not, as there were safety concerns regarding Mr B's wife and possibly the child
- To consider the number of contacts that Mr B had with the police and whether further multi-agency working may have assisted in assessing the risk Mr B posed to others (especially his wife and child) and others
- To consider the wider safeguarding issues in relation to Mr B's wife and child
- Assess the capacity and capability issues and workload concerns raised by the internal report

Appendix B – Documents reviewed

South London and Maudsley NHS Foundation Trust Documents

- Client records for Mr B
- Trust Final Serious Incident Investigation Report dated July 2013
- Trust Action Plan
- Transcripts of interviews conducted during the internal investigation
- Investigation of Incidents, Complaints and Claims Policy v2.3 August 2012
- Incident Policy v3.1 July 2015
- MAP Treatment Operational Policy Final September 2015
- Operational Croydon Assessment and Liaison MAP Final
- Home Treatment Team Operational Policy v2 July 15
- Home Treatment Team Operational Policy v3 1 October 15
- Croydon Triage Operational Policy updated October 2014
- Care Programme Approach Policy v2 2011
- Care Programme Approach Policy v2.1 April 2015
- Supervision Policy v3 October 2011
- Supervision Policy v4 September 2014
- Safeguarding Children Policy and Procedures - June 2008
- Safeguarding Children Policy - August 2015
- Domestic Violence Policy - Final v9 March 2013
- Blue Light Bulletin – expected practice for discharge follow up
-

Other Documents

- Standing Together Domestic Homicide Review report
- Individual Management Reports submitted to the domestic homicide review team completed by all agencies (except for the police)
- St George's University Hospitals NHS Foundation Trust clinical records

- Croydon Health Services NHS Trust clinical records
- Violet Lane Medical Practice clinical records
- The Blackheath Standard Surgery clinical records

Appendix C – Professionals involved

Pseudonym	Role
Dr A	Section 12 doctor
Dr D	Consultant Psychiatrist, Croydon Triage
Dr I	Senior House Officer, Liaison Psychiatry
Dr J	Triage Ward doctor
Dr M	Liaison Psychiatry
Dr N	Specialist Registrar on call
Dr S	Liaison Psychiatry
Dr T	S.136 Doctor, Lambeth
Dr V	Specialist Registrar
Mr A	Psychiatric Liaison Nurse
Mr C	STAR worker, Home Treatment Team
Mr G	Crisis Resolution/Home Treatment Team Practitioner
Mr P	Team Leader, Croydon MAP East
Mr R	Crisis Resolution/Home Treatment Team Practitioner
Mr T	Approved Mental Health Practitioner, Home Treatment Team
Mr Y	Care Co-ordinator, Croydon MAP East
Miss V	Consultant Vascular Surgeon
Ms A	Liaison Psychiatry
Ms C	Home Treatment Team
Ms D	Occupational Therapist, Duty MAP Team East
Ms E	Approved Mental Health Practitioner
Ms G	STAR worker, Home Treatment Team
Ms O	Liaison Psychiatry
Ms L	Liaison Psychiatry
Ms M	Senior Clinical Charge Nurse, Liaison Psychiatry CUH
Ms N	Triage ward staff
Ms R	AMHP, Liaison Psychiatry
Ms S	Home Treatment Team
Ms T	Welfare Benefits Co-ordinator

Appendix D - Chronology of Mr B's contacts with the Trust, local hospitals, his GP and information gained from the Domestic Homicide Review report

Date	Source	Event	Information
Jun-02	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B attended an appointment accompanied by his mother complaining of low mood. Not assessed as suicidal. Mr B was advised to have counselling and no medication was prescribed. No evidence of referral for counselling or follow up regarding low mood. Mr B was resident at his family home at this time.
2003	Standing Together Report: Croydon CCG IMR	A&E attendance	Mr B was admitted to Lewisham A&E after a 99 call, having been involved in a motorbike collision with a car. Mr B sustained back pain, grazing to arms and legs which resulted in him being signed off from work at a supermarket for four weeks. He was also signed off work for fainting attacks and back pain due to heavy lifting at the supermarket at the end of 2003.
Early 2005	Standing Together Report: Croydon CCG IMR	Appointment	Mr B was seen for an unexplained swollen hand
Jul-05	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B was seen for heart burn and chest pain. Mr B was given advice by the GP regarding stress management, physical exercise and prescribed Gaviscon for the heart burn. Mr B was resident at his family home at this time.
Late Jun 2006 to late Aug 2008	Standing Together Report: Croydon CCG IMR	Appointment	Mr B was seen a number of times regarding problems at work with his manager, work related stress, complaining of sleeping problems and back/joint pains.
October to November 2008	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B seen for chest pain and blood pressure monitoring by GP practice.
Early 2009 to August 2009	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B sought advice regarding family planning as he had been trying to conceive with a partner for the previous two years and had a three year old child. The investigations continued to be conducted by the GP practice until August 2009.
05/06/06	Standing Together Report: Croydon CCG IMR	GP registration	Mr B registered with Blackheath Standard Surgery - no initial concerns noted at registration.
30/09/07	Standing Together Report: Croydon CCG IMR	A&E attendance	Attendance at A&E - no evidence for reason for attendance and no follow up.

Date	Source	Event	Information
Aug-08	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B seen for vaccinations to be administered for travel to Turkey.
2009	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B had appointments at a number of GP practices regarding stress at his work, being bullied and managers wanting to demote him. Mr B continued to request sick certificates and had problems with back pain and family planning. A referral to Mayday Urology Department was made [date unknown].
27/03/09	GP records	Document receipt	Received from Mayday Healthcare NHS Trust advising that insufficient sample of sperm was present for the planned test to be completed. Test to be repeated.
Nov-09	Standing Together Report: Croydon CCG IMR	GP contact	Mr B left a telephone message for the GP but the reason is not documented neither is there evidence of any follow up.
Early 2010	Standing Together Report: Croydon CCG IMR	GP contact	Mr B contacted the GP practice by telephone, as he had not received an appointment following the referral to the urology department. The GP practice informed Mr B that the letter had been sent to his Croydon address. Mr B informed the practice that he had moved back to Blackheath and wished to stay with the Blackheath practice. The practice informed him that he needed to re-register with a Croydon GP to be referred back to Mayday Hospital.
07/04/10	GP records	Appointment	New patient check - unclear at which practice.
18/03/11	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B was seen by Dr Y at Blackheath Standard Surgery as he felt unwell and expressed suicidal thoughts. There was a query as to whether he had taken an overdose of tablets. It is documented that his sleep was poor, waking early and that he had urges to kill someone from his previous job. Mr B felt angry and felt like destroying things like his sofa, and then didn't know why he had done it. Mr B told the GP that he had "jarred" someone when he was 17, had difficulty staying in one job for long and that his family had a strong history of schizophrenia. The GP made a referral to the Assessment and Shared Care Team for urgent assessment and possible admission.

Date	Source	Event	Information
25/03/11	Standing Together Report: Croydon CCG IMR & GP records - not Violet Lane Medical Practice	GP appointment	Mr B was seen at Blackheath Standard Surgery where he was screened for depression with a score of 21/24 [this would be considered high]. It was documented that he felt low, had poor appetite or binge eating, no suicidal thoughts. Mr B requested a sick certificate as he was due for a hearing at work the following day. The GP prescribed citalopram 20mg for one month and advised Mr B to attending the work hearing and contact the anger management team he had been referred to. The GP advised Mr B to contact the Samaritans or A&E if he felt suicidal. There was no discussion regarding the referral earlier in the month to the Assessment and Shared Care Team, or a repeat referral. The GP planned to review in one month, or earlier. There was no further follow up and this was the last consultation at Blackheath Standard Surgery.
Late March 2011	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B was seen at South Street Medical Centre where he was screened for depression with no action or follow up.
11/04/11	Standing Together Report: Croydon CCG IMR	GP appointment	Mr B was seen at South Street Medical Centre, Greenwich for ongoing depression and screened for depression with a score of 23/24 [this would be considered a high score]. He was referred to Ferryview.
06/07/11	GP records - not Violet Lane Medical Practice	Letter	GP practice received a letter from Ferryview to advise that Mr B had not attended his appointment with the Assessment and Shared Care Team at Ferryview Health Centre. There is no evidence of any follow up.
Feb-12	Standing Together Report: Croydon CCG IMR	GP contact	Mr B telephoned South Street Medical Centre; there is neither a record of the reason for the call nor evidence of any follow up.
12/03/12	GP records - not Violet Lane Medical Practice	Contact with others	Discussion with Mr B's mother who advised that Mr B's girlfriend had reported him missing. Mother wondered when he was last seen by the practice. Appears to be April 2011, telephone conversation in February 2012 to check smoking status.
22/03/12	St George's Hospital records	A&E attendance	Mr B presented at A&E and reported that he was advised by his GP to attend. Previous risk of self harm, increased depression and previous anxiety. Stated that he wanted to harm his manager "beat him up", had been arrested for throwing a jar at a friend, overdose in October 2011. Admitted cannabis use two weeks previously. Reported that he lived with his girlfriend Miss N (who was also recorded as his NOK) and that he had no children. Plan: discharge home to be seen by CMHT on 30/3/12, TTA diazepam 5mg x 3 days, to see GP if needs further medication.

Date	Source	Event	Information
05/10/12	SLAM records	A&E attendance	<p>Assessment in A&E following referral by the SHO. Mr B was admitted that afternoon by ambulance, accompanied by police following three days of self harm. Mr B reported a three week period of low mood with increasing thoughts of self harm. Over the previous three days he had taken an overdose of diazepam, attempted to hang himself and took cocaine with the intention of harming himself. Records show that Mr B was medically fit for discharge from A&E. Mr B reported that at that time he was living between his partner's home, his ex-wife's home and friends' homes. He reported a long history of depression and cycling mood and said that he had seen a psychiatrist on several occasions. Also reported that he had been diagnosed with depression and bipolar disorder and that he had been seen in Tooting and Greenwich. It was noted that he <i>"attends for the first appointment and does not return and does not follow the treatment plan"</i>. Mr B initially denied any alcohol or substance misuse but later disclosed to the AMP that he had been using steroids for the previous three weeks. Mr B initially presented as agitated and aggressive and not wanting to engage in the assessment process. However as the assessment progressed his behaviour became increasingly inappropriate - he poured water on the floor of the room, emptied the paper towels, emptied the gloves, threatened to trigger the fire alarm, tried to pull the wires from the computer and set off the alarm in the room on several occasions. Mr B's mood appeared to fluctuate between being calm, rational and engage to being verbally aggressive and elated. No evidence of psychotic symptoms, disorientated to time, orientated to place and person.</p> <p>Risks: threatening to self harm on arrival but denied self harm when informed that the psychiatrist wanted to assess him.</p> <p>Carers view: Mr B's partner was very concerned about his safety, feeling that his mood was cycling and that he would be at risk again if he left the department.</p> <p>Plan: assessment by psychiatrist offered, but declined by Mr B, not willing to remain in department, given information where he could get help in the future should he need it.</p>
10/10/12	SLAM records	Action	Staff member checked Mr B's details on NHS Smart Card - <i>"No GP Registered"</i> .
23/10/12	CUH records	A&E attendance	Attendance

Date	Source	Event	Information
23/10/12	SLAM records	MHA Assessment	Mr B presented to Croydon Hospital A&E on 23/10/12 at 15:09 with his wife, mother and father. Mr B complained of trying to kill himself three weeks previously. On the day of attendance at A&E he reported that he had taken cocaine, steroids and had drunk and injected white spirit into his arm. He also tried leaving the gas on and sucking the gas from the cooker. An informal admission was initially agreed with Mr B, however when he was informed about the bed allocation he changed his mind and said he did not want to go to hospital. A MHAA was therefore requested. The assessment found that Mr B was calm with normal speech and no delusional beliefs or obsessive thoughts, and no visual or auditory hallucinations. Mr B described his mood swings with low mood and depressive symptoms, anxious and agitated and at times verbally aggressive. Mr B said that when he felt low he sometimes acted impulsively and said that he had no control over the feelings. The assessor said Mr B needed help but that he did have protective factors of his wife and child and that Mr B was frightening with what he had done. Mr B was he no longer had self harm or suicidal thoughts and did not want to die. Mr B wanted to get support with his mood difficulties. The assessing doctors felt that the least restriction would be to consider HTT involvement and assessment of possible depressive and mood difficulties, which were contributing to a chaotic life. Mr B said he would agree to HTT but didn't want to go to hospital. Mr B told doctors that he could guarantee his safety and he would let HTT staff know if his suicidal feelings returned. As Mr B agreed to the treatment plan with HTT the doctors did not consider him to be detainable as he was agreeing to seek help to try and manage his mood disturbances.
24/10/12	SLAM records	First contact and discharge	First contact and discharge from Croydon Home Treatment Team. See following note from GP records for content of contact.
24/10/12	GP records	Document receipt	Receipt of discharge summary report from Croydon Home Treatment Team. No diagnosis made yet and no mental health assessment as Mr B had to be sent for emergency medical attention during the consultation. HTT staff found Mr B in bed at home; Mrs B informed staff that Mr B was in a lot of pain. HTT staff saw that Mr B was writhing about complaining of severe pain in his arm that he had injected with white spirit. Staff examined his arm, which was very swollen, almost white, and Mr B said that he was unable to move his fingers. The lower arm was also very swollen, looked red and discoloured in places. Mr B was very shivery and his forehead was hot to the touch. Staff were very concerned about Mr B's physical health and advised him to attend Croydon Hospital A&E immediately. Mrs B agreed to drive him.

Date	Source	Event	Information
24/10/12	CUH records	A&E attendance	Mr B was seen in A&E and then admitted to an orthopaedic ward. Mr B reported that the previous day he had been feeling suicidal and injected cocaine, fly spray and white spirit into his arm in an attempt to end his life. Mr B reported that afterwards he was annoyed that he hadn't been successful.
24/10/12	CUH records	Letter	Letter from Dr H, SHO to "whom it may concern" providing summary of Mr B's presentation, surgery and post operative plans.
25/10/12	CUH records	Progress note	22:00 SPR doctor reviewed Mr B and explained that the operation would need to be repeated 48 hours later for a further assessment of the injury.
25/10/12	CUH records	Progress note	22:36 Psychiatric liaison staff called to ward as Mr B had been presenting with several management problems. Several members of Mr B's family were present when Ms M, Senior Clinical Charge Nurse, Liaison Psychiatry arrived on the ward. Ms M spoke at length to Mr B and reinforced what behaviours were and were not acceptable whilst on the ward. Mr B agreed to 'tone down' his irritability.
25/10/12	SLAM records	Assessment	Liaison psychiatry staff reported that they had received a number of calls from CUH ward staff that day as he had become increasingly difficult to manage. The situation on the ward was reported as so difficult that the matron had requested immediate attendance by the liaison team. Ms M went to the ward to see Mr B at approximately 22:00 and on approaching the bed area she could hear Mr B's raised voice complaining to the nurse about the level of pain he was experiencing. Ms M also noted that several members of Mr B's family and his ex-wife were seated and standing around his bed. It was reported that Mr B's relatives had acted in a confrontational and accusatory manner towards the nursing staff about ignoring Mr B and allegedly <i>"telling him that it was his own fault why he was in the situation"</i> . Mr B told Ms M that he had repeatedly asked ward staff to give him something to help calm him, but he believed he was being ignored. Mr B also spoke of his fear and vulnerability being on the ward and his worry of possible amputation of his arm or total loss of use, and the effect this would have on his physical self image. Ms M spoke with Mr B's mother, brother, father and ex-wife whom she understood had been visiting throughout most of the day. Ms M suggested that they go home so that Mr B could get some rest - they agreed and left the ward. PLAN: further review both physical and psychotropic medication; assess mental state and toleration of current pain management; observe for signs relating to possible opiate withdrawal; consider whether 1:1 RMN was required; review progress of current treatment plan

Date	Source	Event	Information
26/10/12	CUH records	Progress note	09:45 The doctor explained the procedure and findings. He explained to Mr B that necrotic tissue had been taken and that he had compartment syndrome and that it was not possible to predict how much muscle function would return. The doctor explained "it would be difficult and he had to be patient".
26/10/12	CUH records	Progress note	Mr B was seen by Mr A, Psychiatric Liaison Nurse. Mr B presented as calm and rational during interview, reported a history of low mood, suicidal ideation and "giving up in life". Mr B was happy to remain in hospital for further medical treatment and follow up by mental health services upon discharge from CUH. Mr B requested that his wife be allowed to stay with him overnight as it made him feel less "paranoid and trapped". Plan if Mr B tried to discharge himself against medical advice, consider Section 5(2) MHA.
26/10/12	SLAM records	Assessment	Mr B was seen by Mr A, Mr B was unable to recall the events of the previous evening. Mr B informed Mr A that he had left his job as a fitness instructor approximately 4-5 weeks previously as he felt himself becoming unwell. Mr B also told Mr A about his court case for fraud and that he expected a one year prison sentence. PLAN: further review on 27/10; Mr B requested that his wife be allowed to remain with him overnight as it made him feel less "paranoid and trapped" - if not feasible 1:1 RMN overnight; if Mr B attempted to discharge himself against medical advice consider Section 5/2 MHA.
27/10/12	CUH records	Progress note	Mr B was seen by psychiatric liaison services (unable to identify clinician). Seen with wife present. Mr B willing to remain in hospital, reported having nightmares and aggressive response, very anxious.

Date	Source	Event	Information
27/10/12	SLAM records	Assessment	<p>Mr B was seen by Ms O both independently and then with his wife. When seen independently he was standing in an upright position visibly distressed by physical pain. Mr B said that his pain was not well managed and became anxious as he believed that Ms O was there to arrange for him to be moved to another ward. Mr B explained that during the night he had had a nightmare and had responded in an aggressive manner which had disturbed other patients. Mr B said that he had apologised to those patients that morning. When seen with his wife, the general opinion appeared to be that Mr B continued to be irritable and impulsive. Mr B believed that staff on the ward were unsympathetic to him and that staff attributed his current situation to his own making and said that this view upset him. Mr B's wife remarked that his behaviour had improved during the three days he had been on the ward - Mr B said that his wife had a positive influence in controlling his agitation on the ward.</p> <p>Ms O recorded that although Mr B was calm during assessment, she was not certain that his agitation and challenging behaviour was being well managed in terms of medication therapy. Plan: discuss medication management with the on-call psychiatrist the following day.</p>
27/10/12	CUH records	Progress note	<p>23:30</p> <p>Mr B was seen by psychiatric liaison services (unable to identify clinician). Mr B appeared settled and calm. PRN haloperidol administered. Plan: continued with diazepam 5mg, patient needs 1:1 RMN, to be reviewed by psychiatrist.</p>
28/10/12	SLAM records	Assessment	<p>Mr B was seen and reviewed by Ms O. No change in presentation compared with the previous day, pain not managed by medication, unable to sleep during the night, continued to experience fleeting thoughts of self harm. Risk to self and others - moderate. Managed at that time by the presence of Mr B's wife. Staff to consider use of antihistamine to manage anxiety.</p> <p>PLAN: medication to be reviewed by Dr S on 29/10.</p>
28/10/12	CUH records	Progress note	<p>15:00</p> <p>Mr B was seen by psychiatric liaison services (unable to identify clinician). Mr B felt that his pain was not being managed, presented as tremulous and nervous, low in mood with fleeting thoughts of self harm. Mr B wanted to know the long term plan but was aware that medical treatment was ongoing.</p>

Date	Source	Event	Information
28/10/12	SLAM records	Assessment	<p>23:15</p> <p>Ms A received a call from the SHO who informed her that Mr B was very agitated, verbally abusive to nurses, refusing treatments, threatening to leave the ward against medical advice. Unable to assess capacity. Diazepam and haloperidol was discontinued without rationale. Ms A suggested calling security and tried to administer diazepam and haloperidol. On assessment, Mr B appeared calm and agreed with the medical treatment. PLAN: continue with current treatment, suggested that SHO prescribe diazepam and haloperidol on a regular basis. Suggested 1:1 RMN obs and nursing in a single room to provide privacy and dignity. To be reviewed by psychiatrist the following morning.</p>
28/10/12	CUH records	Progress note	Mr B became increasingly aggressive towards staff, shouting , swearing and threatening violence. Mr B stated he was going to leave, staff informed him this would be against medical advice. Security staff were called, psychiatric liaison were bleeped and urgent review was requested. Mr B left the ward and staff were advised to administer diazepam and haloperidol as per previous psychiatric advice.
29/10/12	CUH records	Progress note	Dr S, liaison psychiatry came to assess Mr B but he was recovering from surgery and in a deep sleep. Plan discussed with Mr B's wife: to use regular diazepam; to be reviewed again, if possible the same day.
30/10/12	CUH records	Progress note	Dr S saw Mr B who gave a history of many attempts to harm himself and end his life. Events triggered by changes in circumstances. Denied alcohol or illicit substance misuse, but admitted occasional use when his mind was disturbed. Normal speed and happy to be alive after latest attempt. Plan: referral to talking therapy, information leaflet and application form to be given to MR B by Dr S, gradual reduction of diazepam, started with sertraline - dose to be titrated, to be reviewed by psychiatric liaison team the following week.
30/10/12	SLAM records	Assessment	Mr B was seen on the ward and case discussed with medical team. Mr B gave a history of many attempts to harm and end his life. Attempts triggered by various changes in his circumstances, some may be minor/trivial such as an argument with his wife. MR B denied being a regular user of alcohol or illicit drugs, admitted occasional usage when his mind was disturbed and having unpleasant moods, then he could use anything available to harm himself. Sleep was improving, healthy diet. Mental state appeared relaxed, maintained good eye contact and cooperative in manner. Normal speech. Happy to still be alive after latest attempt to kill himself and wanted to make positive changes in his life. PLAN: referral to talking therapy, information leaflet and application form provided; gradual reduction of diazepam; start sertraline 50mg; staff to monitor and support; to be reviewed by liaison team the following week or earlier if necessary.

Date	Source	Event	Information
04/11/12	CUH records	Nurse transfer letter	Nurse transfer letter completed but unclear to where he was being transferred. Risk issues noted as self harm and that "needs wife to be there at all times or special".
05/11/12	SLAM records	Assessment	15:00 Ms L assessed Mr B as an emergency. Mr B had not been sent to SGH as according to the notes there were no beds, however the ward sister had said his referral had not been accepted due to the history of self harm. The ward sister advised that the plastics team would see Mr B in his current ward. Mr B was being treated by the tissue viability nurse so Ms L was unable to assess properly. Impression was that Mr B was not currently suicidal. PLAN: for complete assessment the following day or later in the week.
06/11/12	SLAM records	Assessment	10:45 Mr B was seen by Dr M, staff grade psychiatry doctor and the ward sister. Ward sister advised that Mr B had been very unsettled, getting angry with staff and had threatened the security guard with a knife. He had also become fixated on the nurses who used to be a neighbour and said he wanted to murder her. Mr B had also described suicidal thoughts. Dr M noted that Mr B had three female visitors staying by his bed 24/7 which had been agreed by the nursing staff - Mr B stated they were his "life-line" in hospital. Mr B described that he felt he "wanted to murder the nurse who used to be his neighbour and that he felt suicidal as if was going to kill himself she would deserve to go as well". Mr B said that he heard voices that had negative content but denied that they directly instructed him to harm others, although it was felt that may be some potential association. Mr B said he saw a little man at the end of his bed with a "screwed up face" - he was aware that nobody else had seen the man and said that this had concerned him, that he was "unable to tell reality". Mr B expressed concern about being taken to a psychiatric unit and being locked away against his will but accepted that he needed help to talk about his issues. PLAN: required urgent psychiatric assessment and transfer for inpatient care; staff to clarify if information admission can be agreed, if not then MHAA given risk and threat of murder; surgical ward advised to maximise on security; surgical staff agreed to transfer to psychiatry and will give surgical handover re ongoing care; ongoing risk assessment needed as well as psychiatric assessment to determine appropriate management.
06/11/12	CUH records	Progress note	16:15 Mr B was seen by the tissue viability nurse who reviewed and redressed the wound. The wound appeared clean and healthy.

Date	Source	Event	Information
06/11/12	SLAM records	Contact with others	18:00 Ms R was asked by a colleague to see Mr B as Dr M had requested a MHAA, but had not completed a first medical recommendation for S2. Ms R advised that the liaison team request completion of first medication recommendation by the duty SPR. PLAN: Dr A, S12 doctor to attend at 21:30 to undertake assessment. Bed identified at The Dene Hospital, Hassocks. EDT AMHP Ms E to undertake assessment.
06/11/12	SLAM records	MHA Assessment	20:00 Dr V saw Mr B with his wife. Mr B was calm and pleasant. Dr V found that Mr B was low in mood but this was not pervasive. Mr B had intent to end his life but this had improved over the previous few weeks. Mr B cited his family as protective factors. Dr V noted clear narcissistic and antisocial personality traits that complicated the picture. Ongoing risks noted of <i>"IMPULSIVE self harm and, because of his nature, these are likely to be violent and extreme. There are also risks of violence towards others, but I am not convinced these are driven by mental illness"</i> . Dr V noted that Mr B's surgical situation was not stable and that he required close ongoing care and the input of a plastics team. Dr V's opinion was that a transfer to the bed in Hassocks was not in Mr B's best interest and noted that Mr B was accepting psychiatric medication, and was consenting to information psychiatric admission when required. PLAN: no need for further assessment under MHA; remain at CUH; continue sertraline and diazepam; prn haloperidol for agitation; prn zopiclone at night; Mr B advised that if his behaviour became unmanageable again staff would call the police; liaison review in the morning.
06/11/12	CUH records	Progress note	Mr B was seen by plastics staff who recorded that he had become psychologically unstable, aggressive and abusive. Referred to the psychiatric liaison team. Noted that Mr B was not on the ward at that time.
06/11/12	CUH records	Progress note	Consultant agreed to transfer Mr B to a psychiatric hospital as Mr B was being aggressive, paranoid and abusive to the nursing staff.

Date	Source	Event	Information
07/11/12	SLAM records	Assessment	Dr I assessed Mr B who stated he wished to be discharged home with input from the Home Treatment Team and 24 hour telephone helpline access. Dr I noted Mr B was supported at home by his wife and felt that she was the only person who stopped him from harming himself. Dr I noted Mr B had a 6-year old child and that he denied harming himself when his wife or child were around. Noted that wife would be taking time off work to care for Mr B who did not want admission to psychiatric unit as this would unsettle him. Dr I noted that Mrs B confirmed that prior to being admitted to hospital three weeks' previously Mr B experienced hallucinations. Mrs B said he seemed possessed and like he was being controlled by something. Mr B said he thought his wife was pregnant but now did not believe this. PLAN: reduce diazepam to 5mg bd; continue sertraline; refer to HTT, consider discharge to Mood and Anxiety CAG; IAPT referral form given to patient; surgical team informed liaison psychiatry that Mr B would be discharged home that day.
07/11/12	CUH records	SAP Contact Assessment	Completed by staff nurse at CUH, Document stated no registered GP, to attend walk in clinic and recorded wife's name as her maiden name.
07/11/12	CUH records	Progress note	The SHO noted that Mr B had refused to allow his vital signs to be checked for the previous 48 hours, however the SHO persuaded him to allow the observations to be taken that day.
07/11/12	CUH records	Discharge	Discharged from CUH following surgery.
07/11/12	SLAM records	Leave	Discharge letter for liaison psychiatry returned from GP surgery stating that Mr B was no longer registered at Waterfall House. Smart card check showed no GP registered.
08/11/12	SLAM records	Home visit	Ms S, HTT visited Mr B at home with a colleague. Mr B was casually dressed and appeared clean - he was seen with his wife. Mr B speech was hard to follow and difficult to interpret at times; Mr B informed HTT that he was feeling very 'horny' and that he and his wife had intercourse six times overnight but he was unable to ejaculate. Mrs B reported that Mr B would never usually discuss personal issues with anyone. Mr B said that his time in CUH had been very stressful and was adamant that the nurse that had been his neighbour had been 'winding him up'. Said that as long as his wife was with him he would be fine. Mrs B said that Mr B had always had mood highs and lows and experienced hallucinations since childhood, but his presentation was unusual and she felt it had worsened since he started taking the antidepressant a week previously. Mr B was not registered with a GP but intended to sort this out. Further contact agreed for the following morning and a medical review to be organised asap.
08/11/12	GP records	Registration	Mr B registered with Violent Lane Medical Practice.

Date	Source	Event	Information
09/11/12	SLAM records	Telephone call	HTT received a call from Mr B stating that he had been to the walk in clinic regarding the dressing on his wounds. Stated they were infected and he had been told to go straight to A&E as his arms were leaking puss. Mr B would therefore be unable to attend the medication review with the doctor that day. Call made to A&E liaison psychiatry to inform them Mr B was on his way and to read previous entries regarding his inappropriate behaviour.
11/11/12	SLAM records	Home visit	<p>Home visit by Mr C and AMHP. Mr B was at home with his wife and child. Met in Mr B's bedroom - he was calm and able to converse coherently. Mr B's main concern was the injury to his arm and the difficulties getting it dressed - he described being anxious when having to wait and becoming frustrated that the wound was infected. Staff assured Mr B that HTT doctor would see him early the following week when he would be able to discuss his concerns.</p> <p>HTT care plan: daily home visits; monitor mental state and risk to self and others; encourage concordance with medication; regular medical reviews with HTT doctors; offer education re illicit drug use; facilitate handover to appropriate team in due course.</p> <p>Mr B care plan: daily visits, reducing as progress made; allow HTT to explore mental health symptoms; feel able to discuss mental health with HTT; take prescribed medication; attend medical reviews with doctors.</p> <p>RECOMMEND: HTT do not visit unaccompanied.</p>
12/12/12	SLAM records	Home visit	Mr C and Mr G, HTT visited Mr B at home. Initially seen with wife and child but as staff were discussing his mental health and risks "we agreed that we would see him on his own". Mr B engaged well but at times seemed distracted or perplexed - Mr B described times when he felt he was not there and that things were not real. Discussed Mr B's work and recent events, Mr B explained that he hadn't disclosed his previous criminal record so that he could get the job but was later told he may need to do some work at Buckingham Palace so then chose to disclose his criminal record. Mr B was concerned as the judge had told him to expect one year in prison - he said he "would rather be dead than go to prison" - staff noted the statement was at odds with a typical criminal who would not be bothered by a small sentence. Mr G was happy that Mr B's guarantee of maintaining his own safety and protective factors of wife and child would be sufficient to keep him safe. Mr B denied thoughts or plans to harm himself. PLAN: needs urgent medical review, maintain daily contact h/v, monitor mental state and diagnosis.
12/11/12	SLAM records	Child Needs & Risk	Noted that Mr B's mental health was likely to impact on his capacity to meet the needs of the child. Alternative carer identified as Mrs B. Further details about child to be sought - to be followed up with liaison mental health at A&E. Mr C noted that he had " <i>handed this over to the team to gain further information on 30/10/12</i> ".

Date	Source	Event	Information
13/11/12	SLAM records	HTT ward round	10:00 Mr B's history noted, medical review planned for 9/11 but Mr B was unable to attend as his arm wound needed medical attention. Child risk needs to be assessed further - noted that HTT requested that liaison team follow this up but no evidence of this being documented. "PLEASE ACTION". Mrs B agreed that Mr B had always had mood swings but that his presentation was unusual and she felt it had worsened since Mr B had started taking antidepressants. VIEW: Mr B likely to have personality traits, compounded by abuse of prescribed and non prescribed drugs. Possibility of a functional illness, recent hypo-manic presentation may be secondary to stimulant use or possible iatrogenic due to medication. A number of risk issues, considerably concerned about six year old at address, risk to himself and others partially mitigated by HTT involvement. PLAN: medical review Thursday; HTT to urgently refer risk to child to social services; ask for UDS at next visit; continue visits in pairs; low threshold for admission given potential risks to himself and others.
13/11/12	SLAM records	Telephone call	Ms R called Mr B to offer him an appointment that evening. Mr B said that he was fine and more settled in his mental state and therefore did not require a visit that evening but "would appreciate one tomorrow am". Reported that Mr B continued to attend A&E to have his wound dressings changed. Ms R informed Mr B of his medical review with Dr J on 15/11 - Mr B said that he had another appointment with the muscular specialist that day so "would appreciate another appointment". RISK: unstable mental state in the context of stress was deemed to be ongoing.
14/11/12	SLAM records	Home visit	Mr B was seen at home by W and D (HTT staff). Mr B noted as welcoming, no hostility or aggression shown, mental state stable - denied hallucination but reported he easily forgot things, planned a walk with his wife and felt good after walks. Informed of medical review on 16/11. Mr B reported he was taking his medication and that he had some medication left. Staff informed Mr B that the child had been referred to Children & Family social services - "he was okay with that". Urine sample collected and sent for screening.
14/11/12	GP records	Document sent	Letter sent to patient re referral appointment
14/11/12	GP records	Appointment	Examination: weight 100kg; height 183cm; BMI 29.86 Medication: co-codamol 30/500 tablets; ibuprofen 400mg; movicol plain powder sachets 13.7g/sachet; sertraline hydrochloride 50mg; amoxicillin 500mg; metronidazole 400mg; flucloxacillin 500mg; diazepam 5mg
15/11/12	SLAM records	Contact with others	HTT staff contacted Croydon C&F social services to see if they had already received a child in need form. They confirmed they received a form from A&E on 6/10.

Date	Source	Event	Information
15/11/12	SLAM records	Home visit	Mr R and Ms S visited Mr B in the evening who was at home with his wife and child. Mr B reported that his mood was a little low in the morning and evening but said he had been sleeping well. Mr B denied taking any illicit substances since his admission to Croydon Hospital and informed staff that a skin graft would be required for his arm. Staff reminded Mr B of his medical review the following morning. No risks identified.
18/11/12	SLAM records	Home visit	Ms G visited Mr B at home accompanied by another member of staff. Mr B appear bright, speech was rapid but did not appear to have pressure of speech. Mr B informed staff that "he was getting worse", he stated that when waking at 4-5am he was experiencing increased thoughts to self harm. He stated they went and he was "fine all day" but then his mood became low before going to bed. Mr B was concerned that his medication could be wearing off - staff suggested he discuss it with HTT medic at review the following day. Mr B appeared to keep himself distracted during the day by going out, playing computer games etc. He told staff he was "never left alone and gestured to a female whom he called his carer. She stated that she used to be his boss." Mrs B was out with their child for the day but Mr B had to ask his carer where his wife was. No immediate risks identified at time of meeting.
19/11/12	SLAM records	Medical review	16:10 Mr B attended the medical review with Dr J. Mr B felt supported by his wife "I'm not going to kill myself while I'm supported by my wife". Dr J noted a long history of affective instability without triggers but Mr B was unclear and inconsistent when Dr J tried to clarify numerous statements from earlier entries. Dr J noted no evidence of mental illness that day and suggested to Mr B that his anxiety could be related to his court hearing and that the anxiety may reduce once he had attended. Mr B appeared surprised, saying that he "thought you would be writing to the courts to say I could not go" and that HTT staff had indicated that "being under HTT was like being in hospital so I would need to go". Dr J explained the support that could be provided to him and Mr B responded "I'm not worried about going, it's just that I was told I didn't need to go". IMPRESSION: Mixed personality traits - antisocial and emotionally unstable; harm use of cocaine and steroids. RISK: moderate to high risk of impulsive suicide. PLAN: continue HTT daily visits to closely monitor; no changes to treatment regime; HTT to obtain collateral history (following consent) from family regarding inconsistencies (psychotic symptoms, drug abuse, forensic history, premorbid personality, evidence of cognitive symptoms and family views around current and past risks).

Date	Source	Event	Information
19/11/12	SLAM records	Telephone call	17:40 Call received from Mr B's friend Miss N who was concerned about Mr B following his appointment with Dr J earlier. Mr B had called Miss N because he was told that his anti-depressant was going to be stopped and he was losing hope for the future. HTT staff asked what response Miss N wanted - Miss N was unsure why his medication was being stopped. HTT staff advised Miss N that Mr B could ring the team if he wanted to discuss aspects of his care; and that there were no immediate plans to discharge Mr B and he would be seen again the following day.
19/11/12	SLAM records	Telephone call	20:30 Miss N left a message on the HTT answerphone as she was more concerned about Mr B's risk of suicide. Staff rang Mr B and spoke with both him and his wife. Mr B said he was not happy with how the meeting with Dr J had gone and said he felt the doctor didn't listen to him. Mr B also said that he had been told by staff that he wouldn't have to attend court because of his involvement with the service and had been told by Dr J that he should attend. HTT staff advised Mr B and his wife that if his safety was compromised overnight they should call an ambulance and go to Croydon University Hospital for assessment by psychiatric liaison. Mr B talked about going to the hospital the following day to have further treatment on his arm. Staff reinforced that Mr B had not been discharged from the service and that he would continue to be supported and assessed during the court case.
19/11/12	GP records	Appointment	New patient health check
19/11/12	GP records	Appointment	New patient health check. Bipolar; urinalysis = no abnormality; had appointment with GP later; alcohol screen - AUDIT C completed 0 BMI 30.17; weight 99.4kg; height 181.5cm; BP 126/68
19/11/12	GP records	Document receipt	Copy of letter dated 14/11/13 from Croydon IAPT to Mr B advising that a referral had been received and that the waiting time was approximately seven weeks. Form included that Mr B needed to return within 28 days to remain on the waiting list.
20/11/12	SLAM records	Telephone call	Ms S received a call from a woman who stated she was Mrs B and asked Dr J to call her. Staff noted that the woman had an Australian accent - Ms S had met Mrs B several times and noted that the voice was different. Ms S reflected this information to the caller but she insisted she was Mrs B. Later a call was received from Mrs B advising that she and Mr B was at the vascular clinic that day and would not be at home for the home visit.

Date	Source	Event	Information
21/11/12	SLAM records	Telephone call	W received a call from Mr B advising that he was going to have further surgery that day and that he had run out of medication. No thoughts of suicide or harm to self or others reported. Mr B said he was not happy with the doctor who had seen him and wanted to complain. W advised Mr B how to complain and arranged for a prescription for further medication for Mr B to collect.
21/11/12	SLAM records	Ward round	HTT staff discussed Mr B in ward round. Mr B had informed staff that his court case was the following day, CUH staff had advised that Mr B was being admitted for day surgery only and would be discharged by the end of the day. Liaison team informed to risk assess before surgeons discharged Mr B that afternoon given concerns about increased risk to self around the court case. Mr B had told staff that his wife didn't understand his psychiatric condition but that his friend did. PLAN: liaison to risk assess prior to discharge from CUH; HTT to liaise with liaison regarding outcome and formulate further management plan accordingly; continue daily visits.
21/11/12	SLAM records	Telephone call	11:10 Call received by liaison psychiatry from HTT - Mr B was on the ward awaiting surgery, expected to leave CUH by 1800 that day and would not be staying overnight.
21/11/12	SLAM records	Telephone call	17:00 Call received by HTT from Mr B to say that he was still in hospital following his operation. Mr B admitted that he had left the ward earlier in the day as things were taking too long, however a doctor from CUH had called him and advised him to return which he did. Mr B appeared animated and did not mention feeling low or suicidal. PLAN: speak again once Mr B had left the hospital to arrange next contact.
21/11/12	SLAM records	Telephone call	20:55 Call received by HTT from Mr B to ask if staff were visiting as he had just returned from CUH. Staff advised visits not done late in the evening but happy to chat on the phone. Mr G asked Mr B if he would be attending court the following day - he said not as the surgeon had given him a letter to excuse him as he had an open wound and would be risking infection. Mr G asked if he was feeling suicidal - Mr B said not.
21/11/12	CUH records	Surgery	Mr B had further surgery on the wound to his arm.

Date	Source	Event	Information
22/11/12	SLAM records	Telephone call	Ms C called Mr B as he had requested a visit before 6pm that evening. Ms C apologised that she was already committed - offered later appointment or the following day. Ms C advised Mr B that she wanted to discuss onward referral to psychological services to support him in the longer term - he was happy with this. Mr B confirmed the court date had been delayed due to his physical health and denied any risk to self that evening. Ms C noted that originally HTT would support Mr B during the court case but that had been postponed. PLAN: visit the following day assess mental state and risk, if no longer in crisis, consider discharging to GP; onward referral to CIPTS for psychological assessment and intervention.
22/11/12	GP records	Appointment	Mr B had debridement and necrotic tissue excision right forearm, gaping wound and mesh, had further day surgery x4 in total. On treatment for bipolar. Home treatment team psych thought that he may need further assessment but not sure, to check with them. Having regular dressings. Medication: metronidazole 400mg; flucloxacillin 500mg Med cert 31/10-1/1/13
23/11/12	SLAM records	Home visit	16:10 Ms C and Ms S visited Mr B at home - he appeared to have been sleeping prior to the visit. Staff discussed the call where discharge plans had been mentioned. Mr B appeared unsure about what was happening - staff reiterated that referral to CIPTS was for psychological therapy and this was considered the best way for Mr B to move forward. Mr B said he was still unhappy about the medical review and felt the doctor had judged him. Mr B admitted that he put on a brave face when staff visited - staff reminded him of the importance of being honest and that they were not there to judge him. Mr B spoke about the court case and said if he went to prison he would kill himself as he wouldn't be able to cope with being locked up. No thoughts of harming himself at that time. Staff provided 1/52 supply of medication and encouraged him to make a GP appointment before his medication ran out. Staff encouraged Mr B to keep a mood diary and to allow his family to have input. DISCHARGED FROM HTT CASELOAD - LETTER TO GP, REFERRAL TO BE DONE TO CIPTS.

Date	Source	Event	Information
26/11/12	CUH records	Third party contact	Email exchange between Miss N and a secretary at Croydon Hospital. Miss N emailed advising that she was caring for Mr B and that Mr B wanted a second opinion and something in writing from Miss V regarding the treatment of his arm. Miss N advised that Mr B's view was that he should not have been sent him from hospital when he first presented at A&E. Miss N also advised that she and Mr B were making a complaint against the A&E for sending him home, a decision which they believed made his arm worse and resulted in Mr B requiring surgery and a long recovery. Miss N indicated that Miss V had agreed with Mr B and that Miss V had said she would be able to give a second opinion agreeing that Mr B should have been treated and not sent home on the first day. The secretary advised that she would pass the email on to Miss V.
26/11/12	GP records	Document receipt	Receipt of letter from Croydon University Hospital
27/11/12	SLAM records	Letter to patient	Letter from Dr J to Mr B following medical review on 19/12. Advised, should he require further psychological intervention his GP would be able to refer directly to CIPTS.
28/11/12	GP records	Document receipt	Receipt of letter from Croydon University Hospital
28/11/12	SLAM records	Telephone call	Call received by HTT staff from Mrs B - seeking advice as Mr B was agitated and suicidal. Staff advised to attend GP or A&E for assessment. Ms E discussed with team manager who explained there was no further intervention that would be helpful in the short term.
28/11/12	SLAM records	Assessment	16:45 Ms A assessed Mr B at request of A&E staff. Mr B presented to with his wife - alleged he had taken an overdose: 1 box ibuprofen (?12 or 24) at 12 noon. Wife did not see him take the overdose and didn't know about it. Wife found him with lots of tablets around him and stopped him taking more. Mr B felt suicidal and had the intention to kill himself. Court case on 29/11 - Mr B reported that he had an episode of being manic - query bipolar disorder - during the episode feels suicidal and thinks he would try again. PLAN: referral to medical for medical clearance; on call psychiatrist contacted for further assessment.

Date	Source	Event	Information
28/11/12	SLAM records	Assessment	19:40 CT1 doctor assessed Mr B who was accompanied by his wife and his friend Miss N. The previous day Mr B had received a letter from the courts reminding him of his appearance the following day. This triggered a sudden increase in his thoughts of ending his life. Mr B reported he had taken ibuprofen in secret but had been interrupted by his wife. Mrs B tried to persuade Mr B to go to A&E but he refused so Mrs B called an ambulance. PLAN: informal admission, advise Mr B that admission will be short, quick discharge and no influence over court appearance; Mr B to attend court the following morning - ward to organise; assessment for clarification of diagnosis ?personality ?depression; increase sertraline to 100mg OD with plans to further increase; wean off diazepam on ward; 1:1 obs recommended with ongoing review as risk is likely to increase prior to court appearance; repeat bloods to monitor changes in ALT; stop ibuprofen.
28/11/12	SLAM records	Child Needs & Risk	Completed by liaison staff. Primary carer first name recorded incorrectly as "Ruth". Remaining entries the same as previous child needs & risk document.
29/11/12	SLAM records	Admission	Mr B was admitted at 00:05 escorted by his girlfriends. Admitted with IV cannula in left arm. One girlfriend asked if she could stay with him on the ward for the whole night - staff explained why this wasn't possible (male ward). Mr B became agitated and angry due to decision and started kicking the door and attempted to pull out cannula so blood splashed over the corridor. Quickly de-escalated and accompanied to his room. Duty doctor attended, cannula removed. Initially refused nursing intervention but eventually allowed physical obs to be done: BP 116/68; P 74; TEMP 36.6; RESP 17; SATS 98. Family dynamics unclear.
29/11/12	SLAM records	Diagnosis	F60.3 Emotionally unstable personality disorder
29/11/12	SLAM records	Ward round	Mr B was discussed in Gresham's 2 ward round. Diagnosis: mixed traits of dissocial and emotionally unstable personality disorder. Mrs B reported no concerns for child;s safety at home and Mr B denied thoughts of harm towards her or his wife. Admitted he could be impulsive at times - £100 on lottery tickets, reported feeling paranoid and having hallucinations, others had told him that he had previously though people had kidnapped his wife. Discussed talking therapy which would be long term help, Mr B said he thought he needed medication for short term therapy. IMPRESSION: suicide attempt impulsive act; no evidence of depressive disorder; willing to make contact with the Sun Project and comply with addition medication. PLAN: additional sodium valproate; info for Sun Project; inform CMHT for seven day follow up; TTA's one week.

Date	Source	Event	Information
29/11/12	SLAM records	Progress note	Mr B was prompted several times for breakfast and medication; said he had little sleep overnight and was feeling tired. Initially refused lunch but eventually attended after lots of encouragement then said he didn't eat that type of food. Started kicking the main door. Panic alarm activated by staff, Mr B became increasingly agitated and again kicked the door. Denied any wrongdoing. PALS officer arrived shortly afterwards to say that Mr B had called him to report that he had not eaten all day and nobody had offered him anything to eat. Removed from 121 following ward review and discharged. Wife arrived with child to collect him - staff explained children were not allowed on the ward and was shown to the family room. Discharged at 20:30
29/11/12	SLAM records	Discharge	Discharged from Greshams 2.
29/11/12	GP records	Document receipt	Receipt of discharge summary report from SLAM
29/11/12	GP records	Fit note	Duplicate of fit note - job centre had not received it
30/11/12	GP records	Care co-ordinator allocation	CMHT MDT discussion, care co-ordinator required. Allocated to Mr Y.
30/11/12	GP records	Appointment	Mr B left hospital the previous day, wanted his medications but no discharge letter received. Mr B to get medication boxes from home, medication review done.
04/12/12	SLAM records	Diagnosis	Working diagnosis noted as F60.3 emotionally unstable personality disorder
05/12/12	SLAM records	Telephone call	Mr Y called Mr B more than four times the previous day but nobody picked up the phone. Mr Y called Mr B's GP to ask for alternative numbers - provided with Mrs B's (but under her maiden name) number as "partner of" Mr B. Spoke with Mrs B who advised that Mr B had just been taken by police to Bethlem Hospital because he had been kicking and shouting, she had called the ambulance who in turn had called the police. Mr Y asked Mrs B to call when she heard anything from the police.
05/12/12	SLAM records	Assessment	Mr B was taken to CUH A&E on S136. Advice sought from psychiatric liaison as police were told that S136 suite at Bethlem Royal Hospital was full. A&E staff informed police that A&E not appropriate place for assessment - not a place of safety. Mr B informed the liaison doctor that he didn't want to go to a psychiatric hospital and wanted to remain in CUH. Explanation about S136 place of safety not understood by Mr B - became agitated and started threatening that if he went to psychiatric hospital he would harm himself and others and it would be the doctor's fault. Liaison doctor attempted to find alternative place of safety: Lewisham closed due to damage; Lambeth identified as alternative. Mr B attempted to leave A&E as the liaison doctor was organising place of safety and had to be brought back by police. He also re-opened his wound by picking at it.

Date	Source	Event	Information
05/12/12	SLAM records	MHA Assessment	Assessment in S136 suite in Lambeth. Police had picked Mr B up after he had tried to jump out of a second floor window at his flat, after his partner had contacted police as he was shouting and screaming. Duty doctor arrived 50 minutes after Mr B arrived - Mr B appeared to be drowsy and hard to arouse but stated he hadn't taken any medication other than his prescribed meds.
05/12/12	SLAM records	MHA Assessment	Dr T assessed Mr B. Recent history: Mrs B had called police stating Mr B was armed with a weapon (metal bar). When police arrived Mr & Mrs B were in the street. Metal bar handed to police however Mr B started running inside the flats shouting "I'm going to try and kill myself" and attempted to jump from the second floor window. Mr B said that certain triggers made him distressed such as the court hearing on 14/12. Dr T spoke to Mrs B who said that Mr B had been getting worse since discharge from hospital on 29/11. Mrs B said Mr B behaved impulsively and had almost no control over his behaviours - following events he would have no recollection of what happened. Mrs B said that Mr B had increasing memory problems. Mr B had not slept for the previous 48 hours and was convinced there was someone in his car. Mrs B and neighbours had tried to get him inside the house many times. Was also paranoid that people would try to break into his house and kidnap his wife. Mrs B said that she wasn't sure if Mr B wanted to see her as she had called the ambulance to put him in hospital. Mrs B said their child had heard the noises and had asked Mrs B what was going on but hadn't visually witnessed anything. Mrs B said that when she works Mr B usually looked after their child but she had made other arrangements recently as she wasn't sure how he would be. PLAN: to be assessed by on call registrar. Bed identified at Croydon Triage - diagnosis noted as personality disorder. On call registrar assessed Mr B - although he had personality disorder it was possible he was experiencing transient psychotic symptoms sometimes seen in such patients, which are a more vivid nature than usual. Mr B refused informal admission. AMHP informed. Specialist registrar spoke to Mrs B it became apparent that Mr B was not stating the full facts so decision made to admit on S2 MHA.
06/12/12	GP records	Inpatient discharge notification	Received from SLAM.

Date	Source	Event	Information
06/12/12	SLAM records	MHA Assessment	Assessed for detention under the MHA - detained on Section 2. Papers report that Mr B had a diagnosis of PD and that he had been picked up by police after he was found on the street carrying a metal rod. Mr B's wife reported that she was concerned about his behaviour as he was smashing property and that the previous night he had been preparing a cocktail of spirit to inject himself with the intention of ending his life. Mr B had presented bizarrely over the preceding few days and had been quite paranoid and had not slept in the previous 48 hours. On the day of assessment Mr B had threatened to jump from the second floor with the intention of killing himself. It was recorded that he was a risk to himself and that he had refused informal admission, therefore the decision was taken to detain under Section 2 for his health and safety.
08/12/12	SLAM records	Observation records	Urinalysis - NAD UDS - positive benzo & cocaine.
09/12/12	SLAM records	Progress note	Ward staff noted that Mr B remained visible on the ward and that he had been visited by a female friend, then later his wife, child and a male family member. Plan: physical observations to be done as necessary due to wound infection.
09/12/12	SLAM records	Progress note	Croydon Duty SHO reviewed Mr B's arm as Mr B was worried it was infected. Mr B told the SHO that he had been seen regularly in the vascular clinic but that he he not been reviewed there for about a week. Vital signs checked BP 125/75, HR 60, RR 14, SATS 98%, temp 36.9. SHO noted Mr B looked physically well. Plan: continue with antibiotics, review the following day, Mr S to inform staff if he felt any pain.
10/12/12	SLAM records	Progress note	Night shift Mr B was sleeping on the floor and told staff that he was concerned about people coming into his room. Despite reassurance he continued to sleep there until the early hours of the morning when he moved to his bed. Mr B confirmed that he had met with his family and had enjoyed seeing them, said he wanted to be discharged.

Date	Source	Event	Information
10/12/12	SLAM records	Ward round	<p>09:30</p> <p>Mr B was on S.2 MHA and compliant with medication, no evidence of paranoid thinking, UDP positive for cocaine. Medication: sertraline 50mg diazepam 5mg on. Mr B was keen to go home, he had a visitor during the weekend as wasn't happy with the co-ordination. Result of UDP explained by Dr J - Mr B said he didn't know whether he used cocaine prior to admission. Mr B said he had been hearing voices since he was 14 - said he heard them every day and couldn't identify whose voices they were, sometimes the voices tried to influence him to cut himself or get out of hospital. Mr B also said he saw people who command him but he didn't tell his family about this hallucination. Low risk identified but noted risk would increase with cocaine use.</p> <p>Plan: review for rescinding section pending progress of leave that day, potential discharge the following day, care co-ordinator to review in ward round or review within 48 hours of discharge, inform wife about discharge planning and leave.</p>
10/12/12	SLAM records	Welfare benefits check	<p>09:30</p> <p>Ms T met with Mr B for a welfare benefits check. Mr B had recently applied for employment support allowance and was in receipt of housing benefit, he had also recently applied for disability living allowance. Mr B said he had recently started living with his wife again as they had been separated but he moved back in when his mental health became poor. Ms T contacted the Child Tax Credit helpline to seek advice and was advised that Mr B needed to submit both his and Mrs B's P60 for the previous year so that correct income figures could be recorded.</p>
10/12/12	SLAM records	Telephone call	<p>12:40</p> <p>Dr J called Mrs B to inform her of the plan following ward round that day and that Mr B was likely to be discharged the following day with support to follow from the CMHT. Mrs B was pleased to hear that Mr B would received further support in the community.</p>
10/12/12	SLAM records	Group Occupational Therapy	<p>14:00</p> <p>Mr B joined the group later as he had been using leave. After playing dominoes Mr B spoke at length about his work as a personal trainer and taking part in competitions for martial arts and jujitsu. He said that he kept having 'episodes' and thelt that there was something not quite right. Mr B said he felt he was being treated better on this ward than on the previous ward - he had been reluctant to be admitted due to previous experience.</p>

Date	Source	Event	Information
10/12/12	SLAM records	Progress note	<p>20:30</p> <p>Mr B had become more open with staff and was doing small things to aid his peers such as handing out cups during dinner time. Good eye contact maintained within conversation, speaking calmly and joking with staff and patients. Mr B said that he felt better for having been in hospital but that he didn't feel that he needed to be there any longer. Compliant with antibiotics and requested dressing change. Mr B said that the wound was stinging and staff noted that it looked worse than previously. Leave used appropriately, with Mrs B present.</p>
10/12/12	SLAM records	Progress note	<p>Ms N recorded that Mr B remained on S.3 MHA and nursed on general obs. Presented as calm and brighter in mood but remained preoccupied about his wound. Mr B said he felt his wound was infected and asked if he could have his bandage replaced.</p>
10/12/12	SLAM records	Leave	<p>Leave authorised by the RC for one hour daily for two occasions, to be reviewed on 14/12.</p>
11/12/12	GP records	Document receipt	<p>Receipt of discharge summary from SLAM. Mr B presented to Croydon University Hospital with his wife stating he had taken an overdose 12/24 400mg ibuprofen. Wife found him with a lot of tablets around him and stopped him taking more. Mr B feels suicidal and had the intention of killing himself, lots of stresses at the moment - court case 29/12. Mr B had been discharged from Croydon home treatment team 5 days previously.</p> <p>Mr B described an interaction with the HTT doctor prior to discharge in which he was told that 'nothing was wrong with him' and that he should 'stop taking medication'. Mr B said that he felt judged and got the impression the doctor was implying he was just trying to avoid his court case. Mr B said he felt that this made his mood worse and described a worsening of mood over the previous week.</p> <p>Forensic history noted as previous conviction for GBH/ABH aged 17; 2 x convictions of theft from employer; time spent in YOI after GBH; currently due to appear in court for failing to disclose convictions to employer.</p> <p>Risks to others not actually noted. Just reported that Mr B denied any ongoing thoughts of wanting to harm others and was adamant he wouldn't be a risk to staff/patients if he were to be admitted.</p> <p>Risks to child not actually noted. Just reported that Mr B was able to continue to interact with his child and that things were 'fine' when he was with her. Wife reported no concerns for child's safety at home and Mr B denied ever having thoughts of harm towards her.</p> <p>Diagnosis: traits of emotionally unstable personality disorder.</p> <p>Plan: sodium valproate chrono 200mg od added; give information for the Sun Project; inform CMHT for 7 day follow up; TTAs one week.</p>
11/12/12	GP records	Document receipt	<p>Receipt of letter from Croydon University Hospital</p>

Date	Source	Event	Information
11/12/12	SLAM records	Discharge	12:30 Mr B was discharged home having been compliant with his medication, had adequate food and fluid. Mrs B informed of the plan to be discharged. "Section 2 was reclined within the ward round." Mr B left at 12:30.
11/12/12	SLAM records	Email	12:30 Email from Dr D to Mr Y and Mr P to advise that Mr B had been admitted on 5/12 under S.2 MHA. Mr B's mental health and conduct had settled and there were no concerns about his safety. He had been compliant with prescribed medications and the previous day had begun unescorted leave without problem. Dr D noted that Mr B was keen to return home and as continued admission was not indicated Dr D had rescinded the S.2 and was planning to discharge Mr B later that day. It was noted that Mr B planned to return home with his wife who was aware of the discharge plans. Mr B would require ongoing contact with CMHT services and Dr D suggested that arrangements were made for initial contact in the following couple of days. Dr D noted that nobody from the CMHT was able to attend a ward round during Mr B's stay and informed Mr Y and Mr P that ward rounds took place at 9:30am daily.
11/12/12	SLAM records	Telephone call	11:35 Telephone call from Dr J, Triage Ward to Mrs B to confirm Mr B's discharge that day. Mrs B was unavailable - message left for her to contact the ward if any concerns arose during the period between discharge and care co-ordinator follow up. Dr J informed Mrs B that he would call again the following day to check on progress.
11/12/12	SLAM records	Ward round	09:30 Mr B told staff that his leave the previous day went well and that "it should be alright" at home on discharge. Mr B said he needed something in the long terms - ward staff advised that the CMHT had been contacted and that they would contact him by Thursday. Ward staff said they would speak to Mrs B that day and the following day to ensure that everything was okay following discharge. Mr B said he hadn't really spoken to Mrs B about going home. Mr B said Mrs B was being very vague about things and said she didn't know what was happening. Staff noted that Mr B had been given the application to IMPART and that Mrs B was sending it off. Plan: discharge from section and home that day, inform Mr & Mrs B that they could contact the hospital if there were any issues before the CMHT was in touch, ward staff to call Mrs B the following day to check things were okay, ward staff to contact vascular team for appointment for arm dressing, community team to review and slowly reduce the diazepam, care co-ordinator follow up by Thursday at the latest.
11/12/12	SLAM records	HoNOS	HoNOS rating: 2

Date	Source	Event	Information
11/12/12	SLAM records	MHA Rescindment	Detention under MHA was rescinded. Noted that the Mr B was to leave hospital.
12/12/12	GP records	Document receipt	Receipt of letter from Croydon University Hospital with details of Mr B's A&E attendance on 5/12/12.
12/12/12	SLAM records	Telephone call	10:00 As Mr B had been discharged, Ms T had advised benefits agencies accordingly. Ms T had written to Mr B to remind him that he needed to call Child Tax Credit number with both his and his wife's P60 to enable records to be changed and more tax credit to be paid if appropriate.
12/12/12	SLAM records	Telephone call	15:30 Mr Y called Mr B who said he was still anxious about being at home. Mr Y reassured him and advised him to continue to use his medication. Mr B said that his sertraline tablets had been reduced to 50mg from 100mg. Mr Y encouraged Mr B to keep using medication as prescribed. Mr Y asked about the vascular wound which Mr B reported was infected and that he was taking antibiotics. Mr B expressed anxiety about his next court appearance. Mr Y noted that the telephone conversation was seen as a seven day follow up session.
12/12/12	SLAM records	Telephone call	17:15 Dr D had telephone contact with Mr B and others. Spoke to Mr B twice at family home. Confirmed arrangement to attend Tamworth Road the following day in order to see care co-ordinator or duty worker (MAP East Team). Spoke with Mr B's solicitor at Mr B's request - reported that he was waiting authorisation of legal aid in order to represent Mr B. Solicitor advised that Mr B needed to attend scheduled hearing on 14/12/12 - information conveyed to Mr B.
12/12/12	CUH records	Letter	Letter from SPR to GP advising that Mr B had been seen in clinic for review of his wound. Mr B reported that he was feeling much better as he was on medication for bipolar disorder. He was being looked after by his family and had someone with him 24 hours a day. Mr B was keen to let the wound heal itself. Dressings to be done twice weekly by Tissue Viability Nurse, if the wound was not healing then grafting to be considered.
13/12/12	SLAM records	Telephone call	Mr B contacted the Triage ward to inform them that he had not been seen for his discharge follow up as arranged. Triage ward staff informed Mr B that the telephone call with care co-ordinator on 12/12 was noted as his seven day discharge follow up. Triage ward staff informed Mr B that he needed to see his vascular nurse in the community to have his wound dressing changed as he was no longer a patient on the ward. Care co-ordinator to be sent an email.

Date	Source	Event	Information
13/12/12	SLAM records	Appointment	<p>RETROSPECTIVE ENTRY COMPLETED ON 3/1/13</p> <p>Ms D, duty worker MAP East Team saw Mr B. Mr B explained that he was unable to shake hands due to the injury to his wrist/lower arm. Mr B's newly allocated care co-ordinator (with whom the client had previously had telephone contact only) called into the meeting briefly to introduce himself prior to the scheduled meeting the following Monday.</p> <p>Mr B explained that he was feeling down and that his mood had deteriorated since initially feeling positive on discharge from hospital. Mr B gave a history of 10-12 suicide attempts during his life. He talked about the recent episode where he had injected himself. Mr B reported that he had been diagnosed with bipolar disorder, experiencing highs and lows alternating between feeling suicidal and energetic. Mr B reported no current suicidal ideation and said he would be at home with his wife prior to the court appearance the following day.</p> <p>Plan: Mr B to attend CUH re injury, appointment with care co-ordinator on 17/12, Mr B aware of crisis contacts.</p>
14/12/12	GP records	Document receipt	<p>SLAM discharged summary dated 29/11/12 completed by Dr T. Advised that CMHT was to be confirmed. Forensic history noted as previous conviction for ABH/GBH aged 17, 2 x theft from employer, currently due to appear in court - failure to disclose convictions to employer.</p> <p>Plan: sodium valproate chrono 200mg od, give information for the Sun Project, inform CMHT for 7 day follow up, TTAs one week.</p>
15/12/12	SLAM records	Telephone call	<p>Telephone call from a lady requesting information about Mr B. Caller asked whether Mr B had been admitted to hospital. Caller gave her name as Miss N and claimed to be his sister. Staff member identified that the last known ward was Triage and spoke to Triage staff who advised that the caller had already contacted Triage and was not given any information about the patient as there was concerns about her identity.</p>
17/12/12	SLAM records	Telephone call	<p>Mr Y called Mr B several times to change the appointment time from 14:00 to 15:30. Eventually Mrs B called back to say that they would be going out and wouldn't be at home. Meeting rescheduled to Thursday 20/12/12 at 15:30.</p>
18/12/12	GP records	Appointment	DNA - no reason
18/12/12	SLAM records	Telephone call	<p>14:00</p> <p>Mr Y received a call from Mrs B to say that Mr B had left home that morning and she had not heard from him since. Mrs B said that Mr B had taken the two mobile phones with him. Mr Y noted that Mrs B had reported him to the police in view of his mental state. He had left home with the family car. Mr Y called both mobile phone numbers and left messages for Mr B to contact him immediately.</p>

Date	Source	Event	Information
18/12/12	SLAM records	Telephone call	15:45 Mr Y received a call from the duty nurse at Croydon police custody about Mr B having been taken into custody that morning for pulling someone's hair at Croydon Tram Station. The duty nurse said that Mr B was behaving oddly saying that he was seeing faces in the newspapers and that he didn't want to be contaminated. Mr B admitted taking cocaine the previous day. The duty nurse wanted Mr B to be seen for MHA assessment. Mr Y phoned Mrs B to inform her that Mr B was in police custody.
19/12/12	SLAM records	Referral	Referral from Croydon IAPT to Croydon MAP East Team. Mr B had returned a registration form on 11 December which had been screened on 19 December. The result of the screening was that Mr B reported experiencing visual hallucinations and was considered to be in urgent need of help to prevent him harming himself. Request for an assessment by Croydon MAP.
19/12/12	GP records	Document receipt	Receipt of letter from SLAM confirming receipt of Mr B's opt-in registration form for psychological therapy with the Croydon IAPT Psychological Therapies and Wellbeing Service. Due to high levels of risk of harm to himself and experience of visual hallucinations reported by Mr B the service did not accept the referral as they did not have the necessary resources to support him. Referral to be faxed to East MAP team to request assessment.
19/12/12	SLAM records	Referral	Referral to MAP Croydon East Treatment Team. Entry notes that on reviewing the caseload it was noted that despite input from the team Mr B had not been accepted on PJS, hence a retrospective accepted date.

Date	Source	Event	Information
19/12/12	SLAM records	MHA Assessment	<p>Mr B was assessed at Croydon Police Custody by Ms E (AMHP), Dr N (Specialist Registrar) and Dr A (S.12 doctor).</p> <p>Mr B had recently been discharged from Croydon Triage ward, the previous day Mr B had been arrested after reports that he had assaulted his wife by pulling her hair and hitting her. Mr B reported that his wife had been using cocaine as he had noted a sudden change in her behaviour and that he had seen her using it. Mr B said he was worried she was using it in front of his six year old child and had called the police himself due to these worries. Mr B said that Mrs B did not want him to call the police and said she would lie about him hitting her and get him sectioned.</p> <p>History taken from Mrs B over the telephone indicated that Mrs B thought Mr B had been hallucinating. She had known him for about 10 years and said that he did have outbursts sometimes. Mrs B reported that Mr B had taken the keys so she was locked in the house at that point. Mrs B said that Mr B had also taken her mobile phone and that she had no contact with anybody. Mrs B said that Mr B had never hurt their child and agreed to him returning home that night.</p> <p>Ms E noted that Miss N had been to see Mr B in the cells that day, Mrs B noted that Miss N had commented that Mr B played them (Mrs B and Miss N) off against each other.</p> <p>Risk assessment to self: denied thoughts of self harm or suicide intent. Mr B reported that the wound on his arm was healing.</p> <p>Risk assessment to others: denied having hurt anyone that day and said he was no longer angry with his wife. He would go home and sleep on the sofa. Noted that his wife was willing to have him home and he agreed to accept further support from services through his care co-ordinator.</p> <p>Plan: no evidence of mental illness that required acute treatment, not detainable at time of assessment. Assessing team agreed the appeared to be ongoing interpersonal issues within his relationship. Noted that previous assessments had suggested narcissistic and antisocial personality traits. Also noted previous recommendations to consider psychotherapy input eg Touchstone.</p> <p>Ms E emailed the care co-ordinator regarding making a referral to Child and Families due to concerns about aggression and drug use in the home.</p>
19/12/12	SLAM records	Social report following assessment under MHA	Recorded that no previous history of mental health issues until October 2012 when Mr B attended A&E having tried to kill himself by leaving the gas on and sucking from the cooker.

Date	Source	Event	Information
20/12/12	SLAM records	Telephone call	09:40 Mr Y received a call from Mr B at 9:40am to cancel the planned appointment at 3:30pm. Mr Y told Mr B that the meeting should go ahead as he wanted to see Child B as well. Mr B said that Child B would be at school. Mr Y asked how old Child B was - Mr B said 6 years old. Mr B also said that Mrs B would be at work, that she worked at ASDA and that he didn't know when she would be home. Mr Y said he would be coming anyway and that he would wait for Mrs B to return from work. Mr B again told Mr Y not to come as he would not be at home, and neither would Mrs B. Mr Y said he would be visiting anyway and then Mr B put the phone down.
20/12/12	SLAM records	Home visit	16:00 Mr Y left the office to visit Mr & Mrs B as arranged. Mr Y got lost on the way but call the landline and mobile numbers to inform Mr & Mrs B that s/he was on her/his way and to wait. Arrived at Mr & Mrs B's home address to find police cars and police officers preventing access to the flat. Mr Y asked about the child and was informed that police had taken her and she was in the care of social services.
24/12/12	GP records	Document receipt	Receipt of copy letter from CBT therapist, IAPT to MAP Team East requesting they contact Mr B to arrange an assessment.
24/12/12	GP records	Document receipt	Letter dated 19/12/12 from Croydon IAPT to MAP Team East advising that Mr B's registration had been screened and he had reported visual hallucinations and that he was in urgent need of help to prevent self harm. Information about crisis services in Croydon had been provided and MAP Team East were asked to contact Mr B to arrange an assessment.
27/12/12	GP records	Document receipt	Receipt of letter from St George's re caustic injury Ingestion caustic substance, airway oedema at intubation and methylhaemoglobinemia. Treated repeat doses methylene blue. Superficial stab wound to right thigh - sutured. 1 tonic clonic seizure. Impression: suicide attempt, seen by psych liaison - for further input in custody from their mental health teams.