



# INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF DO

## FINAL REPORT

OCTOBER 2018

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# 1 INTRODUCTION

## 1.1 The incident:

1.2 At approximately 08.30 on Friday 22 March 2013, Donna Oettinger walked to a nearby railway station with her three-year-old son, Zaki Oettinger. CCTV footage at the railway station showed Donna and Zaki walk up the ramp onto the platform.

1.3 A commuter train arrived and everyone on the platform boarded the train except for Donna and Zaki. The platform cleared, and the train moved away with its passengers. Donna walked Zaki to the top of the empty platform and waited there until Donna heard the horn from an oncoming train.

1.4 The driver of the oncoming train could see the pair standing too close to the platform edge as he approached, and sounded the horn again, at which point Donna jumped down onto the track with Zaki. The train driver was not able to stop the train before it hit them.

1.5 Donna died from cranio-cervical trauma and Zaki from head and body trauma.

## 1.6 The background:

1.7 Donna was a 41-year-old female with a history of depression and anxiety symptoms. She was a single mother to her son Zaki. At the time Donna lived with her mother in Croydon, South London.

1.8 Prior to the deaths of Donna and Zaki, Donna had received care from South London and Maudsley NHS Foundation Trust (SLAM), with contact with the service beginning on 16 July 2012.

## 1.9 The Inquest

1.10 At the Coroner's Inquest held on 31 March 2015, Donna's death was recorded as "*suicide*", whilst Zaki's death was found to be as a result of an "*unlawful killing*".

## **2 PURPOSE OF REPORT**

- 2.1 In the period between 16 July 2012 and 22 March 2013, Donna was in contact with primary healthcare services, SLAM secondary mental healthcare services, emergency services in Rotherham and private psychiatry services.
- 2.2 In line with the Serious Incident Framework, NHS England has commissioned an Independent Investigation in order to unlock learning for the NHS which is intended to improve the delivery of mental healthcare services for individuals such as Donna and those connected with them.
- 2.3 'Hindsight bias':
- 2.4 'Hindsight bias' is a paradigm that promotes the belief that adverse events were more foreseeable and more avoidable than they actually were. Moreover 'errors' in the chain of events can assume greater importance with the knowledge of the outcome. To a retrospective observer, all the lines of inquiry can point to the end result, but those individuals involved at the time did not have the benefit of foresight.
- 2.5 In order to ensure that proportionate and meaningful learning is achieved, the Independent Investigation Team has taken into account the notion that knowledge of the outcome can colour ideas of how and why an adverse incident occurred when making its judgements.
- 2.6 Desired outcome of the report:
- 2.7 The Independent Investigation Team hopes that this report will allow care providers a chance to reflect upon the care which Donna received, with a view to making improvements for future service users and those who come into contact with them.
- 2.8 In this way, it is intended that some benefit can be gained from these tragic events, and a degree of comfort achieved for those whose lives were affected by the deaths. This is of particular importance to Donna's mother.
- 2.9 The Terms of Reference of the Investigation, Team Membership, Methodology and the Chronology prepared during the course of the investigation can be found at Appendices 1 to 3.
- 2.10 Evidential Considerations:
- 2.11 Donna committed suicide at the time of the killing of Zaki. As a result, there was no criminal trial. This has created a number of evidential issues for those undertaking the Independent Investigation. In particular, there are fewer verifiable facts regarding Donna's life, history, versions of events etc. than would have been available had there been a trial. As a result, the Coroner's Inquest, convened in 2015, proves the single most authoritative inquiry into the 'facts'.

- 2.12 The Trust's internal investigation team met with Donna's mother, incorporated questions about Donna's care into their report and consulted with her prior to their report being finalised. The inclusion of footnotes in that final report was to ensure that Donna's mother's views were included in the final version.
- 2.13 Attempts to contact the Zaki's father during both the Internal and Independent Investigations were unsuccessful<sup>1</sup>. The Independent Investigation Team was advised that Donna's sisters did not wish to be involved in the Independent Investigation.
- 2.14 As a result, the Independent Investigation Team has used Donna's mother as the source of information from Donna's family. Donna's mother was heavily involved in Donna's care and treatment during the period June 2012 – March 2013, as is demonstrated in this report.
- 2.15 The Independent Investigation Team has borne these limitations in mind in performing this investigation and the drafting of this report. As a result, it has attempted to minimise speculation and hypothesis as much as possible.
- 2.16 The Independent Investigation Team in its compiling of this report also benefitted greatly from the views expressed by Trust representatives in a series 'focus groups' held as part of the Independent Investigation process.

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<sup>1</sup> "Croydon Safeguarding Children Board's Serious Case Review", page 12, para 2.6.2.

### 3 EXECUTIVE SUMMARY

- 3.1 This section is intended to provide an overview of the key findings of the Independent Investigation Team. The detail supporting these findings is contained in the main body of the report which follows:
- 3.2 Resourcing issues:
- 3.3 Throughout the period of Donna's care between 16 July 2012 and 17 January 2013, services within Croydon, the London Borough in which Donna lived, were significantly under-resourced. Whilst efforts were being made by the Trust to improve the financial situation, patient safety was not given sufficient consideration whilst additional resources were secured. Insufficient consideration was given to the impact which 'small' adaptations to the day to day operation of the team (such as the provision of a computer in the team meeting room), could have had on improving patient care. The impact which this issue had upon the delivery of care to Donna cannot be underestimated.
- 3.4 During the time of Donna's care, as has been mentioned, there was significant pressure on resources. This permeated all levels of Donna's care. It is clear that there were difficulties in the administrative support for the Team's activities. Consequently, a chance to engage Donna with a view to gaining a better understanding of her illness was lost.
- 3.5 Evidence presented to the Independent Investigation Team which demonstrated a lack of resources included:
- Dysfunctional systems such as the duty system adopted by staff which led to an inadequate assessment of Donna following a failed suicide attempt;
  - Staff referred to significant caseloads and lack of time available to complete tasks;
  - Poor internal systems, for example, those relating to compilation of definitive patient notes;
  - The delays suffered by the MAP team in its remedial internal re organisation following its placement on its CAG risk register due to the *"risk of its failure to meet governance and quality standards"*.
- 3.6 It is the opinion of the Independent Investigation Team that these issues directly impacted upon the care Donna received to the extent that they led to implementation of a series of maladaptive strategies for the handling of a patient presenting as Donna did, and in so doing, contributed to a decline in Donna's mental health as she waited considerable periods of time for access to services which ultimately, may have been able to better address her needs.
- 3.7 As this report will show for example, referral forms not reviewed or investigated further following recorded suicide attempts because staff were "too busy", staff feeling unable to keep their mandatory training current because of time pressures, and discussions about patients occurring during meetings which were not recorded by care coordinators, even where the cases were complex, because the computer in the meeting room worked only intermittently.

3.8 Complexity and availability of services:

3.9 During the period of her contact with the Trust, Donna was unable to navigate the complexity of SLAM services and gain access to services which could have provided her with care and treatment.

3.10 The MAP East Team, through which Donna had the majority of her contact, was known by the Trust management to be facing significant problems and had been placed upon the Trust 'Risk' Register. It was known to the Management of the Trust that the MAP East Team had introduced processes and procedures which did not comply with Trust policy or national guidance. In addition, IAPTS ("*Improving Access to Psychological Therapies*") services which could have delivered psychological care to Donna during this period had a significant waiting list. Once a patient has been placed on a waiting list, a commitment has been given to provide treatment within a reasonable period of time. This did not happen.

3.11 It appeared to the Independent Investigation Team that maladaptive systems of maximising resources had been developed by the MAP East Team. These included the creation of the category of 'interim care co-ordinator'. Notwithstanding that there is considerable conflict in the evidence as to whether Donna was actually allocated a care coordinator, what is certain is that she never received care from this individual, as they were on annual leave. When there is a 'shortage' in NHS provision, some patients will have sufficient 'resources' to seek care from the private sector. Whilst this may have been seen as the best way in which to manage limited resources by the MAP East Team, it failed to put patient safety at the centre of care delivery, because risk was not properly assessed, notwithstanding whether the patient had resources outside the NHS.

3.12 The approach which was adopted to the ongoing management of the IAPTS waiting list and indeed that of the difficulties which were being experienced by the MAP East Team was flawed as it focussed on the service and was not viewed from the perspective of those who wished to access care. The management focus was upon the difficulty which the services were facing, not the risk to, or safety of its patients. Little or no account was taken of the fact that patients upon a waiting list can deteriorate whilst on the waiting list.

3.13 Diagnostic process:

3.14 Donna was given a diagnosis of generalised anxiety disorder on 16 November 2012. However, Donna's presentation also raised the possibility of a depressive illness. Had a more structured and reflective diagnostic process been applied to Donna throughout her care, then there may have been recognition of that uncertainty and the adoption of an enquiring approach towards understanding Donna's behaviours and accordingly, the risk which she posed to herself and others. Significantly, there was an under-emphasis on information from Donna, as well as collateral sources, including her mother and sister, and practitioners outside of the NHS.

- 3.15 During the course of her involvement with the Trust, Donna was reviewed by 7 practitioners. The result was that care was delivered as a series of 'one off' appointments. This led to a weakness in the diagnostic process and an unquestioning acceptance of the opinion of other clinicians without critical re-examination. These weaknesses could have been addressed if the ethos of the care programme approach had been applied in a structured manner.
- 3.16 Donna did not receive care in accordance with the CPA. At no stage was she afforded access to a care co-ordinator. In failing to adhere to Trust Policy and indeed the ethos of the care programme approach, services denied Donna crucial components of the care which she could expect, and in turn created a number of junctures where care could have been delivered differently. Such an approach could have facilitated a reflective review of Donna's diagnosis. The Independent Investigation Team is of the view that had this been applied, different conclusions could have been drawn and accordingly, different decisions taken regarding risk, care and treatment.
- 3.17 Relationship between Donna and Zaki:
- 3.18 There is little evidence available which suggests that mental health professionals explored Donna's relationship with her son. Therefore, the exact reason for Donna's decision to include Zaki in her plans to end her own life is not clear to the Independent Investigation Team. Whilst some of the practicalities of his care were known, how Donna felt about her role as his mother was not explored, either as a protective measure for Zaki, or indeed for Donna herself.
- 3.19 Significantly, Zaki had not constituted a protective factor which had prevented her attempted suicide on 14 December 2012. This issue was not explored or revisited in the wake of Donna's attempted suicide. Indeed, a concern that an objective assessment of whether Zaki's needs should be carried out was never addressed or actioned by professionals within the Trust.
- 3.20 During the night of 13/14 December 2012, Donna was taken to Rotherham District Hospital having taken an overdose of Phenergan and Pregabalin tablets. The overdose consisted of all of the medication which was available to Donna at the time. She was found by her friend who called for an ambulance. Donna was unresponsive and was admitted to intensive care due to a very low Glasgow Coma Scale score.
- 3.21 Factors contributing to the failure to recognise the importance of the Rotherham assessment included:
- 1) Lack of clarity of internal systems operated by MAP East.
  - 2) Time pressures on staff.
  - 3) Failure to review due to a maladaptive approach to assessment as a result of limited resources.
  - 4) Poor supervision of a trainee psychiatrist.



5) Lack of clarity about the appointment of a care coordinator

- 3.22 Junctures where care could have been delivered differently:
- 3.23 A number of 'junctures' where care could have been delivered differently to Donna existed.
- 3.24 The most striking example followed a significant uncompleted suicide on 14 December 2012. Despite a thorough assessment having been undertaken by clinicians in Rotherham, the conclusion of which was that Donna required input from mental health services on a daily basis, the MAP East Team put in place a package of care which involved changes in medication but provided no support in the community and no access to a mental health clinician for a further two weeks.
- 3.25 The clinical assessment made by the team in Rotherham was not accorded the weight it deserved when set against the very limited assessment conducted by MAP on 17 December 2012. Indeed, it is not clear why there was a need for MAP to review the decision of the Rotherham Team that a referral to HTT was indicated.
- 3.26 As a result, new clinically significant information, such as that elicited in Rotherham, in relation to Donna's care in the private sector, or indeed the self-assessment questionnaires undertaken by Donna in conjunction with IAPTS, was not factored into Donna's care. As a result, when Donna presented in crisis to the NHS, clinically significant information about her presentation was not available. When Donna sought to access private care, further confusion and delay occurred to her gaining access to NHS services.
- 3.27 Over reliance on Doctors in Training and lack of supervision:
- 3.28 During the course of Donna's care, whilst she had input from consultant psychiatrists, her care was in fact delivered by a Trainee Psychiatrist who was working in his first role post-qualification as a doctor. Against a background of under-resourcing, there was an overreliance on Trainee Psychiatrist 1, without an appropriate level of structured supervision. For example, Trainee Psychiatrist 1 was using the 'SADPERSONS' diagnostic tool despite it being a tool not authorised by the Trust. Appropriate supervision would have ensured that a more appropriate tool could have been used.
- 3.29 Complaints handling:
- 3.30 A complaint made about Donna's care by her mother on 31 December 2012 could have provided an opportunity to review Donna's care by Trainee Psychiatrist 1's supervisor.
- 3.31 In order to ensure that there were no patient safety issues attached to the lengthy wait for CBT, Donna's mother's complaint could potentially have provided MAP Consultant Psychiatrist 1 with an opportunity to review Donna's care in order to establish whether the delay in obtaining access to IAPTS could prove detrimental.

It would also have allowed for consideration of whether an alternative framework to support Donna could be put in place whilst she awaited access to IAPTS. It could also have provided a training opportunity for Trainee Psychiatrist 1 and potentially reduced the levels of distress experienced by Donna and her mother, which may have had an impact upon their on-going relationship with services.

- 3.32 Instead, Donna's mother's complaint was directed for an 'organisational response', which meant that the matters giving rise to the complaint were not dealt with at an early stage which would have benefited Donna as well as those involved in her care; instead a formal 'procedural' response was adopted.
- 3.33 The response to Donna's mother's complaints was poor. The points made in her complaints were not addressed in correspondence, far less remedial action considered. Complaints made by Donna's mother impacted adversely on Donna's care, causing confusion, and indicating a defensiveness rather than a willingness across the Trust to advance learning and improving from complaints.
- 3.34 This was mirrored in the Trust's Serious Untoward Incident Report ('SUI'). The SUI failed to address a number of key issues in Donna's care, such as the supervision of Trainee Psychiatrist 1. Whilst indicating that Donna's mother had been included in the investigative process, her views were not given any weight in relation to conflicts in the evidence. As a result, further opportunities for learning were lost.
- 3.35 Steps taken to address the learning from Donna's care and treatment.
- 3.36 The CQC inspection in 2017 concluded that the Trust was well led. In the context of organisations, culture is a system of shared assumptions, values, and beliefs, which governs how people behave in an organisation and can have a dramatic effect on whether an organisation is successful or not.
- 3.37 The Trust introduced an action plan in order to implement some of the learning arising from Donna's care. The Trust has faced challenges in embedding some of the learning arising from this action plan.
- 3.38 A significant challenge for any organisation when attempting to make changes is the availability of resources. Relevant in this regard is the ongoing financial issues which are attached to the funding of mental health services in Croydon. The Independent Investigation Team notes however, that the Trust is acting proactively and indeed effectively to improve recruitment and retention of staff which will have a positive impact upon its ability to embed change.
- 3.39 It is also actively reviewing the manner in which it delivers services in Croydon in recognition of the challenges which it faces.
- 3.40 Predictability/preventability:
- 3.41 The Independent Investigation Team is of the view that it was predictable that Donna was at risk of suicide in the period leading up to her death. Donna

committed filicide as part of an extended suicide. As a result, Zaki's death could not be prevented unless Donna's own suicide could have been prevented and the nature of the relationship between Donna and her son had been properly explored.

3.42 The Independent Investigation Team is of the view that whilst there were a number of chances available for services to have reviewed Donna's presentation, intervene and provide support, there is insufficient evidence to fulfil the definition of preventability of her completed suicide set out at Paragraph 4.26 below.

- **Zaki's homicide** – not predictable nor preventable.
- **Donna's suicide** – predictable, not preventable.

## 4 PREDICTABLE / PREVENTABLE

- 4.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether the incident (which resulted in the deaths of Donna and Zaki) was ‘predictable’ and/or ‘preventable’.
- 4.2 As the incident of 22 March 2013 claimed two lives, encompassing the filicide of Zaki and the suicide of Donna, the Independent Investigation Team will consider both in terms of predictability and preventability pursuant to the Terms of Reference for this Investigation, which require an evaluation of these ‘tests’, set out below in relation to “the incident”.
- 4.3 Many Independent Investigations identify failings or gaps in the care with which an individual was provided. However, this does not mean that a homicide or indeed a suicide could have been either predicted or prevented. The following tests are commonly applied to determine whether a homicide could have been predicted or prevented;

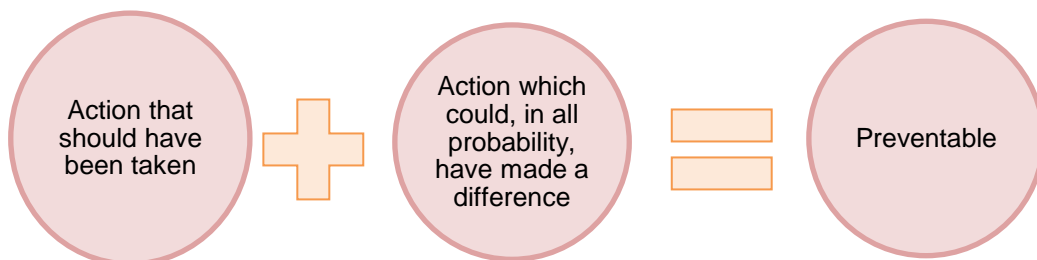
### 4.4 Predictable:

A homicide is ‘predictable’ if *“there was evidence from the service user’s words, actions or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred”*.



### 4.5 Preventable:

A homicide is ‘preventable’ if *“there were actions that healthcare professionals should have taken, but which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken, or opportunities which were missed would not provide evidence of preventability, as there are always things that could have been done better”*.



4.6 Predictability of Zaki's death:

4.7 The Independent Investigation Team's view is that the death of Zaki was not predictable. This is because even if Donna had been properly assessed and the significance of her symptoms been recognised, she would not have been identified as an individual likely to commit filicide-suicide.

4.8 Preventability of Zaki's death:

4.9 The Independent Investigation Team is of the view that Donna committed filicide as part of an extended suicide. As a result, Zaki's death could not be prevented unless Donna's own suicide could have been prevented and the nature of the relationship between Donna and her son had been properly explored.

4.10 Predictability of Donna's suicide:

4.11 The Independent Investigation Team has applied the following definition to whether a suicide can be considered to be predictable. A suicide is '*predictable*' if "*there was evidence from the service user's words, actions or behaviour that should have alerted professionals that there was a real risk of an act of significant self-harm, even if this evidence had been un-noticed or misunderstood at the time it occurred*".

4.12 In the opinion of the Independent Investigation Team, there is a general consensus that there is no reliable method to predict suicide. However, there are warning signs and risk factors that can indicate that an individual may be at risk. It is the combination of warning signs and risk factors that can indicate that someone maybe at risk or indeed increased risk of suicide.

4.13 Evidence given by Donna's GP at her inquest suggested that on 28 February 2013 when she last saw Donna, she appeared more relaxed and had reported that she was doing more things with Zaki. This view was supported by Zaki's childminder who explained at Donna's inquest that she was looking after Zaki less because his mother was playing a greater part in his care.

4.14 The Independent Investigation Team recognises that suicide is a final act of behaviour that is the result of a range of factors, difficulties and distress<sup>2</sup>. For many people, including Donna, an attempt occurs after months of having thoughts and feelings about suicide. Consequently, "*the goal of a suicide assessment is not to predict suicide, but rather to...appreciate the basis for suicidality, and to allow for a more informed intervention*"<sup>3</sup>. Many factors within Donna's presentation were relevant in this respect but were not explored<sup>4</sup>:

- feeling depressed, withdrawn and anxious;
- loss of interest in hobbies, work, socialising or even in her appearance;

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<sup>2</sup> Gviom, Y. & Apter, A. (2012). Suicide and Suicidal Behavior. *Public Health Reviews*, 34 (2), 1-20.

<sup>3</sup> Jacobs, D., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment: An overview and recommended protocol. In D. Jacobs (Ed.), *Harvard Medical School guide to suicide assessment and intervention* (pp. 3-39). San Francisco: Jossey-Bass

<sup>4</sup> American Association of Suicidology. '*Know the Warning Signs of Suicide.*' Available at:

<http://www.suicidology.org/resources/warning-signs>. NHS Choices. '*Suicide – Warning signs.*' Available at: <http://www.nhs.uk/Conditions/Suicide/Pages/warning-signs.aspx>

- expressing feelings of hopelessness or lack of purpose;
- acting impulsively or in a reckless way and not caring what happens to them;
- talking about suicide or wanting it all to end;
- expressions of thoughts of wanting to die in the year before the act to her relatives and friends.

4.15 These signs can offer potential opportunities to intervene if the behaviours are recognised. However, in Donna's case, there was a lack of investigation in order to allow informed intervention. Research indicates that three-quarters of all people who end their own lives are not in contact with mental health services<sup>5</sup>. Donna was not in contact with services at the time of her death. As this report seeks to demonstrate, Donna was not able to access services which recognised and addressed her needs, despite the efforts of herself and members of her family.

4.16 Donna's symptoms were not considered reflectively. Symptoms which were attributed to anxiety could potentially have been reframed to be considered as being 'depressive' in nature. Depression carries a greater 'risk factor' for suicide.

4.17 When Donna was asked by Medical Practitioners if she had any suicidal intentions she would deny such thoughts. Clinicians appeared to take her answers at face value, failing to consider her contradictory actions and the risk of impulsivity which had been highlighted, not least in Rotherham AMHP's report. In addition, different symptoms such as her lack of sleep, worry and upset could have increased the risk of her committing an act of significant self-harm. This does not appear to have been recognised. In addition, the Independent Investigation Team is of the view that Donna's failure to access services could have compounded her feelings of hopelessness. For example, Donna's mother described Donna's concerns following a consultation with Trainee Psychiatrist 1 on 31 December 2011 in the following terms:

*"when we left there Donna was in such a state she said she was never going to get better she didn't know how".*

4.18 The Trust does not accept that Donna's suicide and associated actions were predictable.

4.19 The Independent Investigation Team has considered this response reflectively in accordance with Donna's records.

4.20 In a letter written by Trainee Psychiatrist 1 on 13 November 2012, it is recorded that Donna was feeling:

*"helpless about situations in her life".*

4.21 The Rotherham Report dated 16 December 2012 states:

*"During this lengthy assessment interview with her it was possible to effect some*

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<sup>5</sup> Hewlett, E. & Horner, K. (2015). Mental Health Analysis Profiles: OECD Working Paper No. 81.

*change in her thought process by identifying the helplessness and hopelessness that had driven her to an impulsive suicide attempt and showing that with effective treatment her mood and functioning will improve”.*

4.22 Further, in summarising Donna’s needs, it was noted:

*“Acute onset of anxiety May 2012, full somatic features with gradual deterioration of helplessness and hopeless thinking”.*

4.23 Accordingly, the Independent Investigation Team remains of the view that it was predictable that Donna would commit a significant act of self-harm such as a suicide.

4.24 Preventability of Donna’s suicide:

4.25 A suicide is ‘preventable’ if *“there were actions that healthcare professionals should have taken, but which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken, or opportunities which were missed would not provide evidence of preventability, as there are always things that could have been done better”*. This is a significant legal threshold.

4.26 The Independent Investigation Team recognises that:

*“SLaM had no further contact with Ms DO after 29/01/2013”.*

4.27 The Independent Investigation Team also recognises that evidence given at the inquest of Donna stated that on 28 February 2013 when she was seen by her GP, Donna ‘appeared’ to be more relaxed. The Independent Investigation Team noted that at a number of points in Donna’s care she was described as being *“tearful and at the same time putting on a smiling face”*. Without a detailed examination of Donna’s mental state at this point, it is not possible to determine whether the apparent change in her presentation constituted a ‘false front’ masking her unrecognised depressive illness and therefore the risk which Donna presented. It is the opinion of the Independent Investigation Team that people can present as smiling but are still depressed and accordingly be at risk.

4.28 As will be demonstrated throughout this report, the Independent Investigation Team is of the view that had Donna been offered a pathway which recognised the risk which was posed by her depressive symptoms and her impulsivity, then it is possible that the outcome could have been different as services’ response to her may have been different. Equally, she may have been encouraged to remain in contact with services.

4.29 However, notwithstanding the failures in the delivery of care to Donna highlighted in this Report, the Independent Investigation Team recognises that there is insufficient evidence to fulfil the definition of preventability set out at Paragraph 4.26 above.

4.30 Donna’s mother who was present at all of the consultations involving her

daughter, does not accept that Donna's death was not preventable.



## 5 RECOMMENDED REACTION TO THE INCIDENT BY HEALTHCARE PROVIDERS

- 5.1 In order to provide an insight into the direction of this report at a glance, an overview of the Independent Investigation Team's Recommendations is as follows:

### **Recommendation One – Managing a failing Team:**

The Independent Investigation Team recommends that in teams which are identified as 'failing' or of being at 'risk', an immediate management plan should be initiated by an individual who is not connected in the line management of the failing team which seeks to:

1. Identify risk to new and existing patients of the current administrative processes and protocols; and,
2. Establish whether any immediate practical steps can be taken to reduce risk to patients notwithstanding action taken with regard to long term solutions such as seeking increased funding.

### **Recommendation Two – Improving reflective practice:**

The Independent Investigation Team would make the following recommendation:

- The Trust must conduct regular audits to ensure that its managerial supervision policies and procedures to facilitate supervision are being used to promote the delivery of service user centred long-term care.
- The audit process should include scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the delivery of service user care viewed from a long-term perspective.

### **Recommendation Three – Responding to service users' needs:**

It is recommended that:

1. The ethos of the CPA should be reflected and strengthened in the training programmes which Trust staff are required to attend.
2. Every 6 months, a random audit of 10% of current individual service users' records are audited by the Managers in each service involved in the individual's care with a view to establishing:
  - a) Whether CPA is being correctly applied and adhered to;
  - b) Whether all service users' risk assessments are up to date;
  - c) Whether staff are having regular supervision which includes reference to providing care which recognises the ethos of CPA;

3. Adherence to this recommendation is audited by the Trust on a 6-monthly basis.

#### **Recommendation Four – Impact assessment:**

Commissioners should consider conducting an impact assessment prior to the commissioning of 'new' services in order to establish the potential impact upon existing services in terms of staffing and recruitment in existing services.

#### **Recommendation Five – Management of waiting lists:**

1. It is recommended that the Trust considers whether an IT solution could be adopted which manages patients' need for information about their inclusion on waiting lists.
2. The Trust should review the manner in which it communicates with the patients of its psychological therapy services who are awaiting access to the service in order to ensure that the use of reverse opt-in processes is avoided.
3. Staff are appropriately trained to provide accurate information in response to queries about Trust services, likely waiting times and other sources of assistance.
4. The Trust is to undertake an audit of correspondence produced in relation to waiting list management in order to determine whether all written communications reflect aims and ethos of the service and seeks to promote a positive engagement with potential service users which encourages a sense of hope.
5. The Trust should develop a protocol to provide guidance about information sharing in relation to the situation where a patient is receiving care from the private sector.

#### **Recommendation Six – Accommodating the needs of all service users:**

It is recommended that the Trust review the Operational Policy: PMIC Assessment & Liaison Service (November 2016: Version 5) in order to ensure that all process noted within the policy are clear and accommodate the needs of all groups of service users.

#### **Recommendation Seven – Audit of complaints against trainees**

In order to ensure that the learning from the care and treatment of Donna in relation to the supervision of Trainee Psychiatrist 1 has been established, the Independent Investigation Team recommends that an audit be undertaken by the Trust of the following:

1. An audit of the complaints made against trainees to establish any trends, in order to support the needs of trainees involved and the training provided by the Trust in general.

2. The Independent Investigation Team recommends the introduction of a protocol for supervisors as to how to respond to a complaint about a trainee, whether made through the formal complaints process or otherwise. The Trust should audit the implementation and use of the protocol 6 months after its introduction.

### **Recommendation Eight – Audits of Efficiency:**

The Independent Investigation Team recognises the considerable amount of work completed by the Trust including the reconfiguration of services and the introduction of the single point of access. However, in order to ensure that the learning from the care and treatment of Donna has become embedded in the Trust's current practice, the Independent Investigation Team recommends that the Trust conduct an audit of the efficacy of the receipt of information from out with the Trust in order to determine the action taken by the Trust in response to such a referral.

### **Recommendation Nine - Communication with patients following uncompleted suicide:**

The Trust is required to implement a suicide awareness training programme for its staff which addresses the following elements of care:

- a) the need to create and preserve hope;
- b) assist people to work through suicide towards achievable recovery and growth goals;
- c) integrate suicide care into recovery care.

It is recommended that implementation of this recommendation is audited by the Trust 6 months after inception of the training programme in order to assess its effectiveness.

### **Recommendation Ten – Complaints Policy**

It is recommended that:

- 1) The Trust reviews its training requirements for individuals who are tasked with responding to complaints to ensure that the duty of openness is applied to all complaints, in order to ensure that all elements of complaints are addressed accurately.
- 2) The Trust reviews its complaints policy to ensure that complaints are used as a vehicle to drive improvements in care.

### **Recommendation Eleven - Response to complaints about the care of patients treated by junior doctors:**

1. MAP Trainee Psychiatrist 1 was in an early stage of his clinical practice as a psychiatrist. The complaints made about the care of Donna by her mother would have given his clinical supervisor an opportunity to ensure that there were no patient issues involved in Donna's care as well as presenting a training opportunity for a junior doctor.
2. It is recommended that the Trust introduce a protocol regarding the response by the supervisor to a complaint involving the care of the patient being treated by a junior doctor. This protocol should include the following elements:
  - a) Highlight early warning signs that a trainee maybe struggling;
  - b) Early meeting with the patient or their carer and the supervisor;
  - c) The option to transfer care to another clinician.

### **Recommendation Twelve – 'Being Open':**

The Independent Investigation Team recommends a Trust faced with a similar situation in future must treat the families of victims as individuals. As a result, the Trust must acknowledge the personal knowledge levels of the case itself.

The Trust must review its 'Being Open Policy' with a view to include guidance for internal investigation teams in relation to:

1. Demonstrate an understanding and sensitivity to the traumatic events family members with whom they will be have endured.
2. Arrangements surrounding meetings with families and carers following an incident are made with a view to minimising distress to all those involved.
3. Conflicts in evidence between must be explored in reports in order to demonstrate that the evidence given by family members has been taken into consideration.

## 6 FAMILY STATEMENT

- 6.1 The purpose of this Report is to promote learning.
- 6.2 The death of Zaki and Donna was a catastrophic event which has had a continuing effect upon those most closely involved with it, and lies at the heart of this Independent Investigation. To give them a voice in the Investigation and to allow members of their family to express how their deaths have had an impact upon their lives, the Independent Investigation Team has asked Zaki's relatives to explain their loss. Extracts from their response are set out in the paragraphs below.
- 6.3 The Independent Investigation Team has also included a statement on behalf of Donna's family to encourage a 'reflective process', and to allow those seeking to learn from these events an opportunity to hear about Donna and Zaki, including their lives, characters, and plans. This important because it places the people who died at the heart of this process.
- 6.4 Who were Donna and Zaki?
- 6.5 Accordingly, the Independent Investigation Team asked Donna's mother (who is also Zaki's grandmother) to explain who they were. The following is a summary of her recollections:
- 6.6 Donna:

*"A fun loving person, who had an outgoing personality, who always loved and cared for her family and enjoyed family gatherings, enjoyed meeting up with her friends.*

*Donna had worked in accounts since she left school and was fortunate enough to be fully employed. Donna loved going to the gym and enjoyed running. This came from her schooldays when she used to run for her school at Crystal Palace. She loved football and supported Chelsea.*

*Zaki was born by caesarean section. She was over the moon to be having a boy.*

*Donna was a hands on mum and was adamant she could manage. Donna returned to work when Zaki was five months old. She managed very well.*

*Donna doted on Zaki they would go away for weekends to visit friends they loved going swimming, Donna would take Zaki to see his dad in Egypt when she could.*

*Donna was a fun mum, we took Zaki to London Zoo and Bewlwater to see "In the Night Garden" not to mention many other places.*

*Zaki would stand on the window sill and wait for mummy to appear big smiles and waves to each other, big hugs when Donna came through the door he also found mummy's bed more exciting than his cot, many a night was spent in mummy's bed, the squeal of laughter from the bedroom in the mornings was a joy to hear.*

*We made so many plans Donna used to say Zaki was her life”.*

6.7 Zaki:

*“Our beautiful boy. Zaki was a very contented baby & little boy.*

*He was growing fast, he loved going to the park. He kissed trees and rolling down the hills. Fireman Sam and Thomas was two of his favourite toys. He loved music and many a time we danced in the kitchen to the radio.*

*He loved helping to bake little cakes, helped me when I came in from work to make a cup of tea. His job was to put the tea bag in the cup.*

*He loved jumping in puddles.*

*He liked to play with his friends and go to play school.*

*He loved a story at bedtime and watching his programmes on the TV, the list is endless.*

*Zaki was so special to all of us, so much fun and happiness”.*

## 7 LEARNING FROM PREVIOUS INQUIRIES IN THE NHS

- 7.1 The following Inquiries are helpful at this point in framing the incident of 22 March 2013 in a broader context of the learning which has arisen from a number of inquiries into adverse events within the NHS.
- 7.2 2015 National Confidential Inquiry into Suicide and Homicide:
- 7.3 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015<sup>6</sup> has calculated that in the years 2003-2013 there were an average of 57 homicides per year, involving 61 victims, committed by individuals in receipt of mental health care.
- 6% of individuals in the period 2005-2013 were under crisis resolution/home treatment teams at the time of the homicide.
  - 17% of individuals had been non-adherent with drug treatment in the month before the homicide.
  - 29% of individuals with schizophrenia had been non-adherent with drug treatment in the month before the homicide, an average of 5 per year.
  - 39% of individuals with schizophrenia missed their final service contact before the homicide, an average of 6 per year.
  - In total 57% of individuals with schizophrenia were either non-adherent or missed their final contact with services.
  - 89%, (excluding those with an unknown history), had a history of either alcohol or drug misuse or both, an average of 49 homicides per year.
- 7.4 The Ritchie Inquiry:
- 7.5 On 17 December 1992, Christopher Clunis killed Jonathan Zito, in an unprovoked attack at a London underground station. Mr Clunis had a long history of psychiatric illness, including previous displays of violent behaviour.
- 7.6 The NHS sought to learn from the care of Mr Clunis. His care was described, amongst other things, as a “*catalogue of failure*”, by the Ritchie Inquiry which was tasked with reviewing his care.
- 7.7 The Ritchie Inquiry was instrumental in the development of the Care Program Approach (CPA), which aims to ensure that there is a coordinated approach to the care and treatment of individuals with long term mental health needs where multiple professionals and agencies are involved. A core purpose of the CPA is to provide a framework for care planning which recognises the needs of the individual.
- 7.8 The landscape of mental health provision is far more complex than when the Ritchie Inquiry was written. Significant changes have been made to the legal framework governing mental health and there have also been changes in the manner in which services are delivered. However, analysis of mental health homicide reports since the Ritchie Inquiry into Mr Clunis’ care show that the

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<sup>6</sup> England, Northern Ireland, Scotland and Wales, July 2015 (University of Manchester).

issues highlighted in the report of that Inquiry remain relevant.

7.9 The Ritchie report into the care of Christopher Clunis underlined the need for clarity about who has overall responsibility for co-ordination and review of the progress of care. The message of the Ritchie report was about the needs of the individual being assessed to be understood and was used to construct a template for services to work to in a co-ordinated fashion with someone working with the service-user to oversee the template and the delivery of interventions.

7.10 The Care Programme Approach (CPA):

7.11 The CPA was introduced in England in 1991 and by 1996 had become a key component in supporting and facilitating long-term care. It was introduced in order to provide a framework for the delivery of effective mental health care, partly in response to the Ritchie Inquiry.

7.12 The main elements of the CPA are:

- a) Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- b) The formation of a care plan which identifies the health and social care required from a variety of providers;
- c) The appointment of a “care coordinator” to keep in close touch with the service user and to monitor and coordinate care; and
- d) Regularly review and, where necessary, agree changes to the care plan culminating in regular CPA meetings between all parties involved, including the service user and their carers<sup>7</sup>.

7.13 As will be demonstrated in this report, Donna did not receive care in accordance with the ethos of the CPA. In the opinion of the Independent Investigation Team, such an approach could have ensured that the care which was delivered was assessed, planned, coordinated and reviewed in order to ensure that it met Donna’s individual needs.

7.14 The Francis Inquiry:

7.15 The Francis Inquiry report was published on 6 February 2013 and examined the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report made 290 recommendations. Key themes were identified as being important to allow patient centred care to be delivered including:

- Patient-centred values throughout the system;
- Openness and transparency about how the service is performing and candour about harm to patients;
- Strong patient-centred health care leadership;
- Accurate, useful and relevant information allowing all to understand how safe, effective and good the service is.

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<sup>7</sup> “Refocusing the CPA” (DH, 2008).



7.16 The relevance of the above inquiries in Donna's case:

- 7.17 The Independent Investigation Team recognises that the death of Donna and Zaki took place within weeks of the conclusion of the Francis Inquiry. The Independent Investigation Team is also aware that a homicide-suicide inquiry, in relative terms, is a rare event when considered against the broader scope of day to day NHS operations.
- 7.18 However, the Francis and Ritchie Inquiries are nonetheless relevant to this case to the extent that they represent a commitment to greater openness and candour with families involved in incidents, to developing a culture dedicated to learning and improvement that continually strives to reduce avoidable harm.
- 7.19 The Independent Investigation Team considers the relevance of the Ritchie Inquiry to Donna is that, in this case, some 23 years after the Report published its findings, Donna's care demonstrates that the ethos of CPA may not always drive the delivery of patient-centred care.
- 7.20 The relevance of the findings of the Francis' Inquiry relates to the ethos of the Trust. In this case, it is the view of the Independent Investigation Team that there was a minimal sense of transparency about how SLAM services were performing and openness in relation to the Trust interactions with those affected in this case, particularly with reference to the handling of the complaints made, both to Donna's MP, and to services themselves in December 2012. This is of relevance to the cultural shift in the past few years regarding working with families and being open and accountable to those families.

## 8 PROFILE OF DONNA

- 8.1 This chapter will provide an overview of Donna's background, her relationship with Zaki, his father, and her historic interaction with mental health services, to set the scene for analysis in the Junctions of this report.
- 8.2 Donna's background:
- 8.3 Donna was born in Croydon on 4 December 1971. Her parents separated when she was young, and her grandmother took her own life at around the same time. Donna's stepfather then killed himself in 1991, leaving her mother with his gambling debts. In the same year, Donna's close friend died of a heroin overdose.
- 8.4 After leaving full time education, Donna worked in accounts full time, and continued to do so throughout her pregnancy until three weeks before Zaki's birth. She then returned to work when Zaki was five months old.
- 8.5 Donna's relationship with Zaki's father:
- 8.6 Zaki's father was a foreign national Donna met during an overseas visit. Donna found out she was pregnant at the age of 37 and gave birth to Zaki through an emergency caesarean section on 16 March 2010. Zaki's birth was straightforward, and no concerns were raised in the first months of his life.
- 8.7 Donna attended her GP on 1 June 2012 with an onset of anxiety symptoms. No trigger was identified but Donna was concerned about her relationship with Zaki's father who was living abroad at that time. This relationship broke down shortly thereafter, and the frequency of her visits relating to mental health issues significantly increased after this point.
- 8.8 Donna's relationship with Zaki:
- 8.9 The relationship between Donna and Zaki was not fully explored by mental health services.
- 8.10 The Independent Investigation Team understands that Donna was delighted when she gave birth to Zaki. She was a 'hands-on' mother and was adamant she could manage with caring for Zaki. Donna and Zaki would spend weekends away together and they would often watch Chelsea and go swimming. When possible, Donna would take Zaki to visit his father. Donna and her mother also took Zaki for visits to the zoo and a farm.
- 8.11 Overview of Donna's historic interactions with services:
- 8.12 Donna's involvement with mental health services appeared to have begun on or around 5 November 1991, when she was seen by a Community Psychiatric Nurse from another service in relation to the loss of her step-father to suicide in May that year, and then the loss of one of her friends shortly thereafter.
- 8.13 This consultation came at the request of Donna's mother and was to address the

traumatic effect of the suicide and the unhappiness caused to Donna by this loss and then subsequently that of her friend.

- 8.14 By August 1993, although she was described as “*recovering from*” bulimia, her mental health at this point had already started to suffer and manifest itself physically.
- 8.15 On 4 March 1994, following a further request from her mother, Donna was seen by the same Community Psychiatric Nurse she had seen in November 1991, at which point she was described as “*very depressed*”, scoring 34 on the Beck Depression Inventory, indicating ‘severe depression’. As at May 1995, Donna was still involved with services in relation to her mental health. Donna then did not have any further known involvement with mental health services until over 17 years later.
- 8.16 The critical period: June 2012 – February 2013:
- 8.17 Donna first presented with ‘anxiety/stress’ related symptoms at an appointment with her GP on 1 June 2012. In the time between this appointment and the tragic events of 22 March 2013, Donna attended NHS services over 40 times for various appointments and tests relating to her mental health.
- 8.18 Concurrent to that, during this nine-month period, she also engaged the private services of three separate psychotherapists, attending over a dozen private psychotherapy sessions. In the nine months leading up to the incident, Donna had sought to access care from six different SLAM services.

## 9 DEATH OF ZAKI

- 9.1 Filicide is the act of a parent killing their child.
- 9.2 Donna committed an act of filicide by placing Zaki and herself in front of a moving train. The account of Donna and Zaki's death given by the Train Driver at the inquest included the following description of Donna's actions:

*"She jumped down; I think she almost rolled over to cuddle the child. She had a gentle arm, a consoling arm around the child".*

- 9.3 Demographics of filicide:
- 9.4 Establishing a rate of filicide has proven to be problematic, both in the UK and internationally. However, it appears that on average there are approximately 30 filicide incidents per year in England and Wales<sup>8</sup>.
- 9.5 Of the 297 instances of filicide in the UK between 1997 and 2006, 45 cases involved filicide and suicide. Key demographic characteristics of the individuals who commit filicide-suicide in the UK<sup>9</sup> appear to be as follows:

Characteristic	Applicable to Donna and Zaki?
Filicide is more likely to be perpetrated by men, who make up 62% of cases.  Men committed almost twice the number of filicide-suicides.	Donna was female.  <b>Not applicable.</b>
The average age of the perpetrator is 37 years old.	Donna was 41 years old.  <b>Sufficiently proximate to be applicable.</b>
Biological parents commit the majority of filicides.	Donna was Zaki's biological parent.  <b>Applicable</b>
Unemployment and financial difficulties are common.	Donna was unemployed.  <b>Applicable</b>

<sup>8</sup> (NCI, unpublished data).

<sup>9</sup> Filicide: Mental Illness in Those Who Kill Their Children, Sandra M. Flynn, Jenny J. Shaw, Kathryn M. Abel Published: April 4, 2013 <http://dx.doi.org/10.1371/journal.pone.0058981>.

The median age of a filicide-suicide victim is 6 years old.	Zaki was 3 years old.  <b>Sufficiently proximate to be applicable.</b>
An estimated 71% of mothers who committed maternal filicide suffered from depression.	Donna suffered from anxiety and depression.  <b>Applicable</b>

9.6 The features associated with filicide are relatively common and could be said to be applicable to a large group of individuals. However, in absolute terms, filicides occur infrequently. Many of the risk factors are common to many families. There is a significant risk in using the risk factors to stigmatise individuals who may present with one or a number of these factors.

9.7 Contact with Social Services:

9.8 Donna had not carried out any violent acts towards Zaki prior to his death. Indeed, the evidence which has been made available to the Independent Investigation Team strongly suggests that Donna was a loving mother, but that she did not believe in her abilities to be a good mother to Zaki, possibly as a result of her illness.

9.9 Zaki was made the subject of an email referral to Croydon Council, Children and Families Service on 16 November 2012 by the MAP Team at SLAM.

9.10 The referral was not made on the appropriate form. Accordingly, the Children and Families Service wrote to the MAP Team at SLAM on 20 November 2012 in the following terms:

*“we would ask that you complete our referral form as we require more information regarding mothers mental health, the time scales of incidents, diagnosis, intervention by your service etc. Furthermore if there are any other children or if there is a father involved.*

*...therefore Croydon Social Services will not be taking any further action until we receive the further information required”.*

9.11 The Terms of Reference of this Independent Investigation do not require the Independent Investigation Team to consider the response of Croydon Social Services to Zaki’s referral. The Independent Investigation Team recognises that Croydon Social Services undertook a Serious Case Review into the learning which arose out of the death of Zaki.

9.12 The Serious Case Review made the following recommendations concerning actions which the Trust should take in relation to the analysis of risk surrounding children whose parents are experiencing mental health difficulties:

### “Recommendation 5

*Analysis of risk to children should be comprehensive and explicit in order to fully account for risks but also to ensure there is accountability and clarity in decision making processes. There is clear evidence that the junior doctor made a good assessment of the welfare of Josh. However a key opportunity was missed as the doctor did not follow up the outcome of the referral. There is also evidence of some confusion regarding the terminology of the referral.*

### Recommendation 6

*Trust services need to improve the focus of Think Family within assessments and risk assessments. This is particularly relevant when assessing the protective function of families. These assessments need to be explicitly recorded and include a clear rationale of decisions. These assessments whilst including families, need to include individual assessments to inform practice. Within the Think Family agenda practitioners should also be mindful of partner agencies with whom information could be shared for example in this case the health visitor.*

### Recommendation 7

*The Trust system of monitoring referrals to Children’s Social care needs to be reviewed within the Community Mental Health Team to ensure it is consistently effective. A key opportunity was missed as the team junior doctor did not follow up the outcome of the referral and the referral monitoring system which each team is expected to have implemented and be monitoring should safeguard against this happening again. At the time of this incident, this referral monitoring system was in its early stages however the team should take action to reassure the Trust that this system has been implemented as is consistently monitored by the team”.*

#### 9.13 Trust Efforts to Assess Risk to Zaki:

- 9.14 A completed Children’s Social Care Referral Form was forwarded to Croydon Social Services by the Trust under cover of an email sent at 11.30 on 27 November 2012. The referral form was scanned into Donna’s electronic records. The form was completed by MAP Trainee Psychiatrist. It includes the following comments:

*“I have concerns regarding possible future self harm by the mother. Currently the grandmother... is helping to care for [Zakil], however in the consultation, she, as well as her daughter were tearful, and unable to continue coping with DO’s behaviour...*

*I am referring now because I have met the mother and parent for the first time on 16th November 2012.*

*...I am hoping that this CAF referral will objectively assess the mother and grandmother’s ability to meet the child’s needs and to suggest support to make up any shortfall”.*

- 9.15 There is no record that Social Services responded to the concerns or request for information about Donna and her mother's ability to care for Zaki. On 18 January 2013, an entry in Donna's notes made by Trainee Psychiatrist 1 states:

*"Re-referral sent to ...in Children's Intake following yesterday's events".*

- 9.16 The form which was resubmitted did not contain any updated information. In particular, the form did not make any reference to Donna's uncompleted suicide on 14 December 2012. The assessment form completed by the Rotherham Access Team contained Information which was received by the Trust in relation to this incident and included the following description of the difficulties experienced by Donna and her family at that time:

*"DO came to stay with a friend in Rotherham on 11th December to give her a break from her son whom she has been struggling to care for due to her agitation. He would be looked after by DO's mother back in Croydon. DO's mother explained separately that this was also necessary to give her and her husband a break as they could not cope with DO's mood and behaviour, described as being constantly demanding of their attention, permanently seeking reassurance, at times hostile and physically threatening"*<sup>10</sup>

- 9.17 The Serious Case Review which was conducted in relation to the death of Zaki made the following points in relation to this referral:

*"Details of how this referral was made are not explicit within the SLAM notes and the current review has not been able to satisfactorily establish exactly why, or to whom, this second referral was made. It is therefore not known exactly what triggered this referral but it could be speculated that it was because Claire failed to attend a prearranged appointment with CT1 psychiatrist the day before.*

*It is of great concern that no-one seems to have any proper record of this referral or the outcome. The psychiatrist (CT1) could not recall what referral form was completed or how the referral to Children's Social Care was made and SLAM records hold no correspondence letter attached to the system, which links to the referral screen. For their part, Children's Social Care has no record whatsoever of this apparent referral having been received, and consequently no action taken by them".*

- 9.18 Trust Child Need and Risk Screen Tool:

- 9.19 The Trust had adopted a 'Child Need and Risk Screen Tool' which was used on three occasions in relation to Zaki. The occasions on which this tool was utilised were as follows:

- 13 November 2012 - MAP Team.
- 7 December 2012 – Psychiatric Liaison Team.
- 17 January 2013 - Psychiatric Liaison Team.

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<sup>10</sup> Assessment by Rotherham Access Team Approved Mental Health Professional, 15 December 2012, A & E Department of the Rotherham Hospital, page 2, faxed to Trainee Psychiatrist 1 at East Croydon MAP at 20.17.39 16 December 2012.

9.20 The Tool states in its introductory paragraph that:

*"This should be completed on assessment at time of new or re-referral, review via CPA and on changes to circumstances effecting family life".*

9.21 What is striking in all three completed Child Need and Risk Screens completed by different limbs of SLAM services, is the lack of information which they contain. In addition, there is no fundamental difference between the Child Need and Risk Screens performed on 7 December 2012 and 17 January 2013, save for the name of the individuals who applied the Child Need and Risk Screen, notwithstanding the uncompleted suicide on 14 December 2012.

9.22 In relation to referral to Social Services, the Child Need and Risk Screen dated 13 November 2012 states in relation to the question:

*"Is the mental health of the patient likely to impact on his/her capacity to meet the needs of the child(ren). The author stated 'Yes'. However, no further detail was given".*

9.23 A further question states:

*"...are there any concerns whether the child(ren)'s needs are being met".*

9.24 The author of the Risk Screen stated "No".

9.25 The Screening Assessments dated 7 December 2012 and 17 January 2013 both state in relation to referral to Social Services:

*"Grandparents are present with mother and child, no identified risks".*

9.26 The Child Risk Forms dated 7 December 2012 and 17 January 2013 contains no information in relation to the following section:

**"PARENTAL MENTAL HEALTH/SUBSTANCE MISUSE/LEARNING  
DISABILITY**

*Please describe how the patient's mental health/substance misuse/learning disability maybe or is impacting on his/her capacity to meet the needs of the child(ren)".*

9.27 In addition, no referrals to Social Services are attached, nor is there any information relating to the Children and Families Service letter dated 20 November 2012.

9.28 Filicide:

9.29 Whilst personal attachment towards family members and parenthood are usually considered to be protective factors for suicide, this is not the case in filicide-suicides. Therefore, the risk profile for filicide-suicide and suicide are different.



- 9.30 Research suggests that the majority (70%) of the motives for filicide-suicide were identified as altruistic, that is, the parents (90% of the mothers and 60% of the fathers) were motivated by the desire to alleviate real or imagined suffering in their children<sup>11</sup>. The weight of evidence available to the Independent Investigation Team suggests that Donna did not intend to actively harm Zaki as a primary motive for her actions.
- 9.31 Instead the Independent Investigation Team is of the view that Donna's primary aim was her own suicide. It is clear that at the time of her death that Donna felt depressed and anxious. Her perception may have been that her only option was to take her own life. She had expressed the view that she did *"not feel she is being a mum for Zaki"*.
- 9.32 In addition, Donna was a single parent experiencing relationship difficulties with Zaki's father. Evidence suggests that at the time of her death she was driven by her emotional state. Donna had been suffering from anxiety with a potentially unrecognised depressive illness. As this report seeks to demonstrate, she was unable to access resources to help her resolve a situation which she found overwhelming and insurmountable. The limited research which is available suggests that this group of women are the most likely to commit filicide-suicide, believing that the best option available to them in the circumstances in which they find themselves is to kill their child<sup>12</sup>.
- 9.33 The Independent Investigation Team is of the opinion that the evidence set out in this section of the report suggests that across SLAM services, there was a lack of curiosity about the nature of the relationship between Donna and Zaki. Accordingly, the risk assessments which were performed were perfunctory in nature.
- 9.34 The Independent Investigation Team noted the following references to Zaki in Donna's medical records:

Date	Author	Context of reference	Content
15 November 2012	Trainee Psychiatrist 1	Telephone call from GP	<i>"asking her mother to look after her child" 'was working full time, looking after child now working part time, child looked after by her mother"</i>
16 November 2012	Trainee Psychiatrist 1	Consultation	<i>"patient and mother told I would be making a CAF referral for [Zaki]"</i>

<sup>11</sup> Filicide-Suicide: Common Factors in Parents Who Kill Their Children and Themselves  
Susan Hatters Friedman, Debra R. Hrouda, Carol E. Holden, Stephen G. Noffsinger and Phillip J. Resnick  
Journal of the American Academy of Psychiatry and the Law Online January 2005, 33 (4) 496-504.

<sup>12</sup> Filicide-Suicide: Common Factors in Parents Who Kill Their Children and Themselves  
Susan Hatters Friedman, Debra R. Hrouda, Carol E. Holden, Stephen G. Noffsinger and Phillip J. Resnick  
Journal of the American Academy of Psychiatry and the Law Online January 2005, 33 (4) 496-504.

			<i>"patient given self referral for CIPTS – family therapy maybe appropriate"</i>
16 November 2012	Trainee Psychiatrist 1	CAF Referral	<p><i>"[Donna's mother] says she is happy looking after her grandson. However she is says she can't cope anymore looking after her daughter DO. DO is extremely anxious, and has put a knife to her own throat twice threatening impulsively to kill herself.</i></p> <p><i>I wonder how (sic) what the emotional atmosphere is like in the house, and how this might be affecting [Zaki]. I mentioned I was making a referral to you, with a view to how to support the entire family, however I am not sure they retained much information from the consultation".</i></p> <p>(Trust ePJS record, 16 November 2012, Trainee Psychiatrist 1).</p>
4 December 2012	Trainee Psychiatrist 1	Telephone call from DO	<p><i>"patient feels she's not looking after [Zaki] – appears to be fulfilling her caring responsibilities, but is obviously upset in the mornings'</i></p> <p><i>'also mentioned I have made a CAF referral for [Zaki]"</i></p>
7 December 2012	Nurse	Attendance in Liaison Psychiatry	<i>"Ms DO has a two year old child that lives with her and her mother and step father"</i>
17 December 2012	MAP Registered Mental Health Nurse 1	Attendance at MAP East	<p><i>"She feels useless unable to look after her son or do anything without depending on her mother"</i></p> <p><i>"She identified her son and mother as protective factors"</i></p>
31 December 2012	Trainee Psychiatrist 1	Consultation	<i>"Does not feel she is being a mum for son [Zaki], her mother is looking after [Zaki]"</i>

17 January 2013	Bank Nurse 1	A & E Attendance	<p><i>"DO repeatedly denied any suicidal intent or plans and when questioned cited her son as a protective factor."</i></p> <p><i>'DO lives at home with her mother and 2 year old son: at the moment she is relying heavily on her family to support her both with child care and with her anxiety'.</i></p> <p><i>"...she is now able to take her son to school , something she wasn't able to do".</i></p>
18 January 2013	Trainee Psychiatrist 1		<i>"Re -referral sent to .... Children's Intake Team following yesterday's events"</i>

- 9.35 The above references cite Zaki repeatedly being referred to as a 'protective factor' by Donna. Both Registered Mental Health Nurse 1 and Trainee Psychiatrist 1 gave evidence at the inquest of Donna to the effect that Donna herself held the view that Zaki and members of her family were a significant protective factor. In addition, evidence given at Donna's inquest by Trainee Psychiatrist 1 was that the impact upon Zaki of his mother's illness at a critical point in his development was actively explored. This is an element of good practice.
- 9.36 However, identifying and understanding protective factors are as important as identifying and responding to an individual's risk factors. The significance of individual protective factors varies. Whilst the Independent Investigation Team notes that those involved in Donna's care considered Zaki to be a protective factor, the basis for this does not appear to have been explored systematically in order to obtain information which could have informed clinical practice on behalf of Donna. In particular, Zaki did not appear to have acted as a protective factor in relation to Donna's significant uncompleted suicide on 14 December 2012.
- 9.37 There is no evidence in Donna's records that this issue was explored in a structured manner following Donna's admission in Rotherham in order to gain a better understanding of Donna to ensure that emphasis which was placed upon Donna's assertions that Zaki was a protective factor had a secure clinical basis. The answer to the question, 'what made Zaki a protective factor for Donna', was not sought, nor was the question 'why this had not prevented Donna's uncompleted suicide on 14 December 2012' answered.
- 9.38 Equally, a similar exercise was not conducted into whether other members of Donna's family, whilst being extremely supportive of Donna and Zaki, were a 'protective factor' if viewed from a clinical perspective. Indeed, evidence in Donna's medical records suggests that such an exercise may have been of value

from a clinical perspective in order to gain a better understanding of Donna. For example, an entry in Donna's notes made on 31 December 2012 states:

*"Mother and daughter are exacerbating each other's anxiety, neither appear to retain information well during consultation. Both are problem-focussed, not solution-focussed, eliminating drugs and discounting therapists, which then perpetuates the problem".*

#### **Comment One: Lack of understanding of the relationship between Donna and Zaki**

There is little evidence available which suggests that mental health professionals explored Donna's relationship with her son. Therefore, the exact reason for Donna's decision to include Zaki in her plans to end her own life is not clear to the Independent Investigation Team. Whilst some of the practicalities of his care were known, how Donna felt about her role as his mother was not systematically explored either as a protective measure for Zaki, or indeed for Donna herself.

Significantly, Zaki had not constituted a protective factor which had prevented her attempted suicide on 14 December 2012. This issue was not explored or revisited in the wake of Donna's attempted suicide. Indeed, MAP Trainee Psychiatrist 1's concern that an objective assessment of whether Zaki's needs be carried out was never addressed or actioned by social services, nor indeed, other professionals within SLAM.

This conclusion appears to have been reached without investigation into their relationship which might have given clinicians a valuable insight into the challenges which Donna was facing as well as affording the clinical team an opportunity to properly assess the risk which Donna's illness presented to her son.

## 10 PROFILE OF SLAM AND ITS RELEVANT SERVICES

- 10.1 The services provided by SLAM:
- 10.2 SLAM NHS Foundation Trust ('the Trust') provides mental health services to a local population of 1.3 million people. The Trust supports adults, older people and children in the boroughs of Lambeth, Southwark, Lewisham and Croydon.
- 10.3 The Trust also provides more than 20 specialist services for children and adults from across the UK, as well as providing a range of mental health services internationally. The Trust has an annual turnover of around £364 million, employs 4,600 staff, who provide inpatient care for approximately 5,300 patients each year, and treats 45,000 patients in the community.
- 10.4 In total, the Trust has more than 230 separate services including inpatient wards, outpatient and community services. The Trust has four main hospital sites, the Maudsley, the Ladywell Unit at Lewisham Hospital, Lambeth Hospital and the Bethlem Royal Hospital. In total the Trust has 830 beds across nine inpatient sites and 85 community sites.
- 10.5 The organisation of the Trust:
- 10.6 The services provided by the Trust are organised into seven clinical academic groups (CAGs). The aim of the CAGs is to bring together the clinical and academic skills in areas such as psychosis and child and adolescent mental health. Each CAG has a clinical and management lead. The Trust is proud of the research taking place.
- 10.7 The Trust has its own biomedical research centre, hosted jointly with the Institute of Psychiatry, Psychology and Neuroscience Kings College London, which has the aim of translating scientific developments into new ways of screening, detecting, treating and preventing mental illness. The Trust has eleven locations registered with CQC.
- 10.8 A service finder allows patients to search for services by geographical area on the Trust website, and the Trust maintains a National Services website<sup>13</sup> which provides advice and information for mental health professionals.
- 10.9 CQC review<sup>14</sup>:
- 10.10 The Trust was reviewed by the CQC in September 2015. The services which were individually reviewed did not specifically include those which were involved in Donna's care. However, the CQC inspectors made references throughout their report to the care and challenges faced by the Trust as a whole. The CQC made the following comments in summarising its findings:

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<sup>13</sup> [www.national.slam.nhs.uk](http://www.national.slam.nhs.uk)

<sup>14</sup> Information in this section taken from South London and Maudsley NHS Foundation Trust Quality Report Date of inspection visit: 21-25 September 2015 Date of publication: 22/01/2016

*“We have given an overall rating to South London and Maudsley NHS Foundation Trust of good.*

*We have rated two of the eleven core services that we inspected as outstanding, six as good and three as requires improvement.*

*The trust has much to be proud of and also some significant areas that need to improve. The trust was well led with a dynamic senior leadership team and board. There were also many committed and enthusiastic senior staff throughout the organisation working hard to manage and improve services. The trust recognised that they needed to focus on getting the basics right and the results of the inspection would confirm that this was correct”.*

10.11 The CQC most recently inspected the Trust in July 2017, the findings of that inspection published in October 2017<sup>15</sup>. Although the Trust community services was given an overall rating of “requires improvement” in that report, there were notable positives to be taken from the report in several respects, some of which were relevant to the care and treatment received by Donna. For instance, in the report the CQC rated the Trust services as “good” under the overall rating heads of “are services caring?” and “are services well led?”<sup>16</sup>.

10.12 Resource Issues:

10.13 SLAM delivers care through 220 services. The Trust is currently under financial pressure with an increasing population, limited staff and services available.

10.14 The Trust was the subject of review by Monitor in relation to its resource issues, with Monitor requesting further information following deterioration in the Trust’s financial position before deciding the next steps.

10.15 On a scale of 1 to 4, 1 being ‘highest risk’ and 4 being ‘lowest risk’, Monitor has rated the financial sustainability risk at ‘2’ for the Trust. However, the financial position is unlikely to get worse in the near future.

10.16 The Trust set out in their Operational Plan for 2014/16 that they are:

*“an organisation with exceptional human and capital resource, located within an organisational system of tremendous strength and potential”.*

10.17 This system is, however facing unprecedented challenge with current models of healthcare delivery effectively unaffordable and unsustainable in the face of broader economic hardship, societal change and demographic shift.

10.18 The Trust also set out in the Operational Plan that:

*“we know we need to make substantial changes in service delivery and we are mindful of the need to protect service quality and patient safety. In support of this,*

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<sup>15</sup> “CQC: South London and Maudsley NHS Foundation Trust, Community-based mental health services for adults of working age: Quality Report”, date of inspection visit 17-20 July 2017, date of publication 31 October 2017.

<sup>16</sup> CQC report published 31 October 2017, page 3.

*we have worked with commissioners to agree shared transformational plans with appropriate risk share arrangements and contingencies, with a view to ensuring financial sustainability and stability during a period of unprecedented system-wide pressure”.*

- 10.19 Trust wide there remains a challenge of maintaining safe staff levels, the CQC made note of many agency nurses and a lack of consistency of care. The CQC also noted that service users were not kept informed about changes in the service, i.e. staff leaving.
- 10.20 In the community based mental health services for adults the CQC found that use of temporary staff and changes to the how the recovery teams were configured meant changes in care coordinators for patients, with some staff being anxious about caseloads and the acuity of people they were supporting.
- 10.21 Particular concerns were raised by the CQC regarding the community based mental health services which were reviewed for adults of working age. These concerns were about the use of temporary staff. The CQC advised that the Trust should monitor the number of changes experienced by patients in care coordinators in the recovery teams and keep this to a minimum.
- 10.22 Trust wide there were consistent deficiencies in permanent staff. The CQC report states that between February and April 2015 there were 36,550 shifts filled by bank or agency staff. The CAG with the highest usage was psychosis CAG with 18,117 shifts. There were 3,405 shifts not filled in the same period. 1,526 of these were in psychosis CAG.
- 10.23 Positives that came from the CQC inspection in 2015:
- 10.24 The 2015 CQC report into SLAM was positive in ways relevant to the investigation in the following regards:
- Caring and professional staff.
  - The Trust provides services for a diverse population.
- 10.25 The 2017 CQC report found that the Trust;
- “was working to improve relationships between the community teams, wards, and home treatment teams<sup>17</sup>”...*
- “service managers were aware of the issues [the CQC] found relating to risk assessments and care plans, and working to address them<sup>18</sup>”...*
- “had taken proactive steps to address long waiting times in the Croydon A&L team<sup>19</sup>”...*

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<sup>17</sup> Page 3.

<sup>18</sup> Page 4.

<sup>19</sup> Page 4.

10.26 Donna's interactions with SLAM:

- 10.27 As previously mentioned, in the nine months preceding the deaths of Donna and Zaki, in addition to her constant contact with primary healthcare services at her GP surgery, and three private psychiatrists she had seen, Donna had interactions with six separate SLAM services.
- 10.28 Donna's interactions with three of these services, namely the IAPTS, the MAP, and the CADAT, were repeated and over a significant percentage of the relevant period, whilst her interactions with the remaining three, namely the CIPTS, the Psychiatric Liaison Team and the Home treatment team were either one off occurrences or incidental, *ad hoc*, transient interactions.
- 10.29 Donna's interactions with the above six limbs of the SLAM services during the relevant period will be considered in the next chapter.



## 11 DONNA'S JOURNEY THROUGH THOSE SERVICES BETWEEN JULY 2012 – FEBRUARY 2013

11.1 As shown above, SLAM is a large organisation, comprised of many specialties providing local, regional and national services. In the period between July 2012 – February 2013, Donna had varying forms of interaction with six separate limbs of SLAM; IAPTS, MAP, CADAT, CIPTS, HTT and the Psychiatric Liaison Service.

- IAPTS – *“Improving Access to Psychological Therapies”*.
- MAP – *“Mood and Personality disorder team.”*
- CADAT – *“Centre for Anxiety Disorders and Trauma”*
- CIPTS – *“Croydon Integrated Personality Therapy Services”*.
- HTT – *“Home Treatment Team”*.
- PLS – *“Psychiatric Liaison Service”*.

11.2 To aid in the understanding of Donna's case, and the evaluation of her care in the Junctures later in this report, Donna's journey through these services is set out in this chapter. The 'commentary' (in italic text) was provided to the Independent Investigation Team and the Trust as part of this investigation by Donna's mother in a written "recount" of events as she perceived them<sup>20</sup>. It has been included in this section of the report in order to provide a 'carer's' perspective of the reason for contact with each of these services and the issues which she believed Donna was facing at the time.

11.3 SLAM Service 1 - Improving Access to Psychological therapies service (IAPTS):

11.4 IAPTS was the first SLAM secondary mental health service to which Donna was referred by her GP surgery on 16 July 2012.

*“In May 2012, Donna started feeling agitated and surging rushes through her body, she used to run to try and help with these symptoms, and she then started having panic attacks. Donna had never suffered with anything like this before and this worried her. I would say come on get a grip it isn't that bad, then she started talking quickly and going over things time and time again talking for hours, Donna wouldn't stop and wouldn't let you do anything you had to listen, Donna would follow us around. This was not the Donna we knew, we became very aware this was not short term and appeared to us a serious illness and we were extremely worried...”*

11.5 The service provided by IAPTS:

11.6 SLAM's web-site provided the following description of this service;

*“The Improving Access to Psychological Therapies (IAPT) program is an initiative that aims to greatly increase the availability of NICE recommended psychological treatment for depression and anxiety disorders.*

*NICE advocates a stepped-care approach to the delivery of psychological*

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<sup>20</sup> Donna's mother's written recount of events was provided to the Independent Investigation Team by letter of 19 November 2014.

*therapies in mild to moderate depression and some anxiety disorders. In moderate to severe depression and in some other anxiety disorders (such as post-traumatic stress disorder) low-intensity interventions are not recommended and instead it is suggested that patients should at once be offered 'high-intensity' face-to-face psychological therapy".*

- 11.7 What this service could have been able to do for Donna on an analysis of the above:
- 11.8 Applying the above, IAPTS would appear to be a service well suited for Donna's needs in terms of her presenting conditions. Donna suffered from both an anxiety type disorder, and depression.
- 11.9 Donna's interactions with IAPTS between 16 July 2012 and 29 January 2013:
- 11.10 Following her registration with IAPTS, on 3 September 2012, IAPTS called Donna to perform a 'triage telephone call' to assess her mental state. She was placed on a waiting list for CBT with IAPTS, and informed that there could be up to a 21 week wait for this service.

*"In September 2012, we went away for a weekend, Donna & Zaki went to stay with her sister, Donna had [her sister] up all night because of her anxiety and state of mind, I received a phone call to say she had been up all night..."*

*Donna rarely had a night's sleep, only a couple of hours if she was lucky, this worried her as Donna had always been a good sleeper. Donna was working full time as an accounts assistant and found it difficult to concentrate, especially on a couple of hours sleep. Donna was also worried about her job... One lunchtime she had thoughts of killing herself I brought her home...*

*Because she was so worried about what was happening to her she believed she was going mad, Donna was increasingly talking about taking her own life. Some mornings she said she was unable to get the train herself. Donna talked about anxiety all the time, she was so scared about what was happening to her that on an increasing number of nights was unable to sleep, would wake me up and ask me to sleep in her bed with her if she couldn't sleep she would ask me to go downstairs with her. This lack of sleep had a huge impact on both of us...*

*Donna had her hours reduced at work because she was struggling to cope. Donna did not like being at home with time on her hands...*

*...Then in October 2012 Donna contracted a chest infection and was signed off from work. Donna did not want to be on her own because Zaki was with his child-minder, I worked full time and my ex-partner three days a week. Donna used to call me as many as thirty times a day and if it wasn't me it was her friends...*

*...On my ex-partner's days off she would constantly talk about anxiety you would have to sit down and talk to her about it for hours as she wouldn't let us get up...*

*Donna was terrified by these symptoms...she thought she was dying..."*

11.11 The IAPTS waiting list:

11.12 Donna remained on the IAPTS waiting list (whilst concurrently pursuing private CBT), and was written to by IAPTS on 7 November 2012 asking if she wished to remain on the IAPTS waiting list. According to Donna's mother's account of her daughter's care, Donna never received this letter. The letter was copied to Donna's general practitioner and a copy of it is included in Donna's GP records.

11.13 On 11 November 2012, Donna woke in the middle of the night and held a knife to her throat. This incident is also recorded in Donna's medical records, for example in relation to a consultation which she had with Trainee Psychiatrist 1 on 15 November 2012.

11.14 Donna's mother informed the Trust's internal investigation team of this incident, who recorded in the following terms in the internal report;

*"She reported getting up in the middle of the night, totally unaware of what she was doing, and held a knife to her throat, fighting off her mother's attempts to take the knife from her..."<sup>21</sup>*

11.15 Donna's mother informed the Independent Investigation Team that;

*"...On more than one occasion when Donna was really desperate she took a knife from the kitchen drawer and put a knife to her throat, we would try and coax her to give us the knife which she would do eventually, we were terrified she would harm herself...We resolved this problem by taking every knife in the house and locking them in the garage.*

*Donna would fight with us to stop us going to work, because she was so frightened to be on her own, how dreadful we felt about this. Staying at home was not an option we had to work.*

*Donna loved shopping and was a wonderful shopping companion, but her anxiety made shopping an impossibility. On one occasion we went to Croydon as Zaki needed a coat, she was constantly on the phone to her friends saying how anxious she was, wasn't getting any help and she couldn't get better. Donna refused to come into the shops with Zaki and I when we bought Zaki his coat; we made our way to the station. During this walk Donna said to me she could take no more and was going to jump in front of a train, this absolutely terrified me.*

*I was aware the train was not due for some time, I stopped at a coffee shop so we did not have to wait too long on the platform. We had a few minutes to wait we were on a seat on the platform and Donna said she was going to throw herself under the next train of course I was terrified not only did I have Donna I had Zaki in his pushchair, I had no alternative but to sit on her. The next train was not the one we wanted, we got on it all I wanted to do was get off that platform. Donna calmed down and we eventually made our way home. These incidents are so draining it takes all the energy out of a person.*

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<sup>21</sup> "South London and Maudsley NHS Foundation Trust Acute Mental Health Comprehensive Level Two Report", February 2014, page 15.

*Donna was still complaining of seeing terrible faces at night and having dreadful thoughts. She was constantly saying that she couldn't change her thoughts, CBT therapy was not helping she was far too anxious to change her thoughts. Donna was convinced the reason she couldn't engage with CBT was that the illness she had was too severe for CBT to help her.*

*Donna talked about nothing but her anxiety and cried most of the time...*

*We often used to lock all our doors as she said she couldn't take anymore she was going to kill herself...<sup>22</sup>*

- 11.16 As will be evidenced later in this report, such concerns were communicated to the Trust during Donna's various interactions with the Trust prior to her death.
- 11.17 After a wait of over 2 months since her telephone triage with IAPTS on 3 September 2012, on 17 November 2012, Donna's mother called IAPTS to enquire as to her position on the IAPTS waiting list for CBT and was informed that she was number 89 on that list<sup>23</sup> and that the psychiatrists "*have no idea of the waiting times*", but it could potentially be a wait of up to 18 months.
- 11.18 Evidence given to the Independent Investigation Team by Donna's mother was that on 18 December 2012, she telephoned the IAPTS to enquire where Donna was on the waiting list at that time. She was told that "*she was near the top of the waiting list*". Donna's mother then asked "*how long could this be*". She was told "*2 day's weeks or months*".
- 11.19 Donna's removal from the IAPTS waiting list:
- 11.20 Having received no response to their letter of 7 November 2012 asking if Donna wanted to remain on the IAPTS waiting list for CBT (which, as stated above, Donna's mother informed the Independent Investigation Team that she did not believe that Donna received this letter), and despite phone calls made by her mother and Donna on 17 and 18 December 2012, by letter of 20 December 2012, IAPTS wrote to Donna removing her from the waiting list.
- 11.21 Upon receipt of this letter, Donna's mother called IAPTS the same day to inform them that they had never received the letter of 7 November 2012 and that they wished to be restored to the waiting list. According to Donna's mother, IAPTS restored Donna at number 46 on the waiting list, confirming this in writing by letter of 24 December 2012. Donna's mother wrote to the Trust by email of 26 December 2012 re iterating this concern<sup>24</sup>.

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<sup>22</sup> Extract from Donna's mother's written recount of events, provided to the Independent Investigation Team by letter of 19 November 2014

<sup>23</sup> As will be shown later in this report, Donna's mother emailed her Member of Parliament in relation to the length of the IAPTS waiting list and informed him of Donna being 89 on the list. Donna's mother also made CADAT aware of this by email of 09.24, 26 December 2012.

<sup>24</sup> Donna's mother's email to the Trust, senior administrator at CADAT ("*Centre for Anxiety Disorders and Trauma*") of 09.24 Wednesday 26 December 2012.

- 11.22 Donna's inclusion to the IAPTS waiting list:
- 11.23 On 26 December 2012, Donna's mother wrote an email to IAPTS to ascertain the reason for Donna's removal from the waiting list and sought confirmation of her current position on the waiting list following her restoration. The email contained details of Donna's overdose and stated that Donna *"nearly lost her life as she couldn't see any way out because there is no immediate help available"*.
- 11.24 Upon receipt of this, IAPTS on 27 December 2012, Donna's mother attempted to contact Croydon Integrated Psychiatry Services (CIPTS) on Donna's behalf to ascertain if she was on a waiting list for CBT, but CIPTS was closed for the Christmas holidays. After being on the waiting list for over five months already by this point, IAPTS also suggested that Donna may be better suited to CIPTS than IAPTS.
- 11.25 IAPTS wrote to CADAT asking whether Donna was on their list for a private assessment, and IAPTS wrote to MAP to ascertain the situation regarding a care coordinator for Donna. IAPTS then wrote to Donna's GP updating on all of this and spoke to her on 28 December 2012 re-iterating the position.
- 11.26 On 15 January 2013, Donna had an assessment with IAPTS for CBT, the outcome of which was that IAPTS offered her ten sessions of CBT.
- 11.27 The issue surrounding Donna's position on the IAPTS waiting list is more fully explored at paragraphs 11.17 – 11.21.
- 11.28 IAPTS' discharge from service:
- 11.29 On 29 January 2013, Donna spoke with IAPTS and declined the offer made by IAPTS of ten CBT sessions, having started CBT with a third private therapist by this point. IAPTS' letter to Donna dated the same stated:
- "During our conversation you reported that you are no longer having thoughts of being better off dead or wanting to harm yourself. You stated that these thoughts stopped approximately a week ago and that your son is currently a protective factor"*.
- 11.30 Donna's mother has also provided the following evidence to the Independent Investigation Team:
- "Donna had rejected the 10 sessions and she was not made aware she could re-refer, I also was not informed when I rang them after Donna rejected them. I questioned whether...halfway there<sup>25</sup>".*
- 11.31 As a result, IAPTS informed Donna that they were closing her case. IAPTS then emailed the other services updating them and saying as she was having CBT privately, her file was closed, although Donna was advised that she could self-refer in the future if she wished.

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<sup>25</sup> Extract from Donna's mother's written recount of events, provided to the Independent Investigation Team by letter of 19 November 2014

- 11.32 SLAM Service 2: Croydon ‘Mood Anxiety and Personality Team’ (MAP) East:
- 11.33 Whilst she was still on the IAPTS waiting list for CBT but had not been reviewed, assessed, or received any care from Service 1, Donna contacted MAP, which was to become the service with which she had the most contact throughout her involvement with SLAM.
- 11.34 On 13 November 2012 (at which point Donna was already on the waiting list for IAPT), Donna circumvented the requirement for GP referral to MAP and presented herself directly to MAP. Donna had attempted to contact her GP that day prior to her self-referral, but her GP was on leave.
- 11.35 MAP Nurse 1 assessed Donna and concluded Donna’s issues were “*primarily related to social stressors and adjustment difficulties rather than any mental health disorder*”. Donna was deemed “*low risk*” as her family was viewed as a “*protective factor*”. Donna was determined “*unsuitable*” for MAP, and she was discharged back to the care of her GP.
- 11.36 The service provided by MAP:
- 11.37 During the course of the Independent Investigation, the Independent Investigation Team noted a reference on the Trust’s website<sup>26</sup> describing the service provided by the MAP Team at that time (May 2017).
- 11.38 When this was drawn to the Trust’s attention, they responded in the following terms;
- “we have investigated this further and confirmed that the information on the external website is incorrect. This is being urgently addressed. We would like to thank you for bringing this to our attention”.*
- 11.39 The Trust have since updated their website, which is an element of good practice, and the website now provides the following description of this service;
- “We provide a service for people aged 18-65, who live in the London Borough of Croydon or are registered with our aligned GP Practice and have a main diagnosis of a non psychotic mental illness.*
- We provide advice on the best treatment and care options available to people who have moderate to severe mental illness, such as anxiety, depression or personality disorder.*
- We work with a team of health and social care professionals including nurses, doctors, social workers, psychologists. We also work closely with the patients, their carers and GPs”.*
- 11.40 However, the ongoing challenge which the Trust faces in this area is illustrated by the fact that a URL address to the updated webpage provided by the Trust to the Independent Investigation team was the same webpage as was provided for

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<sup>26</sup> <https://www.slam.nhs.uk/our-services/service-finder-details?CODE=SU0498>

a different service (Mental Health Liaison Service) and made no reference to the CPA process or the MAP Team at the time.

- 11.41 The issue of the challenges which the Trust faces in the way it communicates information about its services remains an issue following its care of Donna. It was also raised as an issue by some of the Trust staff who participated in the 'Focus Groups' as part of the Independent Investigation. In the most recent inspection by the CQC<sup>27</sup>, this issue was noted to be an ongoing challenge.
- 11.42 It is also evident in relation to the individual staff members, as will be shown, in relation to their ability to accurately define and impart a description of the services to patients such as Donna, for example, in relation to the services available through Home Treatment Team.
- 11.43 A further, manual search of the external website also fails to find any formal information on the circumstances under which a service user would be placed onto a CPA or how this would affect their care as the search produced a "404-page error".
- 11.44 What this service *could* have been able to do for Donna on an analysis of the above:
- 11.45 Applying the above, MAP would appear to be a service suited for Donna's needs in terms of her presenting conditions. In order to access this service, patients are required to be on a CPA.
- 11.46 Donna's interactions with MAP:
- 11.47 Donna self-presented at East Croydon MAP on 13 November 2012 in an unplanned visit in crisis. She was seen by MAP Trainee Psychiatrist 1.
- 11.48 A letter to Donna's GP which was included in the medical records disclosed to the Independent Investigation Team includes the following references;

*"event that happened I (sic) the evening of 11/12. She reported that she had taken her usual medication as prescribed which had included citalopram 20mg and gone to bed. She added that in the two weeks she was on citalopram she would not even look at her son with any feeling. Her presentation changed completely;*

*DO reports that in the middle of the night an usual (sic) feeling overtook her and she took a knife to her own throat, fighting off her mother and totally unaware of her behaviour.*

*She reported that this was out of character behaviour scared her so much. She reckoned it is because of the anxiety even though she stated she was not aware of the cause of her current anxiety".*

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<sup>27</sup> CQC report published 31 October 2017.

*DO denied any history of harm to self or others. DO denied any current self harm or suicidal thoughts.*

*The formulation I acme (sic) up with at the end of this assessment was that this young lady was struggling with going through life as a single woman, who has given birth in her later stages in life, finding herself alone with her child, feeling helpless about situations in her life.....*

*'You may continue to prescribe the anxiolytic to help manage her anxieties and the promethazine to help but only on a short-term basis.*

*'After a full discussion of the above in our MDT meeting we agreed that at this stage she will require secondary services.*

*However please feel free to re-refer if any of the symptoms escalate".*

- 11.49 The Independent Investigation Team have not been provided with any minutes from the MDT meeting referred to in Trainee Psychiatrist 1's letter. The criticisms made in respect of a failure to record the discussions of MDT meetings set out at paragraph 19.25 and later in this report are relevant in this respect.
- 11.50 On 16 November 2012, the East Croydon MAP team Trainee Psychiatrist 1 saw Donna for an urgent appointment for medication review following a telephone call from her GP. Trainee Psychiatrist 1 was made aware of the incident during which Donna held a knife to her throat several days earlier.
- 11.51 Donna was given a diagnosis of *"generalised anxiety disorder secondary to life events"*. Trainee Psychiatrist 1 used a 'SADPERSONS' clinical assessment tool to determine suicide risk, assessing Donna at 3/10 – *"not requiring secondary services"*. Research published at around that time questioned the clinical value of this test as studies have found although the scale has specificity, its sensitivity is so low it is of limited clinical value<sup>28</sup>.
- 11.52 Trainee Psychiatrist 1 endorsed Donna's GP's treatment plan and a 12-point plan was formulated following discussion with MAP Consultant Psychiatrist 1.
- 11.53 On 19 November 2012, Donna's case was discussed in the MAP team meeting and the decision to discharge Donna back to her GP was made. It is not clear which members of the multi-disciplinary team were present at the MAP Team meeting when Donna's case was discussed. Equally details of the clinical discussion which took place at the meeting are not contained in Donna's clinical records. Following the meeting, Trainee Psychiatrist 1 discharged Donna from MAP by letter to her GP. The exact date of this is unclear, as the records show there to be two dates for this letter, 26 and 29 November 2012.
- 11.54 On 4 December 2012, Donna called Trainee Psychiatrist 1 at MAP, informed him she had been panicking all day, and that felt she was not looking after Zaki properly. Donna's mother informed the Independent Investigation Team that:

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<sup>28</sup> Bolton, James M.; Spiwak, Rae; Sareen, Jitender (15 June 2012). *"Predicting Suicide Attempts with the SAD PERSONS Scale"*. The Journal of Clinical Psychiatry. 73 (06): e735–e741. doi:10.4088/JCP.11m07362. PMID 22795212.



*“During this period the medication that was prescribed had caused side effects, bruising, suicidal thoughts, bleeding which added to Donna's anxiety. Throughout her illness Donna had body spasms her hands and legs would tremble and she would have spasms with her feet. Numbness in her head, constant night sweating, and most frightening of all seeing faces. When Donna told me she was seeing faces it was the most terrifying thing I had heard from her in terms of symptoms,*

*Donna said she never came back to herself, she felt detached from herself. Donna was prescribed pregabalin she appeared to be in a zombie like state when taking this. Donna woke me up one evening to tell me she was suffering from hallucinations, that she was seeing faces and she was very scared, I slept in her bed that night. One morning Donna attempted to climb the stairs and was unable to do so she fell down on them, at the time she was taking pregabalin we thought she was having a seizure...<sup>29</sup>”*

11.55 The Trust Internal Investigation reported<sup>30</sup>;

*“On 4 December 2012 Ms DO called East Croydon MAP and spoke with the team junior doctor. Ms DO said she's been having sensations of panic all day and felt she was not looking after her child properly”.*

11.56 Trainee Psychiatrist 1 reassured Donna but was concerned that she was being prescribed a sub-therapeutic dose of pregabalin, and subsequently advised Donna's GP about increasing her dose. He also advised Donna as to what to do should she find herself in crisis, both in and out of hours, to persevere with the CBT and continue to await the services of IAPT. Trainee Psychiatrist 1 also informed Donna that he had made a referral to Social Services in respect of Zaki.

11.57 On 14 December 2012, MAP sent a letter to Donna's GP discharging her from the MAP service.

11.58 On 17 December 2012, Donna's GP made an urgent referral call to MAP for their assessment for Donna's suitability for the Home Treatment Team (HTT). Donna was seen the same day by a Registered Mental Health Nurse (RMHN) within the MAP Team, MAP Nurse 2. Donna's medication was reviewed but she was not referred to the HTT. A follow up appointment with Trainee Psychiatrist 1 was offered for 31 December 2012.

*“...Donna was still unhappy to have survived, she couldn't look after Zaki, we were terrified of her repeating another attempt on her life... We tried our best to ensure that Donna was left alone as little as possible...”*

*Donna was very ill with her anxiety it consumed her... We left there despondent and once again this made Donna's anxiety worse...”*

11.59 On 31 December 2012, Donna saw Trainee Psychiatrist 1 once more. Donna and

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<sup>29</sup> Extract from Donna's mother's written recount of events, provided to the Independent Investigation Team by letter of 19 November 2014.

<sup>30</sup> At page 16

Donna's mother were dissatisfied. Trainee Psychiatrist 1 did not action the HTT recommendation in Rotherham's report, and told Donna's mother that he could not help beyond the offer of CBT and medication. Donna's mother informed Trainee Psychiatrist 1 that Donna could not wait for CBT, and that the private CBT that she was having was not helping. She also informed Trainee Psychiatrist 1 that she would complain.

*"...my daughter nearly lost her life and two weeks later Donna was still feeling the same helplessness...When we left there Donna was in such a state she said she was never going to get better she didn't know how, as a family we were terrified if no help came Donna would harm herself again..."*

11.60 Receipt of Rotherham referral:

11.61 Trainee Psychiatrist 1 confirmed at Inquest that the referral from Rotherham did come to Tamworth Road, the MAP East Team, and that he had seen it in the manager (at the time's) office. When asked by the Coroner at Inquest whether he had seen the Rotherham discharge letter of 16 December 2012 (faxed the same day) and addressed to him, Trainee Psychiatrist 1 confirmed that he *"definitely saw something"* but could not remember which document he saw. He stated that he *"probably"* would have seen it. When asked if he had seen the actual assessment, Trainee Psychiatrist 1 stated that he could not recall, but did not refute that he was aware of Donna's overdose in Rotherham. This awareness is also referred to in the MAP team notes as will be shown later.

11.62 Whilst there remains uncertainty on the evidence as to when exactly Trainee Psychiatrist became first aware of the referral from Rotherham following that attempt (there is no record in the ePJS), the available evidence, including that contained in Donna's medical records, does make clear that those individuals involved with Donna on behalf of services were aware of the involvement of Rotherham and Donna's overdose at the time of their respective meetings with Donna thereafter.

11.63 On 17 January 2013, Donna was due to attend for a follow up appointment with the MAP East Team. Donna did not attend as she was at A&E having been taken there by her mother having made further comments to her sister about suicide. Trainee Psychiatrist 1 made another appointment with Donna but acknowledged that he could not conduct the appointment himself as Donna was pursuing a complaint against him. The A&E Psychiatric Liaison Nurse notified the MAP team of her emergency attendance that day.

11.64 There is significant confusion surrounding the issue of a series of appointments which were supposedly offered to Donna. This issue is more fully dealt with later in the report.

11.65 Notwithstanding this confusion, Donna did not attend any further appointments with MAP East Team. She was not however discharged from the service.

11.66 SLAM Service 3: Centre for Anxiety Disorders and Trauma (CADAT):

11.67 Following Donna's suicide attempt on 14 December 2012, Donna's mother,

worried for Donna's declining state, contacted a third SLAM service, CADAT in an attempt to obtain assistance for her daughter.

11.68 On 18 December 2012, Donna's mother made an inquiry with CADAT as to the price of their services. This request is not supported by documentary evidence. CADAT emailed Donna's mother back in relation to private assessment by this service.

11.69 SLAM's website currently provides the following description of this service;

*"We are an outpatient clinic which treats people whose primary problem is a specific anxiety disorder, ...CADAT now also offers intensively delivered CBT for perinatal OCD and anxiety disorders, and we prioritise treatment for these women during pregnancy or in the first postnatal year.*

*We work with people to free them from their anxiety disorder and to improve their quality of life. We provide cutting edge cognitive behaviour therapy (CBT) treatment for anxiety disorders, including trauma-focused CBT for PTSD. The CBT treatments we offer are those recommended by the National Institute for Health and Clinical Excellence (NICE). Our services are particularly suitable for people with severe anxiety disorders, or those who have not made sufficient progress with CBT locally, or where the local secondary care services are not well developed for people with severe anxiety disorders".*

11.70 What this service could have been able to do for Donna on an analysis of the above:

11.71 Applying the above, CADAT would appear to be a service suited for Donna's needs in terms of her anxiety disorder, though not necessarily the depressive element of her presentation. CADAT accepts referrals from private patients.

11.72 Donna's interactions with CADAT:

11.73 On 28 December 2012, CADAT wrote to Donna's mother with the prices of the CADAT services. A private appointment with the service would have cost £526. Donna's GP subsequently contacted CADAT informing them that the family could not afford this, at which point Donna's GP was reminded that Donna was on the waiting list for IAPT.

11.74 On 7 January 2013, Donna's mother emailed CADAT asking to speak to a clinician. The recipient at CADAT sent an internal email instructing a colleague to provide a response to this on 8 January 2013, but this request was not actioned. Despite consideration of this issue throughout the course of this investigation, the Independent Investigation Team did not establish why this request was never actioned.

11.75 Following a chasing email from Donna's mother, there followed an exchange of emails between CADAT and IAPT concerning what each service could offer Donna including discussions as to who was best placed to respond to Donna's mother.

11.76 It appears from that exchange of email correspondence, that following contact between IAPTs and CADAT, IAPTS had a discussion with Donna's mother. The discussion touched upon the similarities between the two services and what treatments could be offered by each service. However, by this time Donna had commenced CBT with a private therapist. Her expressed wish was to stay with that therapist and therefore rejected an offer of CBT through IAPTs which had the impact of also bringing her involvement with CADAT to an end.

11.77 SLAM Service 4: Psychiatric Liaison Team - Croydon Hospital:

11.78 On 7 December 2012, Donna saw her GP complaining of being unable to urinate and a worsening state of anxiety. Donna was given a referral letter to "see *the liaison psych team today*", whereupon she attended A&E and was assessed by the Psychiatric Liaison Team at Croydon Hospital A&E.

11.79 A Psychiatric Liaison Nurse (PLN) assessed Donna, she advised Donna to discuss medication with her GP. The PLN found that Donna was suffering reaction to recent life events that had "*challenged her equilibrium and exacerbated her anxious predisposition*".

11.80 Recent medication changes were discussed with the Liaison Team Psychiatrist and Donna's current negative symptoms were considered to be a consequence of withdrawal from clonazepam rather than of the increasing the dose of Pregabalin.

11.81 Donna was prescribed 2mg of diazepam up to 3 times a day for 3 days to assist with symptoms of anxiety over the weekend. It was agreed Donna's mother would administer and monitor Donna's medication to ensure appropriate use.

11.82 The Psychiatric Liaison Team was of the view that "*no more action was needed at present*".

11.83 SLAM's web-site now provides the following description of the Mental Health Liaison Service:

*"The Mental Health Liaison Service (Croydon University Hospital) provides psychiatric assessments for people, aged 16-65, to determine if they need mental health care and treatment.*

*We care for people who live in the London Borough of Croydon.*

*Our aim is to ensure that people get the expertise they need to address their mental health problems.<sup>31</sup>"*

11.84 On 17 January 2013, Donna was again taken to Croydon University Hospital by her mother after she made a comment to her sister about not wanting to be around anymore. She was assessed in A&E and again found not to require

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<sup>31</sup> SLAM website.

treatment. An email was sent to MAP requesting a follow-up appointment, and Donna's involvement with the Psychiatric Liaison Service ended here.

11.85 SLAM Service 5: Croydon Integrated Psychological Therapy Services (CIPTS):

11.86 On 10 December 2012, Donna was referred to CIPTS by her GP.

11.87 SLAM's web-site provided the following description of this service:

*"The SLAM CIPTS is a team of psychologists and psychotherapists based at Tamworth Road who deliver a range of "talking therapies", including Cognitive Behaviour Therapy. CIPTS provides psychological assessment and treatment for patients living in Croydon between 18 – 65, who are presenting complex mental health difficulties requiring a secondary care level of treatment. CIPTS is related to IAPT by virtue of the fact that it receives referrals from IAPT, either passing on an original GP referral, or making referrals of their own to CIPT, but is a separate service<sup>32</sup>".*

11.88 What this service could have been able to do for Donna on an analysis of the above:

11.89 At Donna's inquest, it was declared that whilst IAPTS and CIPTS were similar, CIPTS offered much broader therapies for longer term treatment, and had the capacity to work with families. Evidence given at Donna's inquest was that IAPTS was a service which worked with individuals on a short-term basis working alongside primary care. CIPTS was able to provide broader therapies on a more long-term basis. Crucially, it had the capability to work with families.

11.90 On this basis therefore, CIPTS was potentially a service from which Donna could have benefitted.

11.91 Donna's interactions with CIPTS:

11.92 CIPTS received Donna's referral form on 3 January 2013, and rejected Donna's referral on 9 January 2013, saying that she is *"better suited for IAPT"*. No further information was given.

11.93 SLAM Service 6: Home Treatment Team:

11.94 This service aims to offer an alternative to inpatient hospital care.

11.95 The HTT service criteria is set out at paragraph 11.91 of this report and are more fully discussed at paragraphs 11.92 to 11.93

11.96 The Home Treatment Team can visit the patient's home to carry out an assessment and the team will have daily contact until it has been agreed for care to be transferred. This may be to an existing team, for example a community mental health team or if ongoing care is not needed care will be discharged back to the GP. The HTT accepts referrals from a wide source of referrers including

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<sup>32</sup> SLAM website.

community mental health teams, doctors, and approved mental health practitioners; they did not accept direct referrals from patients, GPs or the police.

11.97 The Trust has since updated the process for referral to HTT and allows direct referral from external services. There is now a single point of referral through the Acute Referral Centre, with local operational protocols that support the service.

11.98 Donna's interactions with HTT:

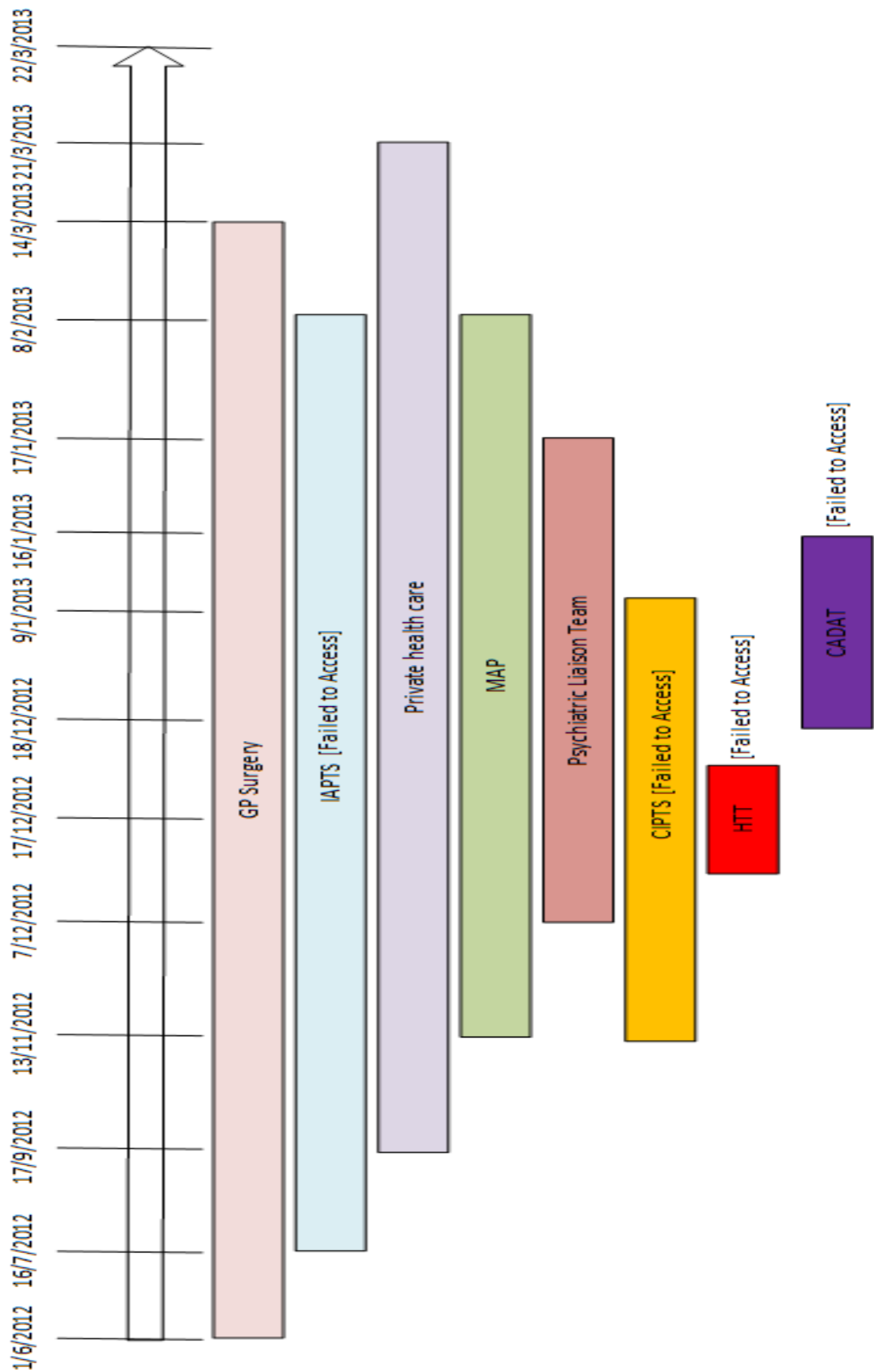
11.99 There were four points at which Donna could have been considered for access to HTT:

- Attendance Croydon University Hospital Psychiatric Liaison – 7 December 2012. There is no record of any consideration of HTT by the PLN.
- MAP Attendance - 17 December 2012. There remains a question as to exactly what information was provided to Donna regarding the services afforded by the HTT, and there is no record in the patient notes of the description provided to her.
- MAP Attendance – 31 December 2012. (Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 1 felt Donna did *“not meet the threshold for home treatment yet<sup>33</sup>”*).
- A&E Attendance, Psychiatric Liaison - 17 January 2013. (Bank Nurse 1 did not consider it appropriate. Her full-time position was in the Croydon HTT).

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<sup>33</sup> Trainee Psychiatrist 1's evidence at Inquest.

**OVERVIEW OF DONNA'S CONTACT WITH SERVICES:**



DATE	EVENT
16 Jul 2012	Donna referred to SLAM IAPTS by GP.
19 Jul 2012	Referral to IAPTS received by service. Assessment pack dispatched.
3 Sep 2012	IAPTS triage telephone call to Donna – outcome placed on CBT waiting list. PHQ-9 10 (severe) and GAD-7 18 (severe). Patient alert generated.
17 Sep 2012	GP appointment with Donna – private CBT discussed as NHS waiting list too long – Referred to private psychiatry.
18 Sep 2012	Private psychiatric outpatient clinic assessment recommended CBT and medication.
5 Oct – 2 Nov 2012	At least 2 CBT sessions with Private Psychiatry 1, 5 October and 2 November (exact dates of other sessions unknown).
2 Nov – 14 Dec 2012	Donna and Donna's mother then found another CBT therapist Private Psychiatrist 2, who visited Donna at her home once (exact date unknown).
7 Nov 2012	IAPTS sends letter to Donna asking if she wishes to stay on the waiting list. Donna's mother informed the Independent Investigation Team that this letter was not received by Donna. A copy of this letter is present in Donna's GP records.
11 Nov 2012	Donna's mother informed the Independent Investigation Team that Donna woke up in the middle of the night and held a knife to her throat fighting off her mother's attempts to remove it <sup>34</sup> .
12 Nov 2012	Donna visited her GP. GP advised her to stop taking citalopram with immediate effect.  GP notes record;  <i>"Held a knife to her throat this am, but says doesn't mean it".</i>
13 Nov 2012	Donna self-presented at East Croydon MAP in an unplanned visit crisis.  A letter to Donna's GP includes the following references;  <i>'event that happened I (sic) the evening of 11/12. She reported that she had taken her usual medication as prescribed which</i>

<sup>34</sup> Taken from Donna's mother's written recount of events, provided to the Independent Investigation Team by letter of 19 November 2014.



	<p><i>had included citalopram 20mg and gone to bed. She added that in the two weeks she was on citalopram she would not even look at her son with any feeling. Her presentation changed completely;</i></p> <p><i>DO reports that in the middle of the night an usual (sic) feeling overtook her and she took a knife to her own throat, fighting off her mother and totally unaware of her behaviour.</i></p> <p><i>She reported that this was out of character behaviour scared her so much. She reckoned it is because of the anxiety even though she stated she was not aware of the cause of her current anxiety'</i></p> <p>Donna denied any history of harm to self or others. Donna denied any current self harm or suicidal thoughts.</p> <p><i>'The formulation I acme (sic) up with at the end of this assessment was that this young lady was struggling with going through life as a single woman, who has given birth in her later stages in life, finding herself alone with her child, feeling helpless about situations in her life.....</i></p> <p><i>'You may continue to prescribe the anxiolytic to help manage her anxieties and the promethazine to help but only on a short term basis.</i></p> <p><i>'After a full discussion of the above in our MDT meeting we agreed that at this stage she will require secondary services . However please feel free to re-refer if any of the symptoms escalate.'</i></p>
<b>14 Nov 2012</b>	Telephone call between Donna's mother and GP.
<b>15 Nov 2012</b>	<p>Donna saw GP – chest problem, signed off from work. GP records state that GP;</p> <p><i>"Discussed with Duty Doctor [Trainee Psychiatrist 1]"</i></p> <p>Letter from Donna's GP to Trainee Psychiatrist 1 highlighting the following:</p> <p><i>"She has sever (sic) physical symptoms of generalised anxiety, sweaty palms, palpitation, pain attacks, tearfulness and agitation..."</i></p> <p><i>DO has had suicidal ideation and of late as I discussed with you earlier new suicidal intent...</i></p> <p><i>I am concerned for the following reasons:</i></p> <ol style="list-style-type: none"> <li><i>1) General decline, previous caring for son and working full time – now dependant on mother and not able to work part time.</i></li> <li><i>2) Use /development of dependence of clonazepam</i></li> <li><i>3) Options for further management. Pt is also having CBT privately and I am unsure of whether she is having any benefit from this. I welcome your very kind review".</i></li> </ol>

16 Nov 2012	<p>MAP team Trainee Psychiatrist 1 saw Donna for an urgent appointment (Donna's mother was present), and according to Donna's mother (supported by the ePJS entry below), MAP was informed of the incident with the knife, given a diagnosis of <i>"generalised anxiety disorder secondary to life events"</i> - not requiring secondary services. Plan as follows:</p> <p><i>"PLAN (Discussed with Consultant MAP East)</i></p> <ol style="list-style-type: none"> <li><i>1. Commence pregabalin (and discontinue clonazepam)</i></li> <li><i>2. GP to uptitrate dose next week.</i></li> <li><i>3. Patient to continue using Promethazine</i></li> <li><i>4. Patient given Lantern Hall contact details</i></li> <li><i>5. Patient given IAPT telephone number for counselling / CBT</i></li> <li><i>6. Patient and mother told I would be making a CAF referral for [Zaki]</i></li> <li><i>7. Patient and mother told to call or come to Duty if in crisis in office hours if she is suicidal</i></li> <li><i>8. Patient and mother told to present to A&amp;E if in crisis.</i></li> <li><i>9. Patient given self referral for CIPTS – family therapy maybe appropriate</i></li> <li><i>10. Patient advised to continue with CBT course already started privately</i></li> <li><i>11. Patient advised to concentrate(sic) on solutions rather than negative thoughts</i></li> <li><i>12. All aspects of the plan explained and repeated, but poor attention.</i></li> <li><i>13. I have phone GP to let her know the plan".</i></li> </ol> <p>The Trust's ePJS system records the following under the heading</p> <p><i>"CAF referral for [Zaki]</i></p> <p><i>I saw:</i>  <i>DO, (date of birth, age, address, telephone number)</i>  <i>In my outpatient clinic today for a one off medical review. She is extremely anxious. Currently she is living with her mother____, who is also looking after DO's son.</i>  <i>[Zaki] for whom I am making a referral.</i>  <i>The grandmother____ says she is happy looking after her grandson. However she says she can't cope any more looking after her daughter DO. DO is extremely anxious, and has put a knife to her own throat twice threatening impulsively to kill herself..."</i></p>

	According to <i>“Croydon Safeguarding Children Board’s serious case review into the circumstances surrounding victim”</i> <sup>35</sup> ; <i>“It is believed that Trainee Psychiatrist 1 telephoned and emailed his referral to Children’s Social Care on Friday 16<sup>th</sup> November 2012, although it is not clear who he spoke to or what time of day the referral was made”</i> .
<b>17 Nov 2012</b>	Donna’s mother called IAPTS. Evidence which she gave to the Independent Investigation Team was that she was informed psychiatrists <i>“have no idea of the waiting times”</i> – Donna on the list at number 89 and it could be up to 18 months <sup>36</sup> .
<b>19 Nov 2012</b>	Donna’s case was discussed in the MAP team meeting and the decision to discharge Donna back to her GP was made. The Independent Investigation Team has not been provided any evidence confirming the occurrence of this meeting.
<b>20 Nov 2012</b>	CAF duty assessment officer wrote to Trainee Psychiatrist 1 asking for CAF referral form as the original contact from Trainee Psychiatrist 1 failed to provide the requisite information relating to <i>“mother’s mental health, timescales of incidents, diagnosis, intervention by your service etc”</i> .
<b>26 Nov 2012</b>	<p>Date of dictation omitted from letter from Trainee Psychiatrist 1 addressed to Donna’s GP. Letter appears to relate to consultation on 16 November 2012.</p> <p><i>“Plan:</i></p> <ol style="list-style-type: none"> <li><i>1. Patient is to commence Pregabalin 50 mgs bd (and discontinue Cllonazepam)</i></li> <li><i>2. GP to see patient next week to up titrate Pregabalin dose.</i></li> <li><i>3. Patient continue to use Promethazine prn.</i></li> <li><i>4. I have given the patient contact details for Lantern Hall. She tells me that she has been using cocaine for about 6 months with a period culminating in a week in May where she used 4grams in a week. At that point she discontinued her cocaine use. I have encouraged her to contact them if she feels like she may relapse and continue with her cocaine.</i></li> <li><i>5. I have given the patient contact details for IAPTs just in case she iis (sic)mistaken when she says she already is on the waiting list for IAPTs CBT.</i></li> <li><i>6. I have told the patient and her mother that I will be making a referral.</i></li> </ol>

<sup>35</sup> *“Croydon Safeguarding Children Board’s serious case review into the circumstances surrounding victim “*, January 2014, page 22, para 5.1.10.

<sup>36</sup> Taken from Donna’s mother’s written recount of events, provided to the Independent Investigation Team by letter of 19 November 2014. Donna’s mother cited this in her email to her Member of Parliament of 10.32, 17 December 2012, and informed the ‘CADAT’ limb of SLAM of this by email of 09.24, 26 December 2012.

	<p>7. I have told the patient and her mother to come into Tamworth Road Resource Centre or to call duty during office hours if she is suicidal.</p> <p>8. I have asked the patient and her mother to present to A&amp;E if she is in crisis out of office hours.</p> <p>9. I have given the patient a referral form for CIPTs. I think family therapy may appropriate, since I saw quite a fractious relationship between mother and daughter in the consultation today.</p> <p>10. I have advised the patient to continue with her CBT course already started privately. She told me that the CBT course was "crap". I pointed out that she should expect to see home good results but not after only having five appointments which she had so far.</p> <p>11. I have advised the patient to concentrate on solutions rather than negative thoughts and problems.</p> <p>12. All aspects of the plan were explained and repeated but with poor retention.</p> <p>13. This was a one off medication review however if the GP feels that there are ongoing or new risk issues I would be happy to see her again".</p>
<b>27 Nov 2012</b>	<p>Trainee Psychiatrist 1 completed and sent CAF.</p> <p>"Ongoing concerns.</p> <p>DO has recently become extremely anxious (due to discovering her partner is married to another woman in Egypt, and has another child with her). She has become so anxious, that she held a knife to her own throat twice, and threatened to kill herself. This seems to be an impulsive act, and DO has said it was not a true wish to die. However, I have concerns regarding possible future self harm by DO. Currently [Zaki's grandmother] is helping to care for victim, however in the consultation, she, as well as DO were tearful, and unable to continue coping with DO's behaviour.</p> <p>There is past substance abuse by DO. She has taken cocaine for 6 months, stopping this in May and denying any current use.</p> <p>I am referring now because I have met DO and parent for the first time on 16<sup>th</sup> November 2012".</p>
<b>29 Nov 2012</b>	<p>Letter: purporting to be from Trainee Psychiatrist 1 to Donna's GP. Letter refers to assessment undertaken that day. However, letter is very similar to the letter dated 26 November 2012 above, but differs slightly in its drafting. It may be a later draft of an earlier version, although the Independent Investigation Team was unable to verify this.</p>
<b>4 Dec 2012</b>	<p>Donna called MAP and spoke with Trainee Psychiatrist 1.</p>

	<p>Trust EPJs records state;</p> <p><i>"Patient rejected.</i></p> <p><i>Rejected by Trainee Psychiatrist 1".</i></p>
<b>7 Dec 2012</b>	<p>Donna attended GP. GP notes record;</p> <p><i>"History - Feels much worse since starting pregabalin, very anxious, came in with step dad- he said she seems worse, very anxious, will not settle at all. Very tearful++ - scared of how she is feeling, wants to be better for her son. Also not passed urine (sic) since last night, has drank this am.</i></p> <p><i>Examination – abdo – soft, non tender, no masses, no palpable bladder.</i></p> <p><i>Comment – chat re options, to see liaison psych team today, will prob need to stop pregabalin came in whilst I was doing letter to psych team to say she had passed urine"</i></p> <p>Attended Psychiatric Liaison service at Croydon Hospital A &amp;E with a letter from GP suggesting that worsening state of her anxiety maybe due to the introduction of Pregabalin three weeks ago, and this medication having been increased.</p> <p><i>'...Anxiety increasing over past week.....</i>  <i>On the morning of 7/12/2012 DO went to see GP because that morning she felt unable to urinate, however when she arrived in the GP surgery she used their toilet freely passed water.....</i>  <i>Continuously anxious in presentation. Repeating herself with the focus on negative aspects of her feelings and the potential for problems to come.....Poor understanding and focus....</i>  <i>Always finding a negative rather than in engaging in a flowing conversation</i>  <i>Anxious. Low in mood...No suicidal thoughts or plans.</i>  <i>Recently put a knife to her own throat – discussed as a means of drawing attention to her feelings rather than having any attention (sic) of harming herself.</i>  <i>No audible hallucinations. Sees horrible faces when closing her eyes and trying to sleep, unable to describe the faces seen or what they look like. Attributes them to current medication and wants to stop current medication. No paranoia, thought insertion, ideas of reference or depersonalisation. Insight poor due to anxiety.....</i>  <i>Risk to self – non (sic) identified. To others – none identified.</i>  <i>... It was considered that the current negative symptoms were more likely to be due to the withdrawal from clonazepam than</i></p>

	<p><i>increasing the dosage of pregabalin....DO declined to consider inpatient treatment.</i></p> <p><i>Prescribed 2mg diazepam prn up to three times a day for the next three days . Advised that this was a short term crisis measure to assist with symptoms of anxiety over the weekend period. With the permission of [Donna's mother] to hold and monitor medication to ensure appropriate use. DO has appointment to see GP on Monday 10/12/2012. Advised to discuss returning to prescriber for further medication review and long term care plan .....</i></p>
<b>10 Dec 2012</b>	<p>Donna attended GP</p> <p>Donna referred to CIPTS a result of her attendance at A &amp; E<sup>37</sup>.</p>
<b>11 Dec 2012</b>	<p>Letter sent to Donna asking her to confirm that she wanted to remain on the IAPTS CBT waiting list.</p>
<b>14 Dec 2012</b>	<p>MAP sent letter to Donna GP discharging her from MAP.</p> <p>During early hours of 14 December 2011, Donna found overdosed and admitted to Rotherham Hospital.</p>
<b>15 Dec 2012</b>	<p>Donna assessed in Rotherham Hospital A &amp; E department by their Access Team, <i>'No active suicidal ideation at assessment but on-going risk of impulsivity. Recommendation: Liaison with Intensive Home Treatment Team in her own locality. Referral for urgent assessment and recommending input to stabilise anxiety. DO discharged from Rotherham Hospital to care of her mother. Mother (nearest relative) advised about Mental Health Legislation and how to access formal assessment process with a view to admission if felt DO's care and safety cannot be managed at home'.</i></p> <p>(As earlier in this report, MAP Nurse 2 was aware of this overdose by the time of her seeing Donna on 17 December below, but had not seen or asked for the referral documentation, nor had she contacted Rotherham.</p> <p>Trainee Psychiatrist 1 was aware of the referral but could not remember what he had seen. He also was aware of the overdose by the time of his appointment with Donna on 31 December 2012 below, and also did not contact Rotherham).</p>
<b>16 Dec 2012</b>	<p>Donna travelled back to Croydon with her mother.</p> <p>Rotherham Access Team fax a letter to MAP East Team accompanying the assessment report regarding Donna's admission to Rotherham at 20.17.</p>

<sup>37</sup> Trust Internal Investigation Interview 4, 2 May 2013.

<b>17 Dec 2012</b>	<p>Rotherham Access Team send a letter to Donna's GP regarding Donna's admission to Rotherham. GP made urgent referral call for East Croydon MAP for assessment for suitability for HTT and seen the same day by MAP Nurse 1.</p> <p>HTT not actioned, Donna told to await CBT. Mention of short term care coordinator – MAP Nurse 1.</p> <p>Follow up appointment with team Trainee Psychiatrist 1 offered for 31 December 2012.</p> <p>Donna's mother emailed her Member of Parliament ("MP"). MP replied. MP letter to SLAM.</p>
<b>18 Dec 2012</b>	<p>According to evidence given by Donna's mother, Donna's mother rang IAPTS- informed wait could be '<i>2 days, weeks or months</i><sup>38</sup>'.</p> <p>CADAT emails Donna's mother regarding private assessment.</p>
<b>20 Dec 2012</b>	<p>Letter from SLAM IAPTS to Donna to say they had not heard from Donna, had been removed from the waiting list. Donna's mother called back, and she informed the Independent Investigation Team that they said would put her back on the list at 46.</p> <p>At Inquest, the Service Lead for IAPTS Croydon at the time when asked by the Coroner whether Donna would have been put back onto the list at the same position she was prior to her removal, stated;</p> <p><i>"I'd be really surprised if she hadn't...."</i><sup>39</sup></p>
<b>24 Dec 2012</b>	Put back on IAPTS list following telephone conversation.
<b>26 Dec 2012</b>	<p>Donna's mother emails Croydon IAPTS seeking clarity about Donna status on list.</p> <p>Donna's mother emails MP.</p>
<b>27 Dec 2012</b>	<p>Service lead for Croydon IAPTS reviewed Donna's recent discharge from list.</p> <p>IAPTS Service Lead contacted MAP Nurse 1 requesting info regarding allocation of a care coordinator.</p>

<sup>38</sup> Taken from Donna's mother's written recount of events, provided to the Independent Investigation Team by letter of 19 November 2014.

<sup>39</sup> Inquest, Day 2, IAPT Croydon Service Lead.

	<p>IAPTS Service Lead email to CADAT.</p> <p>IAPTS Service Lead spoke to Donna and informed her that they were liaising regarding her therapy. Discussed risk and records indicated Donna stated she was not feeling at risk at the moment and is aware that she can contact her GP if she does feel suicidal at any point. Record stated Donna is happy with them to liaise with her mother as necessary<sup>40</sup>. Offered her an appointment ASAP as she would be seen more quickly by IAPTS than CADAT.</p>
<b>28 Dec 2012</b>	<p>CADAT email to Donna mother regarding private assessment.</p> <p>Phone call to GP. Went to see GP – concerned she had received no correspondence from MAP Nurse 1. Told Donna not to take the Olanzapine until knew why had been prescribed.</p>
<b>31 Dec 2012</b>	<p>Donna saw Trainee Psychiatrist 1 again. Donna and Donna's mother dissatisfied.</p> <p>Trainee Psychiatrist 1 discussed case with Consultant Psychiatrist 1.</p> <p>The EPJs notes (and the letter of 9 January 2013 pursuant, as below) of this consultation make no mention of the referral from Rotherham, but do record the following:</p> <p><b><i>Risk to self – Suicide, deliberate self-harm, accidental self-harm...Risk to others – physically violent, threats of violence...</i></b></p> <p><i>Not thinking of harming herself, says what she really wants is help.</i></p> <p><i>Not feeling as bad as she was in Rotherham".</i></p> <p>The entry contains reference to an appointment for Donna to see Trainee Psychiatrist 1 at 11.00 on 17 January 2013. However, no letter was generated on electronic system to Donna, but this appointment is mentioned in a letter to GP.</p> <p><b><i>"RECENT EVENTS</i></b>  <i>Rotherham admission 14<sup>th</sup> December</i>  <i>Suicidal ideation.</i>  <i>Spur of the moment, because wanted to return home.</i>  <i>Took pre-gabalin, promethazine, and friends tablets.</i>  <i>Stayed for 2 nights.</i>  <i>Unhappy to have survived.</i>  <i>Mayday 7<sup>th</sup> December</i></p>

<sup>40</sup> Trust records, 'Non-clinical notes for selected referral', 27/12/2012 at 13.08 added by Service Lead, Croydon IAPT.



Went to Mayday because feeling suicidal, her decision.  
Had not done anything  
Went with mum's partner  
Offered admission, but patient declined  
Feels Pregabalin did not help

### **Psyche History**

Never previously harmed herself

### **Mental State Examination**

A very well kempt  
B tearful, co-operative  
S normal  
T thinks about "not a lot" No formal thought disorder  
Tearful in consultation  
MOOD: 0/10 happy, 10/10 max anxiety, anhedonia, good energy  
BIO: 9PM-9AM interrupted, Appetite ate BD yesterday, weight increasing  
COG future: wants her life back, self: "I hate myself (for taking cocaine)"  
P no hallucinations, no visual disturbances  
I feel her main problem is anxiety, mother says her daughter needs intensive CBT therapy counselling or therapy.  
DO "needs help, "to see how I am". (i.e. admission for observation)

### **Risk**

SADPERSONS (single, depressed, isolate previous) = 5/11  
Not thinking of harming herself, she says what she really wants is help.  
Not feeling as bad as she was in Rotherham.

### **Impression**

Currently low risk of completed suicide. Mother and daughter are exacerbating each other's anxiety, neither appears to retain information well during consultation. Both are problem-focussed, not solution-focussed, resulting in eliminating drugs and discounting therapists, which then perpetuates the problem.

### **Plan** (discussed with [Consultant Psychiatrist 1])

1. patient to wait for IAPTS
2. continue with Citalopram 20mg until next clinic appointment

	<p>3. OPA with me 11am 17<sup>th</sup> January 2013</p> <p>4. patient given contact details of professional psychotherapy organisations if they wish to have psychological therapy privately while waiting for IAPTS</p> <p>5. patient given details of self help books</p> <p>6. mother given 3 weekly scripts as above, given reducing regimen of Clonazepam, 0.5mg for first 2 weeks, then stop</p> <p>7. consultants agree not for HTT or admission yet</p> <p>8. she wanted to make a complaint, and I said if she was unhappy she could make a complaint.</p>
<b>2 Jan 2013</b>	<p>GP entry:  <i>"not on list for CDAT. She has suggested an assessment for them to see if she is suitable. ...will contact DO today to arrange suitable time".</i></p> <p>GP entry:  <i>"Called from [Donna's] mother this am, went to see Trainee Psychiatrist 1 as planned, not at all happy with the serve (sic), still refused DO hospital admission or therapy under CIPTS, told pt she is on the list for IAPTs, or if she wants she can go privately again and offered her a list of Professionals who do CBT. I have called ...IAPTs ....., to inform them that she has been told by Trainee Psychiatrist 1 that she is not for CIPTs and she is for IAPTS. ...will call me back".</i></p>
<b>3 Jan 2013</b>	Trust EPJs patient record notes only <i>"CIPTS referral form given to CIPTS"</i> . No further information is recorded <sup>41</sup> .
<b>7 Jan 2013</b>	Donna's mother emailed CADAT.
<b>8 Jan 2013</b>	Donna's Member of Parliament ("MP") letter to SLAM – last MP involvement.
<b>9 Jan 2013</b>	<p>Private CBT.</p> <p>CIPTS reject Donna's referral.</p> <p>Trainee Psychiatrist 1 letter to GP summarising appointment with team (as above at 31 Dec 2012).  49 on waiting list.</p>
<b>13 Jan 2013</b>	Private CBT.
<b>14 Jan 2013</b>	SLAM director letter to MP.

<sup>41</sup> Record made by Trainee Psychiatrist 1.

<b>15 Jan 2013</b>	Donna appointment at IAPTS for a CBT assessment. Agreed she would stay on the waiting list for a therapist to become available. PHQ-9 23 (severe) and GAD-7 21 (severe).
<b>16 Jan 2013</b>	Donna's mother emailed CADAT as still waiting to hear re private assessment.
<b>17 Jan 2013</b>	<p>Donna taken to Croydon University Hospital by her mother after she made a comment about not wanting to be around anymore - assessed in A&amp;E by Bank Nurse 1. Findings:</p> <p><i>"DO is currently denying any suicidal intent or plans and is citing her son as a protective factor. She seemed to have hope (sic) that CBT would help but is reluctant to be advised on any medication which might relieve her anxiety in the meantime. Given crisis support information... She has a history of overdose. Risk to others- no risks to others identified. No risks to her son identified. She is managing to take care of him with the support of her mother".</i></p> <p>Trainee Psychiatrist 1 tried to follow up on the allocation with an email to the team manager and MAP Consultant Psychiatrist 1. At interview with the Independent Investigation Team, Trainee Psychiatrist 1 stated <i>"I felt she wasn't being contained in outpatients successfully at that point<sup>42</sup>".</i></p> <p>Donna DNA'd appointment with Trainee Psychiatrist 1. Electronic Record states <i>"DO DNA'd her OPA...hence this email".</i></p> <p>Email from Bank Nurse to Consultant Psychiatrist 1 of 16.39 on 17 January 2013 reads;</p> <p><i>"Please can you look up DO and offer her an urgent OPA and or duty appointment in the meantime. There does not seem to be any imminent or immediate risk to herself but her family are concerned and I worry the risk will increase if she doesn't get any respite".</i></p> <p>Consultant Psychiatrist 1 replied at 17.06 on 2013;</p> <p><i>"Hi [Bank Nurse]. No probs. [Admin staff] could we offer this lady an appointment with me on Tuesday 22 January at 11am at TRRC please. The lady booked in for that time has already been seen. We can also tell this lady to come to duty before then if she feels that she's in crisis".</i></p>

<sup>42</sup> Independent Investigation Team interview with Trainee Psychiatrist 1, 23 February 2015, Maudsley Hospital.

<b>18 Jan 2013</b>	<p>Zaki apparently re-referred to children's social care following events of 17 Jan 2013.</p> <p>According to the <i>"Croydon Safeguarding Children Board's serious case review into the circumstances surrounding victim"</i><sup>43</sup>, compiled after the incident;</p> <p><i>"On 18<sup>th</sup> January 2013, a referral was apparently made by Trainee Psychiatrist 1 to Children's Social Care although that agency has no record of receiving such a referral".</i></p>
<b>21 Jan 2013</b>	<p>SLAM's electronic record shows that an appointment letter was generated on 21 January 2013 offering Donna an appointment with the MAP team on 29 January 2013. This letter was not copied to Donna's GP. Donna's mother's evidence is that this appointment letter was not received by Donna.</p>
<b>22 Jan 2013</b>	<p>CADAT chase response to email of 16 Jan. CADAT's involvement ended upon notification that Donna was on the IAPTS waiting list and had been offered CBT.</p> <p>The reason why the email sent by Donna's mother to the Trust on 16 January 2013 was not forwarded internally to CADAT until 22 January 2013 is not known to the Independent Investigation Team.</p>
<b>29 Jan 2013</b>	<p>Donna's mother informed the Independent Investigation Team that there was an appointment at MAP of which Donna, her mother and her GP were, in advance and at the time of the appointment, unaware as they did not attend.</p> <p>The Trust's Internal Investigation Report<sup>44</sup> incorporates Donna's mother's position in relation to this appointment;</p> <p><i>"Donna did not attend because she received no notification of these appointments nor did her GP".</i></p> <p>SLAM's electronic record does not record any activity in relation to Donna's records following 22 January 2013 and none on 29 January 2013.</p> <p>Donna called IAPTs to turn down offer of 10 sessions of CBT.</p>
<b>30 Jan 2013</b>	<p>Private CBT.</p>

<sup>43</sup> *"Croydon Safeguarding Children Board's serious case review into the circumstances surrounding victim"*, January 2014, page 18, para 3.2.17.

<sup>44</sup> Page 19, footnote 9. Some of Donna's mother's comments are included in that report as footnotes *"to ensure that [DO's mother's] views are fully represented where they differ from those expressed in those expressed in [the internal] report"*, Internal Investigation Report, page 3.

<b>8 Feb 2013</b>	<p>LAST CONTACT WITH SLAM SECONDARY SERVICES.</p> <p>IAPT us Note states:</p> <p><i>“DO’s mum CO, called this morning as her daughter was offered something with .... but she denied it. Mum said that she was offered 10 sessions but she is down for GSH so I’m not sure if this is the case. She is already seeing a therapist privately, but I think the mother wants to know if our service would have been better for her. If you look at her notes on IAPTUS there’s been lots of communications. I said I would call [Donna’s] (mum) to explain how (sic) our sessions go as I couldn’t!!</i></p> <p><i>Her number is [REDACTED] (work) and she’s there until 4 today and tomorrow, but is out between 12 and 1.30!”</i></p>
<b>18 Feb 2013</b>	<p>Donna’s mother informed the Independent Investigation Team that Donna had an appointment at MAP of which Donna, her mother and her GP were, in advance and at the time of the appointment, unaware as they did not attend.</p> <p>The Independent Investigation Team was unable to locate any reference to this appointment in the Trust records or correspondence.</p>
<b>23 Feb 2013</b>	Private CBT.
<b>1 – 8 Mar 2013</b>	1 private CBT session.
<b>9 Mar 2013</b>	Private CBT.
<b>14 Mar 2013</b>	GP appointment for gastroenteritis – LAST CONTACT WITH NHS SERVICES.

## 12 SERVICE DELIVERY ISSUES RELATED TO MAP EAST TEAM

- 12.1 Demand for mental health services is high at a time of funding constraints. This is creating difficulties for patient access to care across the NHS.
- 12.2 In providing a report upon the care and treatment of Donna, it is important to acknowledge the effect that high demand for mental health services in Croydon, together with financial constraints, had upon services responsible for the delivery of Donna's care at the time.
- 12.3 The Independent Investigation Team has sought to establish the impact which these challenges had upon Donna's care and whether any learning other than the release of additional funding could be made.
- 12.4 Outline of Trust concerns about the challenges faced by the MAP Teams in Croydon:
- 12.5 On 21 May 2013, in a letter to Croydon CCG, the Trust highlighted its views of the difficulties which the Mood Anxiety and Personality (MAP) Community Mental Health Teams were facing in the period leading up to and including the care of Donna:

*"A fundamental problem for Croydon services is about how to maintain quality whilst being responsible for very large team caseloads. Existing activity is exacerbated by increasing demand and by the impact of teams having to work reactively with service- users and referrers. Attempts have been made to reduce caseload sizes over the last year; however they remain persistently high..."*

- 12.6 In summary, the data highlights five key issues;
1. *"Croydon caseloads are significantly higher than comparative teams*
  2. *Although overall budgeted expenditure across boroughs is similar, 22% of the Croydon team expenditure is made on drug prescribing compared to 2.5% in Southwark and less than 1% in Lambeth*
  3. *Expenditure on staff in Croydon is therefore significantly lower although the caseload is significantly higher...*
  4. *The demand for Croydon assessment services is further compounded by the increase in referrals from the significantly underfunded IAPT service (currently funded to provide only 20% of the activity targets set by the Department of Health)".*

- 12.7 In addition, it was said:

*"The following difficulties emanating from high caseloads can be observed;*

- *Increasing focus on crisis management rather than proactive management of risk, leading to increased demand from patients who begin to experience additional difficulties or relapse.*
- *Caseloads for care coordinators average 30+ when the recommended level is 20 - 25.*

- *Care coordinator's ability to develop and follow care plans is restricted*
- *Medical Staff manage large outpatient caseloads making them less available for multi-disciplinary work on complex cases and team leadership and development".*

12.8 The conclusion was that:

*"It is unlikely that team functioning will improve significantly whilst the work load remains at its current level.*

*A proposed way forward would be;*

1. *Reduction of caseloads to 700 across Croydon MAP (350 patients per team)*
2. *Development of new care pathway to assist the transition of MAP patients out of secondary care.*
3. *Review of demand management, referral and assessment pathways.*
4. *Review of prescribing arrangements".*

12.9 It is clear that the Trust's focus upon the difficulties which it faced in Croydon revolved around addressing the size of caseloads by a number of means including the transition of patients out of the service.

12.10 Clinical Academic Groups (CAGs):

12.11 The services SLAM provides are organised into Clinical Academic Groups (CAGs).

12.12 The CAGs are broadly aligned to care pathways and are each led by a Service Director, a Clinical Director and an Academic lead.

12.13 Clinical Academic Groups are intended to bring people together who are experts in their specific field in order that patients are offered care and treatment, based upon reliable research evidence. This involves clinical staff such as doctors and nurses working alongside academic researchers more closely.

12.14 Reorganisation of services in Croydon into CAGs:

12.15 The reconfiguration into CAGs of the community services in Croydon took place in September 2011 as part of the development of Clinical Academic Groups within the Trust at around that time.

12.16 In Croydon, the changeover to CAGs meant that five generic locality community teams, which at that time undertook assessment as well as treatment for patients across all diagnostic groups would be reorganised into the CAG's which recognised the care pathway which best met the patient's condition.

12.17 Accordingly, the five teams were split into teams which provided care for individuals with psychosis (which were transferred to the Psychosis CAG) and those which provided care for individuals with mood, anxiety and personality

disorders (the Psychological Medicine & Integrated Care CAG). The mood, anxiety and personality disorders (MAP Teams) were then split geographically into MAP East Team and MAP West Team. The MAP Teams also provided initial assessment to referrals made from local GP's as well as other referrers.

12.18 CAGs Governance:

12.19 CAGs are required to put the necessary arrangements in place within their areas for proper governance, safety, quality and risk management.

12.20 CAG forums have the responsibility, through the Clinical Directors, for the risks to their services and for the implementation of appropriate arrangements for the identification and management of risks. The risks can include the Trust's strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular CAG and its services.

12.21 Directorate and CAG management teams are responsible for managing risks that fall within the defined tolerances, and escalating those risks above set tolerances for information, or further action.

12.22 It was recognised by the Trust that the MAP Teams in Croydon were under significant pressure.

12.23 At the time of Donna's care, the MAP East Team had been placed on its CAG risk register due to the "*risk of its failure to meet governance and quality standards*". Accordingly, the Executive Team discussed the issues facing the MAP East Team regularly. The issues which the service faced were not solely restricted to resourcing but included leadership, staff competencies, training and administrative support.

12.24 MAP East Team Leader:

12.25 During the period between October 2012 and January 2013, the MAP East Team Leader was under a structured performance management programme with identified actions; when these were not completed, a decision was made to commence the process that resulted in the termination of their employment.

12.26 The Trust response to this situation was to provide the MAP East Team Leader with additional support from a more senior line manager. The support took the form of monthly supervision and regular contact by phone, email and in meetings. This manager also visited the team at its bases on a regular weekly basis. Supervision of the Team Leader included discussions about team member's performance, targets and other data quality issues.

12.27 Following the dismissal of the MAP Team Leader, this senior manager was required to 'act down' for a period of time to allow a new manager to be recruited.

12.28 The Trust experienced difficulties in filling the post of MAP East Team Leader. A qualified individual had been approached but rejected the position.



- 12.29 The solution adopted by the Trust was to increase the amount of time which the senior manager allocated to the team following the suspension of the MAP East Team Leader.
- 12.30 Individual Staff Competencies and Training:
- 12.31 It is clear that the Trust were aware that at the time of Donna's care, staff performance generally within the MAP East Team was an issue.
- 12.32 Appraisals were not being regularly conducted. A number of other staff were the subject of formal performance management and disciplinary action. A significant number of posts in the Team were filled by locum staff.
- 12.33 During the interviews conducted by the internal investigation members, the uptake by staff of mandatory training in Croydon was described as "shocking"<sup>45</sup>.
- 12.34 The Trust allocated a dedicated HR support (0.4 whole time equivalent – approximately 2 days per week) to assist team managers in improving staff performance in relation to issues such as sickness absence and meeting mandatory training requirements.
- 12.35 Supervision and induction of Doctors in Training:
- 12.36 During the course of the Independent Investigation, MAP Consultant Psychiatrist 1 was asked about the induction process which CT 1's now undergo. MAP Consultant Psychiatrist 1 provided the following description of what currently happens:
- "what I normally do is for the first week I don't have them seeing any patients. So basically they sit in with me, I get a little bit of a sense of what their basic skills are. I go through risk assessment mental state, psych history again with them in that week off".*
- 12.37 However, this was not the procedure when Trainee Psychiatrist 1 joined the MAP East Team and Trainee Psychiatrist 1 would not have had the benefit of that induction and being able to observe the work of his supervisor.
- 12.38 In relation to the supervisor's opportunity to observe the trainee, the current practice of MAP Consultant Psychiatrist 1 is as follows:
- "I try and plan ahead so that we see at least two or three patients together, if you like. For some of those specific assessments but also I'm able to do some of their work-based assessments without sitting in with them because I can go through the document quality and the documentation, diagnosis, treatment. That's why I can do some things with them like that".*
- 12.39 This did not happen in relation to Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 1 did not have an opportunity to sit with Trainee Psychiatrist 1 in order to see how he could structure a new interview for example. However, the

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<sup>45</sup> Trust Internal Investigation Interview 7, 9 May 2013, transcript verified and approved by interviewee 18 June 2013.

Independent Investigation Team was advised that MAP Consultant Psychiatrist 1 did go through psychiatric history, mental state and risk assessment with Trainee Psychiatrist 1 as part of the induction process. In addition, Trainee Psychiatrist 1 also underwent a 'centralised induction'. Risk assessment training is part of the generalised induction.

12.40 In recognising the significant improvements in practice in relation to the induction of Trainees made by the Trust, the Independent Investigation Team is concerned about the lack of focus upon practical skills in the induction process undergone by Trainee Psychiatrist 1.

12.41 During the course of the Independent Investigation, the following information was provided to the Independent Investigation Team by MAP Consultant Psychiatrist 1 concerning the practicalities of undertaking supervision of Trainees within the MAP East Team at the time:

*"The main way that would be managed I would say is through the supervisions with myself every week. Where we would go through every one they've seen and, "What do you think of this? What are the main issues? What are your concerns?" That was probably the only assured way of someone senior sort of reviewing the people that they see".*

12.42 When MAP Consultant Psychiatrist 1 was asked about the information which was available to determine whether a patient should be reviewed by the supervisor, MAP Consultant Psychiatrist 1 made the following comment:

*"we were all relying on the quality of the original assessments, if you like, in terms of how I might need to get involved. There were cases that the SHO were seeing say, for example, following its supervision with me that I would say actually can I see that person now. There were some individuals who were moved from a junior doctor's clinic to mine".*

12.43 During the course of the interviews conducted by the Independent Investigation Team, Trainee Psychiatrist 1 provided an explanation of how supervision worked from his perspective in the MAP East Team:

*"So I would see the patient and then while it was still fresh in my mind go and discuss it straightaway with him (supervisor - [MAP Consultant Psychiatrist 1]). And then we also had supervision every Monday morning at eight. And that always happened. Without fail".*

12.44 MAP Consultant Psychiatrist 1 also told the Independent Investigation Team that there was a further opportunity for supervision and review of cases through the MAP East Team Leader. MAP Consultant Psychiatrist 1 also confirmed that he was provided with a copy of letters which were written by Trainee Psychiatrist 1.

12.45 During the course of the Investigation, the Trust provided the Independent Investigation Team with the following additional information concerning the supervision of trainees.

*"At induction SLAM emphasises to core trainees the importance of supervision.*

*This is included in an educational contract (see attached), specifically measured in feedback after each placement, and given in an induction presentation on the first day”.*

*“All SLaM supervisors must have a training portfolio and are trained to ensure they understand the importance of clinical supervision”.*

*“Like all training programmes clinical supervision is an important measure of the quality management of SLaMs core psychiatry training programme by HEE and clinical supervision has not been raised as a concern”.*

- 12.46 The Trust has produced a significant amount of documentation which is aimed at supporting clinicians in their role as clinical supervisor. Within the documentation which was provided to the Independent Investigation Team is advice for dealing with trainees who are in difficulty, and it explores and defines the challenges which both trainee and supervisor experience in this regard. This is an element of good practice.
- 12.47 The advice makes it clear that there are some early warning signs for poor performance. The Trust advice in this regard mentions that an early warning sign might be *“failing to gain the trust of others”*, although it is not specified whether this relates to colleagues or patients. The GMC advice which is also contained within the pack which is provided to clinical supervisors refers to complaints made by patients; poor notes; failure to follow guidelines and inappropriate investigations.
- 12.48 The issue of poor record keeping by Trainee Psychiatrist 1 is dealt with more fully in sections 19 and 22 of this report.
- 12.49 The documents provided to the Independent Investigation Team by the Trust include a document entitled *‘Core Psychiatry Training Handbook’*. This is a practical handbook which was written in 2012 from the perspective of the trainee. It is a document which is aimed at individuals who have just joined the Maudsley Training Scheme as a core trainee. It covers topics such as *‘Roles and Responsibilities’*, *‘Structure of SLAM’*, *‘Trainee Resources and Pastoral Support’* and a section entitled *‘Handy Hints for the New Psychiatry Trainee’*.
- 12.50 What is absent from this document is advice about interactions with patients, particularly managing difficult clinical relationships or indeed complaints. This issue is dealt with more fully in Juncture 6 of this report.
- 12.51 Departures from Trust Procedures and Policies:
- 12.52 Evidence given to the Internal Investigation Team made it clear that in order to ‘cope’ with its workload, the MAP East Team had developed a number of procedures which it appeared to those within the team would maximise the limited resources which were available. It appeared to the Independent Investigation Team that this was an attempt to allow access to the team of the greatest number of patients. For example, the option of ‘interim’ care coordination and the manner in which the duty system operated at a practical level as described by Registered

Mental Health Nurse 1 at paragraph 18.44. However, these procedures lay outside the Trust's clinical governance regime because they did not comply with Trust policy and procedures.

- 12.53 These procedures did not accord with recognised Trust procedure or indeed national guidance on key aspects of the delivery of safe and effective patient care. Crucially, the procedures impacted on the delivery of care including the delivery of an 'amended CPA' and reduced levels of care coordination. The impact which these maladaptive processes had upon the care of Donna will be discussed in detail in subsequent chapters of this report.
- 12.54 However, for the purposes of this chapter of the report, the concern which the Independent Investigation Team has is the nature and speed of the Trust response to the discovery of these practices. This is dealt with more fully at below.
- 12.55 Administration:
- 12.56 A further issue which was potentially created by the resourcing issues faced by the MAP East Team was the impact of the paucity of administrative support for the team.
- 12.57 During the course of the interviews the Independent Investigation Team was advised that basic equipment such as printers and computers did not work reliably. It is the opinion of the Independent Investigation team that this had a direct impact upon the quality of patient care in a number of respects.
- 12.58 The Independent Investigation Team understands from information provided to the Internal Investigation Team that the MDT meetings which took place at the time of Donna's care were not supported by an administrator because "*it was not considered to be a good use of admin time sitting in a team meeting for 3-4 hours*". The practice which was instead adopted was that following the meeting the Team Manager would write to the patients who had been discussed to inform them of the outcome of the meeting.
- 12.59 In addition, if the computer in the room where the MDT meeting was held was working, whilst new cases would be entered on to the computer system during meetings, the discussion of current cases was not recorded into the patients' notes contemporaneously. The expectation was that the care coordinator or clinician would add any notes after the meeting.
- 12.60 Allocation of Management Support between MAP East and MAP West:
- 12.61 The issue of resourcing was a problem throughout Croydon.
- 12.62 When the services were re configured staff were given the opportunity to state a preference as to what CAG they wished to work in. However, the reconfiguration inevitably led to the transfer of patients to new care coordinators without any reduction in caseloads which were already high.
- 12.63 In the Trust's Internal Investigation report, it was recognised within the West MAP

Team that it was “not working well and that they were overwhelmed by their workload”.

12.64 However, it appeared that the Trust accepted the views of the MAP East Team Leader which were that the MAP East team was “working well” and were “coping”. Evidence which was made available to the Independent Investigation Team was that the MAP East Team Leader had “articulated a very clear plan” about reducing the team caseload. Targets had been identified and were being achieved. The management perception at the time appeared to be that the MAP East Team was coping slightly better than the MAP West Team.

12.65 In addition, the evidence provided to the Independent Investigation Team, in this case, interview transcripts with Trust staff interviewed as part of the Trust’s own internal investigation suggested that there was perception by some of the staff of the MAP Team East that the MAP East Team were not open to change. For example, the Head of Pathways for MAP in Croydon at the time of the incident stated in interview with the Trust Internal Investigators;

*“At the time the team were against any change, as was the team manager... West Team were screaming out for help they were aware that they were not working well and that they were overwhelmed by the workload whereas the East Team were reporting that they were working well and coping... were closed to change and not open to anything they might interpret as criticism...”<sup>46</sup>”*

12.66 Accordingly, management focus switched to the MAP West Team who had recognised that they were struggling and were ‘open’ to change.

12.67 As a result, a further change to the service was made to the operation of the MAP West Team in that the assessment and treatment functions were separated in an attempt to deliver a more effective service for patients.

12.68 This option was offered to the MAP East Team, but they decided to wait and learn from the MAP West experience and the outcome of the changes.

12.69 Adequacy of Management Response:

12.70 The MAP East Team was undergoing a period of significant change in that the service was being reconfigured as a result of the introduction of CAGs.

12.71 It was known that the team was facing a number of issues which could potentially have impacted upon the delivery of patient care and were not strictly related to resourcing. These included staff competencies, poor administrative support and maladaptive internal procedures.

12.72 The Independent Investigation Team recognises that managing change can be difficult particularly in teams which are under pressure because of limited resources and significant caseloads. In the opinion of the Independent Investigation Team, the potential appearance of a Trust focus upon the service to the potential detriment of the needs or risks posed to patients is a matter of

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<sup>46</sup> Trust Internal Investigation Interview 7, 9 May 2013, page 4, transcript verified and approved by interviewee 18 June 2013.

concern. The danger in such an approach is that a team which was known to be operating its own maladaptive procedures and processes which were outside and indeed conflicted with the Trust's own procedures was nonetheless apparently allowed to continue without an assessment of the risk or threat to patients which this might cause.

- 12.73 It is a matter of concern however that when asked in interview the question *'How did you plan to resolve the issues in the meantime'*, the response given by the Head of Pathways Croydon MAP was:

*"At the time the team were against any change as was the team manager. They felt in terms of workload having any more commitment to doing duty would not be manageable so it was decided to leave it until the team split47".*

- 12.74 It therefore appeared to the Independent Investigation Team that a factor in the decision-making process was the willingness to change, as opposed to the focus being upon the patient's needs or risks.

- 12.75 The Independent Investigation Team accepts that it may have been the correct decision to provide more support to the MAP West Team because they had highlighted the fact that they were struggling and therefore required support. However, this decision should have been taken following a structured comparative assessment of the strength of the systems and processes operated by both teams with the focus upon determining and assessing the risk to patients. The decision should not have been influenced by relative difficulties which would be experienced in effecting a change within the culture of each Team.

- 12.76 In addition, it appears that significant reliance was placed upon reassurances provided by a Team Leader who was facing disciplinary action in a team which had recently experienced a homicide and was the subject of an increased number of complaints. It is not clear whether these assurances were supported by any written evidence. This is a matter of significant concern.

### **Comment Two: Managing a failing team**

A number of specialist skills are required in managing a failing team. It is not clear whether the senior line manager or HR individual who were tasked with this responsibility had between them the experience and range of skills which were necessary to do this.

The Independent Investigation Team is particularly concerned that the decision to 'focus' upon the MAP West Team was not reviewed following a homicide committed by a MAP East patient on 20 December 2012.

It is the opinion of the Independent Investigation Team that an assessment of 'threat' to the delivery of safe and effective patient care should have been the starting point for the management response towards the MAP East Team. This may have involved 'bringing in' skills to determine the timetable of change which was to apply to the MAP East Team.

In addition, the Independent Investigation Team is of the view that despite the clear resourcing issues, there were immediate steps which could have been taken to improve patient safety, such as the provision of a functioning printer/computer to support the MAP East Team during their MDT's which would not have had a significant financial implication.

### **Recommendation One – Managing a failing Team:**

The MAP East Team was known to constitute a risk due to its failure to meet governance and quality standards throughout the period of Donna's care.

Notwithstanding this a decision to assign management intervention and initiate change management was not conducted in a timely and structured manner.

A focus was placed upon securing additional funding without reviewing immediate and relatively inexpensive ways of improving patient safety. In addition, reliance was placed upon the views of a Team Leader who had been made the subject of performance procedures without any critical evaluation taking place of the plans which were being proposed.

The Trust has made the following response to the Independent Investigation Team's concern in this regard:

*"Whilst we accept the recommendations may be useful when evaluating a failing team in the future, the recommendation fails to take into account that East Croydon MAP team does not exist in this form anymore.*

*In addition, the recommendation does not take into account service changes that have been made. The investigators may be glad to hear that a robust operational policy is now in place for the teams in their new structure. Team performance is monitored in relation to quality and safety, the service management would not hesitate to put resources at risk whilst engaging the service commissioners in discussions about funding shortfalls in the future".*

The Independent Investigation Team acknowledges the considerable work which has been undertaken by the Trust in this regard and in particular the introduction of improvements to policies and procedures including Croydon Treatment (version March 2017), Assessment and Liaison MAP (November 2016), and Croydon IAPT Operational policy (2017 version).

The MAP East Team was facing challenges which were not solely related to resources. However, notwithstanding the improvements made to the MAP East team, the Independent Investigation Team is of the view that the learning which arises from this case includes improving the speed and quality of the response to a team which is recognised as failing.

Accordingly, the Independent Investigation Team recommends that in teams which are identified as 'failing' or of being at 'risk' an immediate management plan should be initiated by an individual who is not connected in the line management of the failing team which seeks to:

1. Identify risk to new and existing patients of the current administrative processes and protocols.
2. Establish whether any immediate practical steps can be taken to reduce risk to patients notwithstanding action taken with regard to long term solutions such as seeking increased funding.



## **13 JUNCTURES**

- 13.1 Chapter 12 set out the difficulties which the Trust was facing in relation to the delivery of services to the patients of the MAP East Team and indeed in the Trust in general at the time of Donna's care. Indeed, as is mentioned in section 10 of this report, Monitor had concerns about the Trust's financial position and as a result, it is clear that 'resources' was a significant issue for all services across the Trust.
- 13.2 As part of its Terms of Reference, the Independent Investigation Team was asked to construct a timeline of Donna's care from July 2012, which is included in Section 11 of this report.
- 13.3 The Independent Investigation Team used that timeline to identify a number of 'junctures' or significant factors in Donna's care, some of which could potentially have taken a different path, had organisations/clinicians made different decisions. In doing this, the Independent Investigation Team has sought to include its views about the impact which the strain of limited resources had in addition to issues of individual clinical decision making throughout Donna's care. This is intended to act as a prompt to allow reflective practice and unlock learning.

## 14 JUNCTURE ONE: FAILURE TO APPLY A REFLECTIVE PROCESS TO THE DIAGNOSIS OF ANXIETY

- 14.1 The Independent Investigation Team is concerned that, in reaching a diagnosis of anxiety and in implementing a management plan that was orientated solely around that condition, little account appears to have been taken of Donna's symptoms which, if framed in a more sophisticated way, could have indicated a depressive illness or episode. Doing so could have led to a more holistic consideration of Donna's overall presentation.
- 14.2 Had a reflective approach towards diagnosis been adopted, then a more effective package of care could have been implemented in addition to a more accurate assessment of the risk which Donna posed to herself and others.
- 14.3 It is the opinion of the Independent Investigation Team that the actuarial suicide risk for individuals either suffering from depression, or, those who have previously suffered from depression, is considerably higher than that for individuals suffering purely from neurosis/anxiety-type disorders.
- 14.4 It is of critical importance therefore that services which are presented with an individual exhibiting traits that could be attributed to either condition, be vigilant of the possibility of an underlying depressive element.
- 14.5 Simply put, an individual suffering from depression is statistically more likely to commit suicide than an individual suffering from an anxiety disorder.
- 14.6 The failure to adopt a reflective approach had a 'knock on' effect in relation to a number of aspects of Donna's care.
- 14.7 The interaction between anxiety and depression:
- 14.8 In many cases of individuals suffering from depression, that depression has evolved from a history of anxiety. For example, for a period of two years they may have suffered with anxiety, and in the last 6 months, that anxiety has developed into depression. In these cases, the individual would have two separate diagnoses; anxiety disorder and depressive episode.
- 14.9 The diagnosis of "*depression with associated illness*" would be applied in the case of an individual who exhibits the symptoms of an anxiety disorder concurrent to a loss of concentration, the tendency to become tearful, or negative feelings about themselves.
- 14.10 If the symptoms are misread, the patient can be 'misdiagnosed' in relation to one or more aspects of their presentation. A possible consequence of this is the potential misattribution of risk situations. For example, someone suffering 'anxiety' who behaves hysterically and histrionically, putting a knife to their throat for example might be dismissed. Whereas an individual suffering from moderate or severe depression may have their actions interpreted differently.
- 14.11 In these situations, although the behaviour exhibited by the individual may be the

same in both cases, the significance attributed to that behaviour may vary considerably in terms of risk, depending on the underlying diagnosis; someone suffering anxiety doing this might be viewed as seeking attention, whilst someone suffering depression doing this might be viewed more readily as being in a crisis situation and in need of immediate intervention.

14.12 The situation in Donna's case:

14.13 It is the view of the Independent Investigation Team that in relation to Donna, services placed the majority of their focus on the anxiety aspect of her presentation and interpreted her actions accordingly.

14.14 There is little mention of depression in relation to Donna. It is possible that the diagnosis of her anxiety obscured that of her depression.

14.15 The Trust's position is set out below:

*"The Trust does not accept this conclusion regarding Ms DO's diagnosis for the following reasons. It was the view of an experienced consultant psychiatrist who provided medical expertise for the internal SI investigation that Ms DO's symptoms were suggestive of "Generalised Anxiety Disorder as the primary diagnosis with a co-morbid depressive illness." Ms DO was treated in line with such a diagnosis receiving antidepressant and anxiolytic medication but found it very difficult to tolerate medication as prescribed. Much of the input from the MAP medical team focused on trying to stabilise her on medication regime that she could accept including antidepressant medication Citalopram".*

14.16 However, Trainee Psychiatrist 1 has provided the following response to the Independent Investigation Team:

*"with the benefit of subsequent training, and now that I am a member of the Royal College of Psychiatrists, I agree that she ('DO') was a complex case, suffering with symptoms of both anxiety and depression. I agree with the report that she had symptoms of depression; in addition to my experience of seeing a very distressed and anxious woman in the clinic room. I very much agree with the statement that "It is possible that the diagnosis of her anxiety obscured that of her depression." I now think that this is what happened and I am considering the learning and implications from this".*

14.17 Donna's diagnosis by Trainee Psychiatrist 1 – 16 November 2012:

14.18 It is the view of the Independent Investigation Team that the crucial point in Donna's diagnosis came during the assessment by Trainee Psychiatrist 1 at MAP services on 16 November 2012.

14.19 The history which was made available to Trainee Psychiatrist 1 about Donna included the following summary contained within a letter dated 13 November 2012, from Registered Mental Health Nurse 2 to Donna's GP. It included the following:

*“Psychiatric history:*

*DO reports a long battle with depression and anxiety for which she has been prescribed a number of anti-depressants in the past none of which she has responded to very well. The latest one was citalopram which was stopped 12/11/12 due to intense suicidal thoughts in the 2 ½ weeks she was prescribed them”.*

14.20 At this assessment, Trainee Psychiatrist 1 was made aware of the incident with the knife a few evenings earlier. Donna was given a diagnosis of *“generalised anxiety disorder secondary to life events”*. Trainee Psychiatrist 1 used the ‘SADPERSONS’<sup>47</sup> assessment tool, assessing Donna at 3/10 - not requiring secondary services. The SADPERSONS assessment tool was not recognised by SLAM at the time. In addition, SADPERSONS was known at the time to have limitations. The Hospital Anxiety and Depression Scale (HADS) which is a reliable self-rating scale that measures anxiety and depression in patients in both hospital and community settings and is used within SLAM but was not used on this occasion.

14.21 Trainee Psychiatrist 1 wrote to Donna’s GP following this consultation. The letter which appears to be dated 29 November 2012, includes the following details about Donna’s presentation at this time:

*“DO was extremely anxious throughout the entire consultation. Her speech was normal but entirely anxious in content. Her thoughts were entirely anxious and negative, and entirely focussed around possible problems in the future and not about any solutions. Her concentration appeared to be poor and she was unable to retain much information... Her observed mood was anxious and low. She reports that her mood is 0/10 with 0 being as low as she could be; she denies any interests and says she feels shattered.*

*Regarding the future she feels nervous about bringing up a child by herself. Regarding herself she says she hates herself as she feels sad and anxious. Regarding biological symptoms of depression she says her appetite is okay. She sleeps from about 10pm till about 4am. Regarding suicidal ideation she has put a knife to her throat twice recently”.*

14.22 It is the opinion of the Independent Investigation Team that the symptoms outlined above indicate a significant possibility of depression which should have featured prominently in the planning and risk assessment. Depression is not mentioned in Trainee Psychiatrist 1’s notes or plan of 16 November 2012 relating to this consultation.

14.23 Depression is mentioned in Trainee Psychiatrist 1’s letter of 29 November 2012 to Donna’s GP in the following terms;

*“Regarding biological symptoms of depression she says her appetite is okay. She sleeps from about 10 pm until 4 am”.*

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<sup>47</sup> The SADPERSONS tool was not a recognised SLAM tool, but it can be used in conjunction with SLAM processes.

14.24 There is no other express reference to depression in the notes of this consultation.

14.25 NICE Guidelines: Depression in adults: recognition and management Clinical guideline [CG90] Published date: October 2009 Last updated: April 2016 states the following:

*“the assessment of depression is based on the criteria in DSM-IV. Assessment should include the number and severity of symptoms, duration of the current episode, and course of illness.*

*Key symptoms:*

*persistent sadness or low mood; and/or marked loss of interests or pleasure.*

*At least one of these, most days, most of the time for at least 2 weeks.*

*If any of above present, ask about associated symptoms:*

*disturbed sleep (decreased or increased compared to usual)*

*decreased or increased appetite and/or weight*

*fatigue or loss of energy*

*agitation or slowing of movements*

*poor concentration or indecisiveness*

*feelings of worthlessness or excessive or inappropriate guilt*

*suicidal thoughts or acts”.*

14.26 The guidance also states:

*“Step 2: recognised depression – persistent subthreshold depressive symptoms or mild to moderate depression*

*General measures*

*Depression with anxiety*

*1.4.1.1 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the person has an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guideline for the relevant anxiety disorder (see section 6) and consider treating the anxiety disorder first (since effective treatment of the anxiety disorder will often improve the depression or the depressive symptoms)”.*

14.27 However, a significant number of ‘depressive’ features can be seen in Trainee

Psychiatrist 1's assessment letter dated 29 November 2012. It is the opinion of the Independent Investigation Team that the presence of five of the features set out in the NICE Guidance referred to in paragraph 14.25 above were present suggesting that a clinical depression in moderate severity was present in addition to generalised anxiety disorder. This indicates a level of complexity in Donna's condition which was not fully recognised or explored, nor did it appear to be part of the plan formulated for her care nor indeed risk assessment.

14.28 IAPTS information regarding Donna's presentation:

14.29 Donna was unable to access care from IAPTs following her initial referral to the service on 19 July 2012. However, Donna's medical notes record that on 3 September 2012 and 15 January 2013, two 'assessments' were carried out using Trust recognised patient questionnaires, the PHQ-9 and the GAD- 7.

14.30 PHQ-9 is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. However, it can be used to make a tentative diagnosis of depression in at-risk populations. Generalised Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalised anxiety disorder (GAD).

14.31 On 3 September 2012, Donna's PHQ-9 score was 10. It had increased to 23 on 15 January 2013. A score of 10 indicates 'moderate' depression. A score of 23 indicates severe depression which would warrant treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

14.32 On 3 September 2012, Donna's GAD-7 score was 18. It has increased to 21 on 15 January 2013. Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

14.33 At the time of Donna's care and treatment, the MAP East Team would not have had access to the records kept by IAPTs. However, it was known that Donna was attempting to gain access to that service as this is recorded repeatedly throughout her medical records.

14.34 The involvement of the MAP consultant:

14.35 Trainee Psychiatrist 1's supervisor at the time was MAP Consultant Psychiatrist 1. MAP Consultant Psychiatrist 1 never actually saw or diagnosed Donna himself but had knowledge of her through Trainee Psychiatrist 1's interactions with her, and discussed Donna with Trainee Psychiatrist 1 several times, including on 16 November 2012, the team meeting on the 19 November 2012, and during Trainee Psychiatrist 1's second meeting with Donna on 31 December 2012, amongst others.

14.36 In interview with the Independent Investigation Team, MAP Consultant Psychiatrist 1 stated that Trainee Psychiatrist 1's assessment of 16 November 2012 seemed "*quite comprehensive*" in terms of the kind of plan that he had set out, and that Trainee Psychiatrist 1 was "*quite astute in the diagnosis of a*

*generalised anxiety disorder*", which MAP Consultant Psychiatrist 1 pointed out was a similar diagnosis to one formulated by a private psychiatrist who had been involved in Donna's care.

- 14.37 He stated that the medication advice "*seemed sensible*", and that further to their discussion about her historic drug use, Trainee Psychiatrist 1 had also included this in the plan with mention of SLAM's addictions team at the time. He also stated he believed the "*knife incident*" prompted Trainee Psychiatrist to make the CAF referral, and that he believed Trainee Psychiatrist 1 had done "*sufficient risk assessment*".
- 14.38 The MAP Doctor's views now:
- 14.39 During interview with the Independent Investigation Team, Trainee Psychiatrist 1 acknowledged that "*with the benefit of hindsight, looking back, DO did have core symptoms of depression*" and described hers as "*perhaps a strong depressive symptomatology*", and perhaps she was a complex case that needed a discussion with the consultant.
- 14.40 Trainee Psychiatrist 1 stated that "*there were possible depressive symptoms*", but that at the time in his opinion, she did not present as depressed. He made reference to the fact that Donna showed no signs of psycho-motor slowing. He cited early morning waking, low mood and feeling "*shattered*", and stated that this looked like "*generalised anxiety disorder, plus some minor depressive symptoms*".
- 14.41 Trainee Psychiatrist 1 also stated that A&E had also seen Donna and produced a similar assessment. He stated that, at the time, "*she was not particularly complex compared to the other patients that I (he) saw, a lot, most of them, had tried to kill themselves*".
- 14.42 Trainee Psychiatrist 1 also stated in interview that, at the time, it felt like "*DO was somebody who was quite dramatic and that her mother would sort of make threats when she didn't get her way*". Trainee Psychiatrist 1 confirmed in interview with the Independent Investigation Team that it "*never occurred to him that [Zaki] would not be a protective factor*", and that he has since learned that 'SADPERSONS' is not a Trust approved instrument.
- 14.43 The MAP consultant's views now:
- 14.44 MAP Consultant Psychiatrist 1 stated that, in retrospect, although the plan was comprehensive, he would have expected "*more rationale for her discharge on her notes of the team meeting of 19 November 2012*", and that it "*may have been more suitable to see DO on at least one further occasion, even if that was only to clarify DO's access to the psychological services*". MAP Consultant Psychiatrist 1 conceded this could have been an argument against discharging Donna at this point.
- 14.45 MAP Consultant Psychiatrist 1 conceded during interview with the Independent Investigation Team that "*there probably were depressive symptoms*". MAP

Consultant Psychiatrist 1 stated that he now thinks that *“maybe DO had more than just generalised anxiety order that they did not see, and that whilst DO’s anxiety was probably quite prominent, on reflection, there was obviously some real depressive symptoms there as well, and that perhaps their response was more around the anxiety side of it, and even then, it was quite disjointed”*.

- 14.46 It is the finding of the Independent Investigation Team that Donna’s presentation on 16 November 2012 was not fully explored. The failure to employ a reflective approach towards Donna’s presentation was not subsequently addressed. Consequently, clinically significant information was not recognised.
- 14.47 Failure to apply a reflective process towards diagnosis in subsequent consultations:
- 14.48 The Independent Investigation Team is concerned that, in reaching a diagnosis of anxiety and in implementing a management plan that was orientated around that condition, little account appears to have been taken of the symptoms of depression which Donna exhibited and indeed her history of depression. This had significant consequences on the progression of her movement through, and treatment by SLAM in the following months.
- 14.49 Psychiatric diagnosis is an active process in which symptoms and behaviour are evaluated against standardised criteria to arrive at a ‘best match’. In complex cases, the information needed to make a diagnosis is often incomplete or requires a period of longitudinal evaluation. Indeed, the Trust has made reference to the fact that it regarded Donna to be in an ‘assessment’ phase throughout the period of care by the Trust, although the Independent Investigation Team has seen no contemporaneous evidence of this.
- 14.50 Further, a patient’s symptoms or presentation may change over time. Diagnosis, therefore, should be dynamic and be regularly reflected upon, reviewed, and refined. Particular difficulties arise when diagnostic terms are misused in the form of labels due to the misplaced assumptions that derive from them.
- 14.51 The Independent Investigation Team could not see any evidence of a structured framework of diagnosis and treatment being applied after Donna was assessed by Trainee Psychiatrist 1 on 16 November 2012. For example, in a letter dated 9 January 2013 from Trainee Psychiatrist 1 to Donna’s GP, it was said:
- “Currently low risk of completed suicide. Mother and daughter are exacerbating each other’s anxiety; neither appears to retain information well during consultation. Both are problem - focused, not solution focused resulting in eliminating drugs and discounting therapists, which then perpetuates the problem”*.
- 14.52 Registered Mental Health Nurse made reference in her evidence at Inquest that she did not review Donna’s care on 17 December 2012 when she saw her, but simply relied on the findings of Trainee Psychiatrist 1’s consultation of 16 November 2012, notwithstanding the fact that Donna had presented at A and E and in Rotherham following this assessment.



- 14.53 There is no evidence contained in Donna's medical records that the Rotherham incident was reviewed reflectively within the care plan which was formulated for Donna on 31 December 2012. Crucially, the Rotherham fax was not scanned into the Trust's electronic record keeping system. At inquest, the former MAP team manager stated that "generally", correspondences directed to a specific physician would be uploaded onto the system by either the Doctor in question or one of the admin secretaries. He stated this was "generally" done by the admin secretaries.
- 14.54 Trainee Psychiatrist 1 confirmed at Inquest that the referral from Rotherham did come to Tamworth Road, and that he had seen it in the manager (at the time's) office. When asked by the Coroner at Inquest whether he had seen the Rotherham discharge letter of 16 December 2012, addressed to him, at the time, Trainee Psychiatrist 1 confirmed that he "*definitely saw something*", but could not remember which document he saw. He stated that he "*probably*" would have seen it. When asked if he had seen the actual assessment, Trainee Psychiatrist 1 stated that he could not recall, but did not refute that he was aware of Donna's overdose in Rotherham.
- 14.55 The Independent Investigation Team's concerns about the response to the Rotherham incident are more fully set out at Juncture 5. Whilst MAP Consultant Psychiatrist 1 did not see the Rotherham report, Trainee Psychiatrist 1's evidence at inquest was that he had. Indeed, MAP Consultant Psychiatrist 1 stated at inquest that it would have been a good idea to have contacted Rotherham to seek their views following Rotherham's fax of 20.18 on 16 December 2012. However, this was not done.
- 14.56 As stated above, whilst both Registered Mental Health Nurse 1 and Trainee Psychiatrist 1 were aware of Donna's uncompleted suicide in Rotherham as a result of their subsequent interactions with Donna, neither contacted Rotherham to obtain details of Donna's uncompleted suicide or discuss Rotherham's clinical assessment.
- 14.57 The absence of any documentary evidence regarding this referral, i.e. the document being accessible in Donna's patient record, through which more clarity on this issue may have been achieved, is of significant concern to the Independent Investigation Team.
- 14.58 Further, it appeared to the Independent Investigation Team that once the diagnosis of anxiety was made, it appeared to act as a 'label' which impacted upon the rigor of Donna's future assessment and care by other limbs of SLAM, notably in relation to her attendances at A&E on 17 January 2013.
- 14.59 Labelling goes beyond diagnostic terms and represents a shorthand way of categorising an individual without properly formulating their personal circumstances, personal history, and need. This approach, therefore, fails to see the person, as the stigma from labelling is about the blanket application of assumptions about a group of people, rather than exploration of the individual. As well as adversely influencing decision-making with regard to health and social interventions, labelling also acts as a smokescreen to changes in the pattern of a person's difficulties.

- 14.60 There is limited evidence contained in Donna's medical records that significant clinical information gained in Rotherham was considered reflectively as a means of influencing decision-making with regard to appropriate interventions in order to promote a care plan which recognised Donna's needs. For example, those assessing Donna in Rotherham made the following observations:

*"she is currently in receipt of CBT but it is probable she is too acutely agitated to engage in constructive therapy".*

*"full somatic features with gradual deterioration of helplessness and hopeless thinking".*

- 14.61 The Independent Investigation Team could not find any documentary evidence contained within Donna's records that this issue was considered reflectively either diagnostically or indeed in relation to her proposed care planning, nor could they find any evidence of her being in any kind of "assessment phase".
- 14.62 The Independent Investigation Team's additional concerns about the ability of clinicians to determine changes in Donna's clinical presentation on subsequent occasions are more fully discussed in relation to Chapters 11 and 12 of this report.

### **Comment Three: Applying reflective practice**

It appeared to the Independent Investigation Team that the level of rigor that went into the thinking about depression was minimal.

Had a more sophisticated and reflective diagnostic process and bio-psychosocial formulation been applied to Donna then there may have been acknowledgement of diagnostic uncertainty and more impetus to take an enquiring approach to understanding Donna's behaviours and accordingly risk. The Independent Investigation Team holds the view that by doing so, different conclusions could have been drawn and accordingly, different decisions taken regarding care and treatment pathways.

Donna's medical records do not provide evidence of any multi-disciplinary review of her diagnosis although reference is made on two occasions to multi-disciplinary meetings in Donna's notes. The issue of multi-disciplinary meeting is more fully dealt with in section 11.

It is accepted that reference is made to one such an assessment in a letter to Donna's GP dated 13 November 2012 and again on 19 November 2012, but no clear process nor any of the clinical discussions which took place in this respect are set out within Donna's records.

The presentation of anxiety can overlap with, and can be confused with, a depressive episode, crucially, it predisposes to comorbidity rather than excluding it. Snapshot views of patients can lead to both under and over-diagnosis and are more vulnerable to prejudice.

The Independent Investigation Team recognises that Donna's presentation could have been anxiety. However, additional information would have been beneficial, as would more rigorous application of diagnostic criteria and recognised Trust screening tools.

It is the view of the Independent Investigation Team that instead there appeared to have been an over-reliance on symptom profile as inferred from observed behaviour, an under emphasis on the longitudinal course of Donna's difficulties, and an under-emphasis on information from Donna as well as collateral sources including her mother. Potentially an element of information sharing with other services such as IAPTs and Rotherham could have led to a more informed and reflective diagnostic process. This led to a weakness of formulation and an unquestioning acceptance of the opinion of other clinicians without critical re-examination.

The Independent Investigation Team is of the view that had the ethos of the CPA in relation to Donna's care been adopted, then there would have been a greater prospect of the reflective approach to Donna's presentation highlighting changes that were clinically significant.

### **Recommendation Two – Improving reflective practice:**

The Independent Investigation Team recognises as an element of good practice, the following position put forward by the Trust:

*"The Trust had and continues to have robust systems in place to audit and monitor supervision structures within all clinical teams and professions.*

*The CQC inspection in 2015 stated a good rating in this area – "We were shown the supervision and appraisal records in all the teams. All staff had regular supervision and all permanent staff had completed appraisals for the year." This inspection included the Croydon MAP Assessment and Liaison Team: Available from*

***[http://www.cqc.org.uk/sites/default/files/new\\_reports/AAAE6503.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/AAAE6503.pdf)***

However, a number of key participants involved in Donna's care did not hold permanent positions within the Trust at the time of her care. In addition, the Independent Investigation Team was not provided with any documentary evidence that Donna's care was discussed in a designated supervision meeting.

A further concern is that the current Operational Policy: PMIC Assessment & Liaison Service November 2016: Version 5 for the Assessment Team includes a reference which is intended to encourage reflective practice. However, whilst reflective practice is open to all practitioners, it focuses specifically on Personality Disorders. This does not account for the service users who have not been given this diagnosis. There does not appear to be an alternative meeting for clinicians with patients outside of that spectrum.

Accordingly, the Independent Investigation Team would make the following recommendation:

- The Trust must conduct regular audits to ensure that its managerial supervision policies and procedures to facilitate supervision are being used to promote the delivery of service user centred long term care.
- The audit process should include scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the delivery of service user care viewed from a long-term perspective.

## 15 JUNCTURE TWO: FAILURE TO ADHERE TO THE CARE PROGRAMME APPROACH

- 15.1 The Care Programme Approach (CPA) is a system of coordinating the care needs of people with complex mental health problems to ensure that responsive and timely care is delivered by the right services to support the person's recovery in relation to their health and social needs.
- 15.2 The Ritchie Inquiry into the care of Christopher Clunis underlined the need for clarity about who has overall responsibility for coordination and review of the progress of care. The message of the Ritchie report was about the needs of the individual being assessed to be understood and used to construct a template for services to work to in a coordinated fashion with someone working with the service-user to oversee the template and the delivery of interventions.
- 15.3 The Care Programme Approach is a vehicle which was adopted to address some of the concerns in the Ritchie Inquiry. The Care Programme Approach was intended to provide a way of supporting individuals with severe mental illness to ensure that their assessment needs and care plans remain central in what can be complex systems of care. Put simply, the Care Programme Approach is a term for describing the process of how mental health services assess users' needs (including assessment of risk), plan ways to meet those needs, and ascertain whether their identified needs are being met.
- 15.4 The Care Programme Approach is intended as both a management tool and a system for engaging with people. Its primary function is to minimise the possibility of service-users losing contact with services and maximise the effect of any therapeutic intervention.
- 15.5 'ePJS' is an electronic clinical record system operated by the Trust. It is also the primary data source for Trust reporting and submissions. If the patient is not included in the ePJS system, their care cannot be included in the management reporting or audit processes.
- 15.6 ePJS supports the Care Programme approach by supporting clinicians and providing prompts, alerts and templates to support and underpin clinical practices and policies in order that care to be delivered in accordance with the CPA. It essentially assists in the case management of patients by prompting the clinician to undertake aspect of care in accordance with the CPA and potentially highlighting where actions have not been undertaken.
- 15.7 The Trust's '*CPA Policy – Refocusing the Care Programme Approach (September 2008)*' which was in force at the time of Donna's care stated:

### *"3.3 All Clinicians*

*All clinicians working for the Trust must use the process of CPA as a basic underpinning for all care delivered by the Trust. Therefore all service users should be assessed to ascertain whether they fall within the criteria for CPA. Service users who are taken on by the Trust but not within the scope for (New) CPA*

*should still be subject to written (electronic Patient Journey System Epjs) care plans and regular review. However those on Non CPA will usually have a less detailed Care Plan, although this should cover how the Trust is to work with the service user (i.e. treatment plan), who is the main person to contact in the Trust, how to contact them and who to contact in an emergency”.*

15.8 Donna’s Eligibility for CPA according to Trust Policy:

15.9 The Trust’s ‘CPA Policy – Refocusing the Care Programme Approach (September 2008)’ also stated:

*“5.2 (New) CPA*

*The key principles for CPA are the same as those for Service Users in receipt of Trust Services and not on CPA (see above). The difference is that because of the increased complexity and risk, there will need to be a Care Co-ordinator who pulls together various different individuals and agencies, as well as delivering some of the interventions.*

*“Key groups” of service users who must be assessed for [new] CPA include those with parenting responsibilities and those who have significant caring responsibilities. ...The default position for individuals from these groups would normally be under [new] CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in the care records”.*

15.10 The Trust has provided the following information in relation to Donna’s eligibility for CPA:

*“Ms DO had been seen by a member of the medical team in outpatients on three occasions during a six week period. The Trust position is that Ms DO was undergoing such an assessment and decisions about the use of CPA would have been made once the team had a better understanding of her on-going needs in the context of her presentation, risks and diagnosis. As she was essentially in an assessment phase no decision had been made as to whether or not the risks and complexity of her case warranted CPA and it is entirely possible she may have gone on to be registered under the Care Programme Approach in the future had she continued to engage with secondary services”.*

15.11 Having reviewed Donna’s medical records and the transcripts from her inquest, the Independent Investigation Team cannot find any reference to Donna being ‘held’ in an “assessment phase”. In addition, the Trust CPA and MAP East Team Operational Policies which were in place at the time of Donna’s care do not make reference to any criteria for management of this process.

15.12 The Trust has reconfigured services since the time of Donna’s care and there are now two distinct teams. The current structure allows for a ‘non-CPA’ assessment phase to take place within the assessment team. Individuals who require CPA are cared for within the treatment team. This is more fully explored in section 22.

- 15.13 The Independent Investigation Team recognises that the Trust has reviewed its current services provision in this area and has indicated that it is about to reconfigure services once more. This is discussed in more detail in section 22.
- 15.14 Consideration of CPA in Donna's case:
- 15.15 If used as it was intended, i.e. to work with service users and carers to make an assessment, establishing care and support needs, CPA can be a significant asset to the delivery of care. In Donna's case the ethos of the CPA was effectively ignored and as a result, its essential elements were lost.
- 15.16 As has been mentioned in paragraph 12.7 the Trust were concerned that the challenges faced by the MAP East Team had led to an *"Increasing focus on crisis management rather than proactive management of risk"*.
- 15.17 Donna's care appears to have been delivered solely in response to crisis. Despite her holding parenting responsibilities for Zaki and her involvement with a number of services, Donna was not considered for CPA until 17 December 2012, when a discussion was initiated about the appointment of a care co-ordinator.
- 15.18 The Independent Investigation Team is concerned that aspects of the CPA were not undertaken which could have better informed decisions relating to the delivery of patient centred care for Donna. This could have included contacting services in Rotherham to discuss their findings regarding Donna.
- 15.19 Whilst Donna was initially added onto the Trust's computerised ePJS system, the Independent Investigation Team was concerned to note that following an attendance at A&E on 7 December 2012, Donna was then removed from this electronic patient management/record system. Despite being seen by a number of clinicians across the Trust following this time, Donna was not re-instated to ePJS and accordingly, her care was therefore not supported by the Trust's case management system which had the capability of supporting alerts in relation the CPA process including allocation of a care coordinator, flagging DNAs and generating appointment letters.
- 15.20 CPA Reviews:
- 15.21 A CPA review meeting can help clinicians support the delivery of the following aspects of the CPA in order to achieve a longitudinal view of Donna's care:
- An assessment of health and social care needs;
  - A written Care Plan;
  - Regular review meetings to discuss how care plans are working;
  - A named Care Coordinator Crisis plans Assessment of carers' needs;
  - Assessment of risk to self and others.
- 15.22 There were a number of opportunities for a Care Programme Approach Reviews to take place, which could have brought professionals from other services together to talk about Donna, and construct strategies, which could work within each service and the challenges which it faced, but which would deliver a more

effective approach towards her care. Such a meeting ensures that all those involved in the care plan are aware of their individual roles and responsibilities.

- 15.23 CPA is not intended as a bureaucratic exercise. There were potential points in Donna's care where the team meeting system operated by the MAP East Team could have acted as a multi-disciplinary review, thereby delivering an element of the CPA approach. Such meetings could have been arranged, such as following Donna's attendance at MAP on 17 December 2012 after her uncompleted suicide in Rotherham, and indeed when her care was transferred to MAP Consultant Psychiatrist 1 on 17 January 2013. Indeed, such meetings could have enhanced any 'assessment' process. These opportunities were not exploited.
- 15.24 Risk Assessment:
- 15.25 As has been stated, the risk factors for suicide and filicide are different.
- 15.26 Throughout Donna's interaction with services, her family and Zaki were seen as 'protective' factors. However, this 'conclusion' was reached without any systematic or structured evaluation of either relationship. Indeed, as has been mentioned, Trainee Psychiatrist 1 had requested an evaluation from Croydon Social Services about Donna's mother's "*ability to meet the child's needs*", which was not followed up.
- 15.27 Similarly, whilst Donna was noted to act impulsively, there is no evidence in Donna's records which suggests that this was explored as a means to gaining a better understanding of Donna and her presentation and accordingly the risk which she posed to herself and others. For example, there is no record which established how long impulsive behaviour been a problem nor indeed any structured consideration of what the cause was.
- 15.28 Further, possibly due to the lack of continuity in Donna's care, assurances given by Donna (in apparent contradiction to the concerns which her family were expressing), were consistently taken at face value without reflective consideration. This is most strikingly illustrated in relation to the response to Donna's uncompleted suicide in Rotherham on 14 December 2012. A structured approach to CPA would have encouraged reflective and structured care. It is for instance, striking to note that members of SLAM, during the internal investigation, made reference to their lack of confidence regarding their ability to recognise 'anxiety'.
- 15.29 Involvement of Multiple Services:
- 15.30 The ethos of the CPA is the recognition of the fact that some individuals will require the involvement of multiple services which will need to work to the same plan and with the same objective.
- 15.31 The CPA is intended to ensure that those services have an overview of the patient and their care as a whole, and to ensure that all other components of care are present with the long-term goal of delivering patient centred care.
- 15.32 Donna's difficulties in accessing services which could have provided her with



care are more fully set out below. However, also relevant in this respect is the referral made by Trainee Psychiatrist 1 to social services initially made to Croydon Social Services on 16 November 2012.

15.33 Involvement of Donna's family in the Planning of her care:

15.34 Donna's mother acted in a support role for Donna in many regards; Donna lived with her and Donna's mother consistently and repeatedly contacted services in relation to Donna's wellbeing regarding her mental health. She also attended the vast majority of the consultations which Donna had with services. However, it is also clear from Donna's records that Donna's mother was frustrated and distressed by the lack of support which she believed her daughter received and in turn the level of support which she was given in her capacity as Donna's carer. Donna's mother and her needs for assistance in this capacity were never formally assessed, and therefore, were neither addressed nor met.

15.35 It would have been encouraging to see the implementation of a structured plan to explore the relationship between Donna, her mother and Zaki. This would have allowed an assessment of Donna's support mechanisms in a protected and non-judgemental environment as a means to better understanding Donna's illness.

15.36 Information Sharing:

15.37 Donna's care was not planned or delivered with the close collaboration of other professionals who had knowledge of Donna, such as those who were providing her with CBT in the private sector. Indeed, other Trust services such as IAPTs held relevant information about Donna as a result of the self-administered patient questionnaires which Donna had completed. Risk reviews and needs assessments were not devised with knowledge gained from those who knew Donna outside NHS services. If these individuals found it difficult to attend such meetings, a telephone conference could have been considered.

15.38 As a result of Donna not having any form of CPA, information sharing between the various services involved in the care of Donna, including Rotherham, was not as efficient as it could have been, resulting in confusion, anxiety and delays. Also lost was the chance to fully collaborate with those who knew Donna, namely Donna's mother, in the building of an essential longitudinal understanding of her personality and illness, as well as identify any potential safeguarding issues.

15.39 The Trust has provided the Independent Investigation Team with the following observations in this regard:

*"report states that there was no collaboration with other professionals for example the CBT Therapist and/or IAPT on care planning and delivery. Such communication could potentially have been facilitated via a CPA meeting.*

*The Trust would like to draw to the attention ..to..Ms DO's comments during her meeting with the CT1 doctor on 31 December 2012 as described in the patient record. She stated that she had stopped seeing CBT therapists because she felt she wasn't getting anywhere. In this context it is difficult to see how such*

*communication could have been progressed. In addition the MAP team had access to the IAPTus data base used by the IAPT team where information concerning Ms DO's assessment was recorded.*

*It is also noteworthy that information was shared with Ms DO's mother and she contributed to all the clinical discussions and plans as they were made because she was present in every appointment, with the exception of Ms DO's assessment at CUH on 17 January 2013<sup>48</sup>”.*

- 15.40 The Independent Investigation Team accepts that Donna has stated that she had stopped seeing CBT therapists because she felt that she was not receiving any benefit. This statement could potentially have had clinical significance. As a result, a conversation with Donna's CBT practitioners could have been valuable in exploring this issue further, as could a conversation with the Rotherham Team who cared for Donna following her uncompleted suicide.
- 15.41 Equally, whilst recognising that Donna's mother was present at each consultation with her daughter, it does not appear that her input was considered reflectively as part of a structured diagnostic process towards gaining a better understanding of Donna's clinical presentation.

#### **Comment Four: Failure to adhere to the CPA**

It is the view of the Independent Investigation Team that by failing to adhere to Trust Policy and indeed the ethos of CPA, services denied Donna crucial components of the care which she could expect, and in turn, created a number of junctures where care could have been delivered differently. Such an approach could have facilitated a reflective review of Donna's diagnosis.

This problem was exacerbated by Donna's failure to be included on ePJS which potentially could have highlighted the aspects of the CPA which had not been delivered to Donna, such as the appointment of a care coordinator, her failure to attend appointments and the lack of risk assessments for Donna and her son.

It is a particular concern for the Independent Investigation Team that Donna fell into a 'key group' of service users who must be assessed for CPA as she held parenting responsibilities. Trust Policy is clear on this point:

*“The default position for individuals from these groups would normally be under [new] CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in the care records”.*

No decision as to why Donna was considered ineligible for inclusion in the CPA is recorded in Donna's records. The Independent Investigation Team is concerned that the repeated failure by clinicians across the Trust to enter Donna

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<sup>48</sup> Mrs Oettinger disagrees with this recording of events and maintains that she attended this assessment. The ePJS entry for this assessment confirms Mrs Oettinger's attendance.

into the ePJS led to a failure to recognise the lack of adherence of her care to CPA by the Trust control systems.

In addition, it is a significant concern for the Independent Investigation Team that the MAP Team had in fact sought information about how Zaki's needs were being addressed from Social Services. As a result, in the opinion of the Independent Investigation Team it could not be argued that a thorough assessment of need and risk had not been completed thereby satisfying this requirement.

### **Recommendation Three – Responding to service users' needs:**

CPA care management underpins the delivery of "*Service-user centred clinical care*" The essentials of this are contained within the Trust's CPA policy. This includes the systemic review and sharing of clinical information to inform clinical decision-making, and involvement of families (or carers where appropriate) in the management of risk.

The Trust's Quality Assurance Programme should ensure that all care plans reflect a comprehensive understanding of the ethos of CPA in order that individual service users' current psychiatric, social, family circumstances and risk characteristics are addressed, and that service user centred care is delivered and that changes to processes and procedures mirror the ethos of service user centred care.

The Independent Investigation Team is concerned that previous Trust policies, such as the HTT Policy, and the Operational Policy: "*PMIC Assessment & Liaison Service November 2016: Version 5*" concentrated on a service-driven response to care, rather than a 'person-centred' response. It is the opinion of the Independent Investigation Team that the significant financial pressures on Trust services, at least in part, are evident in the manifestation of a service-focussed response.

Accordingly, it is recommended that:

1. The ethos of the CPA should be reflected and strengthened in the training programmes which Trust staff are required to attend.
2. Every 6 months, a random audit of 10% of current individual service user's records are audited by the Managers in each service involved in the individual's care with a view to establishing:
  - a) Whether CPA is being correctly applied and adhered to;
  - b) Whether all service users' risk assessments are up to date;
  - c) Whether staff are having regular supervision which includes reference to providing care which recognises the ethos of CPA.
3. Adherence to this recommendation is audited by the Trust on a 6-monthly basis.

## **16 JUNCTURE THREE: ACCESS TO SLAM SERVICES**

- 16.1 Despite the fact that there was a number of services which could have been involved in Donna's care in the months leading up to her death, Donna experienced multiple and persistent barriers to her accessing any form of substantive care, ultimately leaving her unable to receive an effective and progressive mental healthcare service suitable for her needs.
- 16.2 Essentially, Donna's care represented a series of 'one off' attendances as she tried to obtain care. This led to her care being delivered without any continuity during which Donna was required to repeat potentially distressing descriptions of her concerns about her health to clinicians who had no longitudinal understanding of her presentation and how it might have been changing. These barriers became more significant due to the lack of understanding of Donna's presentation but also because Donna did not have a care coordinator. These difficulties will be dealt with more fully in Juncture 4 of this report.
- 16.3 However, the Independent Investigation Team is also of the view that barriers arose because a lack of 'understanding' of the complex volume of services which are offered by SLAM at a local, and indeed, national level.
- 16.4 CQC findings – Complexity of SLAM services:
- 16.5 Access to services in the Croydon area has been demanding: The CQC found that the patients of the Croydon assessment team faced long waiting times to be seen and offered treatment in the Croydon Integrated Psychotherapy Service. Staff told the Independent Investigation Team that the waiting times were up to six months for assessment and a further eighteen months for treatment. Staff also said they felt this was unacceptable.
- 16.6 The CQC in its 2015 report also found that there were long waits for psychological therapies. Across the Trust, the CQC noted long waiting lists for care coordinators. There were also service users not told when an appointment is cancelled.
- 16.7 Good practice – Access to MAP:
- 16.8 Whilst this report has identified shortcomings in relation to the care which Donna received from MAP, the Independent Investigation Team is also conscious of the presence of good practice in certain instances particularly in relation to obtaining access to this service.
- 16.9 Donna was initially referred to this service by her GP on 15 November 2012. Donna's GP was able to obtain advice and Donna was offered an outpatient appointment with MAP Trainee Psychiatrist 1 the following day.
- 16.10 Following Donna's initial assessment by MAP on 16 November 2012, Donna's case was discussed at a multi-disciplinary meeting and she was discharged from the service, back into the care of her GP.

- 16.11 Donna was subsequently able to access the service once more on 4 December 2012 when she made a telephone call to Trainee Psychiatrist 1 in a state of crisis. It is the view of the Independent Investigation Team that the 12-point plan laid down during the assessment on 16 November 2012 was essentially followed during this phone call.
- 16.12 Trainee Psychiatrist 1 accepted Donna's call on 4 December 2012 despite the fact Donna had been discharged from MAP and back to the care of her GP by this point. Following this conversation where Trainee Psychiatrist 1 informed Donna that he felt she needed a higher dose of Pregabalin, he then went on to follow up the conversation with a further call to Donna's GP.
- 16.13 Notwithstanding the issues which are highlighted above about the MAP East Team's failure to include Donna in the ePJS system, this is evidence of good practice by MAP in terms of the accessibility of the service. In addition, Trainee Psychiatrist 1's actions in this respect were positive because he made the efforts to promptly respond to Donna's calls and indeed most of those of her GP. The Independent Investigation Team is of the view that in this respect, Trainee Psychiatrist 1 demonstrated a willingness and interest in the patient. In formulating a detailed management plan, he took proactive steps to support Donna. He did not simply tell her to *"take her tablets and leave"*.
- 16.14 On 15 December 2012, Donna's GP again called MAP to ask for help with Donna's management following her serious suicide attempt in Rotherham. Further to this telephone call, Donna was again seen by MAP for a duty assessment for suitability for home treatment on 17 December 2012. This was a prompt assessment by a service that had already discharged Donna which again demonstrates an ability to work flexibly. However, the Independent Investigation Team does have a number of concerns about this consultation.
- 16.15 Unfortunately, the ease with which Donna was able to access MAP was not replicated across SLAM services. Indeed, two services which are 'local' in nature were consistently inaccessible to Donna.
- 16.16 Potential referral following Attendance Croydon University Hospital Psychiatric Liaison – 7 December 2012:
- 16.17 Donna attended Croydon University Hospital with a letter of referral from her GP for a urinary problem. Her anxiety was worsening, and concerns were expressed that this could have been due to changes in her medication.
- 16.18 Donna's records state:

*"Recent medication changes discussed with Liaison Psychiatrist...It was considered that the current negative symptoms were more likely to be due to the withdrawal from clonazepam than increasing dosage of pregabalin. DO declined to consider inpatient treatment.*

*Prescribed 2mg diazepam prn up to three times a day for the next three days. Advised that this was a short term crisis measure to assist with symptoms of*

*anxiety over the weekend period”.*

- 16.19 It is unclear to the Independent Investigation Team whether HTT was raised with Donna as an alternative to inpatient treatment or as a possibility for ongoing support. There is no record in Donna’s medical records of any discussion which took place concerning HTT on this occasion. Donna was referred back to her GP. A further review of her medication was instead suggested.
- 16.20 Potential referral from MAP East Team Attendance – 17 December 2012:
- 16.21 Following a significant suicide attempt on 14 December 2012, Rotherham AMHP contacted MAP to provide them with details of Donna’s admission to Rotherham. He also stated that his recommendation was that Donna be offered care through HTT. In addition, Donna’s GP contacted MAP seeking an assessment of Donna in order to *“assess if suitable for HTT”*.
- 16.22 A note of the discussion which took place involving Donna, her mother and Registered Mental Health Nurse 1 states:
- “I discussed the role of HTT with her and if she would like to be referred. She said she is capable to take medication without HTT support”.*
- 16.23 The Independent Investigation Team is concerned that there remains a question as to whether the role of the HTT was fully explained to Donna which may have caused her to fail to understand the benefits of the service, potentially because Trust staff may have been unclear of the purpose of the service. Donna’s mother disputes that an offer of involvement with HTT on any level was made at this consultation. Registered Mental Health Nurse 1 herself in interview with the Trust’s internal investigation team stated she would describe HTT as a service that would *“give medication”* to *“bed blockers”* *“and talk to them”* which does not provide an accurate description of the service.
- 16.24 This concern echoes the findings of the Trust’s internal investigation in relation to this conversation.
- 16.25 The CQC inspection report published in October 2017 contained the following comment;
- “There were barriers to effective patient movement along the care pathway. Patient transfers between teams were sometimes delayed because specialist teams lacked appropriate or sufficient staff, or staff were unclear about the referral criteria and thresholds of different Teams<sup>49</sup>”...*
- “There was a lack of shared understanding of the roles and responsibilities of ward staff and community staff<sup>50</sup>.”*
- 16.26 In a section of that report titled “areas for improvement”, the CQC stated the Trust;

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<sup>49</sup> Page 5

<sup>50</sup> Page 35

*“Should continue to address barriers to effective patient movement along the care pathway...The Trust should ensure that staff clearly understand their roles and responsibilities, clarify referral criteria and thresholds<sup>51</sup>”...*

16.27 MAP East Team Attendance – 31 December 2012:

16.28 It appears that Trainee Psychiatrist 1 discussed and rejected the possibility of HTT with MAP Consultant Psychiatrist 1 during the course of this consultation. No discussion took place with the HTT itself. The basis for this rejection from HTT is unclear, although, in his evidence given at Inquest, Trainee Psychiatrist 1 stated *“discussed home treatment team with the consultant...doesn’t meet the threshold for home treatment yet”*. However, Trainee Psychiatrist 1 had recorded his impression of Donna as being *“Currently low risk of completed suicide”*.

16.29 A&E Attendance – Psychiatric Liaison 17 January 2013:

16.30 Donna attended A&E and was reviewed using a ‘Psychiatric Liaison and Home Treatment Pro Forma’. The outcome of the attendance was that *“Home treatment team or hospital admission not indicated at this stage”*.

16.31 HTT Operational Policy Revised October 2013 which was in place at the time of Donna’s care states:

*‘2.1 Home Treatment Team: Who Will the Service Be Appropriate For?’*

*Any person residing within the London Borough of Croydon aged 18 to 65 years old with severe and enduring mental illness (e.g. schizophrenia, bi-polar affective disorder, severe depressive disorder) with an acute psychiatric crisis of such severity, that without the involvement of the Home Treatment Team, hospitalisation would be necessary.*

*...Beyond initial assessment and in order to focus services on those with the highest level of need, Home Treatment Teams are less likely to be able to offer intensive support for the following conditions because of the priority given to serious mental illness, which would otherwise lead to admission to hospital.*

- *Mild/Chronic Anxiety disorders*
- *Primary diagnosis of Alcohol and/or Substance Misuse*
- *Recent self harm, but not suffering from Psychotic or severe Depressive illness*
- *Crisis related to social issues*

*These are not to be read as exclusion criteria but are offered to assist targeting Home Treatment Team services to service users in greatest need and for conditions that it has proved to be useful in the medium to long term<sup>52</sup>”.*

16.32 The current explanation of the HTT service included on the Trust’s website states:

*“Home Treatment (Croydon) care for people, aged 18-65, who have severe*

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<sup>51</sup> Page 15.

<sup>52</sup> Trust HTT Operational Policy Revised October 2013.

*mental illness, who would benefit from assessment and treatment at home as an alternative to hospital. We provide care for people who live in the London Borough of Croydon.*

*Our aim is to provide short-term treatment for people who are having a mental health crisis. Wherever possible, we avoid the need for hospital admission”.*

- 16.33 Donna’s medical records did not contain a scanned copy of the Rotherham report. This is a matter of significant concern for the Independent Investigation Team. The entry in Donna’s records in respect of this consultation states:

*“DO attended A&E this morning with her mother. It was reported that her sister called an ambulance for her this morning when she made a comment about not wanting to be around anymore; due to her recent suicide attempt they became fearful for her safety.*

*I will not detail her history or history of current difficulties as this has been previously well documented”*

- 16.34 It is clear that Donna met the criteria for care by HTT set out in paragraph 16.32 above. However, the generic ‘exclusion’ criteria put in place by the Trust in order to manage responses may have resulted in her exclusion if the new clinical information from Rotherham was not available to clinicians and subjected to clinical review.

- 16.35 In addition, the Independent Investigation Team is concerned that the reference in the service entry criteria that services should be targeted towards “*service users in greatest need and for conditions that it has proved to be useful in the medium to long term*” introduces an element of subjectivity and judgement which may in turn impact adversely upon the delivery patient centred care.

- 16.36 Difficulties in accessing HTT:

- 16.37 The Independent Investigation Team is concerned about the difficulties which Donna had in accessing HTT. This seemed to be a result of the following issues:

- 16.38 Firstly, some Trust clinicians appeared to be unsure what the service could provide. As mentioned, MAP Nurse 2 stated in interview with the Trust’s Internal Investigation team that she would describe HTT as a service that “*gives medication*” to “*bed blockers*” “*and talks to them*”. If this was the description of HTT afforded to Donna and her mother, it is conceivable that when provided with this information, it could have impacted upon their potential acceptance of the service. Donna’s GP was also unaware of the service and the care which it could deliver, possibly because the service did not accept direct referrals from GP’s. However, this meant that Donna’s GP could not provide her with advice about the service.

- 16.39 Secondly, as referred to in paragraph 16.35 above, the HTT service criteria includes an element of subjectivity in relation to those in ‘greatest need’ which is not focussed upon the individual patient and does not provide a structure to allow clinicians to make judgements in this respect.



16.40 Thirdly, Rotherham AMHP, an approved mental health practitioner, albeit from a different Trust had referred Donna to the service. Rotherham AMHP fell within a category of individuals who could refer to the HTT service. It is not clear therefore why it was necessary for the MAP East Team to review this recommendation, given that HTT would be required to perform its own assessment of Donna in order to determine her eligibility for the service. In this event, HTT could have explained the benefits of their service to Donna.

16.41 The Trust has responded to this criticism in the following terms:

*“The letter to the CT1, dated 16.12.2012, from the Crisis practitioner in Rotherham following Ms DO’s attendance at A&E requests for an appropriate level of follow up that should be arranged urgently, this does not stipulate that the patient required HTT intervention. The MAP team reviewed the patient on the following day, 17.12.2012 and offered HTT assessment; this was declined by Ms DO.*

*Of note the letter to the Ms DOs GP contained different information to the letter sent to the MAP team. This letter, dated 17.12.2012, made a recommendation for HTT assessment in Ms DOs local area.*

*The MAP team acted in accordance with the referral letter that they received from the Rotherham Crisis Practitioner and considered referral to the HTT at the point of assessment”.*

16.42 The Independent Investigation Team has reviewed this statement of opinion put forward by the Trust reflectively and in accordance with the documentary evidence and evidence produced at the Inquest into Donna and Zaki’s death. As a result, the Independent Investigation Team does not accept this statement of opinion in evidential terms.

16.43 In particular, the Independent Investigation Team has been provided with a copy of the letter which was forwarded to Trainee Psychiatrist 1 by Rotherham AMHP. This letter had attached to it a Report prepared by Rotherham AMHP.

16.44 Similarly, an entry in Donna’s GP records dated 17 December 2012 states:

*“Discussed hx with mother this am, as above PT now at home. Was given a few tabletst (sic) of temazepam to sleep. Pt requestin (sic) medication to help her calm down. Declined at present I will call Map EAST team and discussed on going mx options. Mother has expressed a desire for pt to be treated with the crisis at home team where psychiatrist come to you home and review you daily. I have explained i(sic) am not awar(sic) of this service but will discuss with Psych team. Called and left message for MAP EATS (SIC) team requesting and urgent call back”.*

16.45 Lastly, evidence given by Rotherham AMHP at Donna’s inquest included the following explanation of the information which was provided to the Trust:

*“Recommendation – Liaison with intensive Home Treatment Team in her own*

*locality. Referral for urgent assessment, and recommending input to stabilise anxiety. DO discharged from Rotherham Hospital to care of her mother. Mother nearest relative. Advised that mental health legislation and how to access formal assessment process with a view to admission if felt DO's healthcare and safety could not be managed at home.*

*The findings from my assessment were that this had been an impulsive yet serious suicide attempt, caused by the nature and extent of DO's mental illness - severe anxiety. Whilst approaches to treat this through psychological intervention have been tried in the past, and medication had relatively recently been introduced, given the lack of change in her presentation or circumstances, and the ongoing risk of impulsivity, then more assertive efforts to treat were required. If DO were a Rotherham resident, then the plan of care would have involved a referral to the Intensive Home Treatment Team for urgent response.*

- 16.46 This suggests that Rotherham AMHP was of the view that Donna required a model of care which the MAP East Team could not provide i.e. HTT care or the equivalent. Evidence given by Registered Mental Health Nurse 1 from the MAP Team East at Donna's inquest was that a care coordinator could be available to talk to Donna once a week. This does not, in the opinion of the Independent Investigation Team, constitute an 'assertive' approach towards the delivery of care such as that which can be delivered as part of the Home Treatment model of care.

16.47 Attempts made by Rotherham AMHP to contact MAP East

- 16.48 Rotherham AMHP stated in a statement produced at the inquest of Donna:

*Following the assessment with DO, and whilst still on the ICU, I did an internet search for speciality out of hours mental health team in Croydon. I do not have a record of the specific number I have contacted, but I spoke to a duty worker, who confirmed there was a home treatment team covering DO's locality, and I was given contact details of how to make an urgent referral to their service. A full assessment report was completed, and faxed to the service the following day, the 16th December with a covering letter, copy included. Paper copy posted to GP 17th December. Details of team sent to Trainee Psychiatrist 1, East MAP.*

*DO, CO, and Family Friend 1 were all consulted in the assessment and involved in the decision making process. DO had only been seen privately by a psychiatrist and therapists in Croydon, and both she and her family said they were reassured that she was being referred for urgent intervention by the Home Treatment Team in her area. DO gave assurance that she would willingly engage in any offer of services if it would help her.*

*At this presentation DO was not, based on the Mental Health Act 1983 guidance and in my professional opinion, detainable; that is she had mental capacity such that she could understand the consequences of her behaviour, she could retain and recall information through communication, and weigh up facts to make her decision. She also was consenting to early intervention, and so compulsion was not necessary. In spite of this, I explained the role of the Mental Health Act to CO,*

*and how her position as the nearest relative could insist on further assessment should any of the above plan not work”.*

- 16.49 Accordingly, it is the Independent Investigation Team’s view that sufficient steps were taken to ensure that the opinion of the Rotherham Team that Donna’s condition was brought to the attention of the MAP East Team.
- 16.50 The Independent Investigation Team discusses the circumstances surrounding Donna’s potential acceptance of any assessment by Croydon HTT more fully above.
- 16.51 Donna’s difficulty in accessing IAPTS:
- 16.52 The Independent Investigation Team is concerned about several aspects of Donna’s interaction with IAPTS during the relevant period, including;
- The length of the waiting list for CBT.
  - The reverse ‘opt-out’ mechanism for remaining on the waiting list for CBT.
  - Donna’s apparent restoration to the waiting list for CBT at a lower position than that at which she was upon her removal.
- 16.53 What can IAPTS provide:
- 16.54 Improving access to psychological therapies (‘IAPT’) is a national program which aims to increase the availability of ‘talking therapies’ on the NHS. IAPTS is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post-traumatic stress disorder.
- 16.55 These conditions are treated using a variety of therapeutic techniques, including cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and ‘couples’ therapy.
- 16.56 IAPTS seeks to use the least intrusive method of care possible to treat people. This is often called a ‘stepped care model’ and means that the patient is generally offered a low intensity therapy in the first instance. If low intensity treatments are unsuccessful or inappropriate the patient will be ‘stepped up’ to high intensity. This often takes the form of CBT.
- 16.57 The Independent Investigation Team was advised by the IAPTS Service Lead that at the time of Donna’s care, the Croydon IAPT service was under-resourced. IAPT services are intended to meet 15% of the population need. However, Croydon IAPT was, at the time, commissioned to meet approximately 3% of the need. Consequently, there was a greater demand for the service than it was able to meet.
- 16.58 Donna’s inclusion on IAPTS waiting list:
- 16.59 Donna was on the IAPTS waiting list for CBT from around 19 July 2012 when she was referred by her GP until January 2013. Over the course of this period, the only access to CBT that Donna was able to obtain was through privately funded

treatment (which she started 5 October 2012 was still attending as late as 9 March 2013). Donna waited for access to IAPTS for a period of 4 – 6 months before being offered CBT through the NHS. It is clear that IAPTS was at this time facing significant pressure on its resources as a result of commissioning arrangements.

- 16.60 The Independent Investigation Team considers this to be a significant period of time given the symptoms and difficulties which Donna was experiencing. Trainee Psychiatrist 1 in interview with the Independent Investigation team agreed it was a long time to wait. This length of wait to access IAPT services had the following adverse impact on the quality of Donna's overall care;
- 16.61 Firstly, CBT can help individuals change how they think and behave. These changes help to make the individual feel better. CBT focuses on 'here and now' problems and difficulties and looks for ways to improve an individual's state of mind immediately. As Donna's condition deteriorated as she awaited access to IAPTS, it would have become less likely that this treatment would have been as effective.
- 16.62 Secondly, in cases such as Donna where the individual is suffering from anxiety/depressive type disorders, which impact an individual's sense of self-worth and importance, such a delay also has the potential for an increasingly detrimental effect on their overarching condition because it potentially makes the individual feel like they are being ignored or overlooked, because they are simply not important. In addition, because of the passage of time, negative anxiety thoughts can become more entrenched because of the reaction of the services and their 'rejection' of the individual.
- 16.63 Thirdly, the mechanism by which IAPTS operated, combined with the length of this waiting list actually had a 'knock on' effect in terms of damaging and undermining the potential efficacy of other limbs of SLAM in their treatment of Donna. For example, Donna was rejected from CIPTS because she was "*more suitable for IAPTS*". Had Donna already received treatment from IAPTS, which had proven ineffective, by the time CIPTS reviewed her case, they could have reviewed this assessment. Following such an assessment, had it been considered that Donna was unsuitable, perhaps at the very least, such assessment could have provided essential signposting information as to which service next might best be able to assist Donna. Because of the length of the IAPTS waiting list for CBT, this never occurred.
- 16.64 The reverse opt-out mechanism of the IAPTS waiting list:
- 16.65 IAPTS removed Donna from the waiting list in December 2012 because she had not responded to a letter the service sent Donna in November 2012 asking if she wished to remain on the waiting list.
- 16.66 During interview, the service lead for IAPTS informed the Independent Investigation Team that the reverse opt-out mechanism of the waiting list had been borne out of experience because many people drop out whilst on the waiting list. In addition, the nature of SLAM's service structure required individuals to opt

in rather than SLAM reaching out to them as telephoning people was not feasible. The service lead stated that this was done in the interests of “*managing the appointment spaces*”.

16.67 It is the view of the Independent Investigation Team that the more logical mechanism would have been to keep an individual on the waiting list unless or until they expressly requested their removal from it. It is the Independent Investigation Team’s understanding that this issue has now been addressed in that IAPTs have made amendments to the letters which they send to patients.

16.68 Donna’s restoration to the IAPTS waiting list:

16.69 Donna’s removal from the list raises yet an issue with the mechanism in place regarding waiting lists which is that upon Donna’s mother’s notification to SLAM of her intention to remain on the list, and request to be restored to the list, Donna was then returned to the list at number 46.

16.70 However, Donna’s mother informed the Independent Investigation Team that her understanding was that Donna was originally near the top of the list at the point at which she was removed.

16.71 It was this action by SLAM that triggered the series of complaints by Donna’s mother, as will be discussed later in this report at Juncture 6 and reference is also made to Donna’s position on the IAPTs waiting list in her contemporaneous medical records.

16.72 During the course of the Internal Investigation conducted by the Trust, a possible explanation for this apparent confusion was put forward. The Head of Croydon IAPT service at the time of Donna’s care responded to the following question “*Do you let people know that they will have to opt in?*” The response was:

*‘An opt in letter was sent on 11 November asking if she wanted to opt in. Then on 20 December a letter was sent discharging her as there had been not (sic) contact. But it turned out that at the same time CADAT said that she had come to the top of their waiting list and the picture became a bit confused. The family were understandably confused about how they could be at the top of a waiting list and discharged for non contact. They did not understand about the difference between the services and neither service knew the other was involved.’*

16.73 In the opinion of the Independent Investigation Team, this presents a further example of the difficulties which clinicians within the Trust, and also its patients, had in understanding the various limbs of its service.

16.74 The Independent Investigation Team is concerned by the apparent confusion which arose as a result of CADAT, a private provider and IAPTS being involved in Donna’s care at the same time. It was recognised in the Trust SUI that there was “*no protocol to provide guidance on a situation where a client is open to more than one psychological therapy service*”. This was not addressed in the action plan produced by the Internal Investigation Team.

16.75 Private treatment of Donna:

16.76 As mentioned earlier in this report, in addition to her interactions with primary and secondary NHS services during the relevant period, Donna was able to engage the services of three private psychiatrists in the months preceding her death.

16.77 Whilst these private services and their treatment of Donna are outside of the Terms of Reference and therefore the remit of the report, a brief mention of their involvement is useful in a narrative respect in framing the actions of the NHS secondary services which are the subject of this report in a broader context.

16.78 Its relevance to Donna:

16.79 According to the evidence given at Inquest, there is usually no contact between NHS and private Psychiatrists unless a direct referral is made.

16.80 Private Practice Psychotherapist was not aware that Donna had taken an overdose. She knew there had been a period in hospital and that Donna's mother *"looked after DO's pills"*. She therefore drew an inference of risk. Private Practice Psychotherapist also knew about Donna's presentation to A&E on the 17 January 2013 but not the Rotherham incident or Donna placing a knife to her throat.

16.81 Donna's presentation improved in some respects during the course of her private CBT sessions but not all.

16.82 The Independent Investigation Team recognises the potential difficulties in communication between the NHS and private services when patients dip in and out of private and NHS care. However, the Independent Investigation Team is of the view that services must be in a position to take this into account in order to allow for patient centred care to be delivered.

16.83 Conclusions:

16.84 The Independent Investigation Team was concerned to note the 'barrier' which Donna faced, as she was passed back and forth between various services without being able to access care, principally between Rotherham and the Trust, but also between NHS services and private health care services within Croydon.

16.85 What is particularly striking is the disproportionate impact upon the continuity of Donna's care, caused by her passage between services, in relation to the ease with which this problem could have been addressed. The Independent Investigation Team would also refer to Juncture 4 concerning the failure to appoint a care coordinator in this regard.

16.86 A key concern mentioned in the report of the Ritchie Inquiry was the problems which were created as a result of an individual moving between services. Communication methods have significantly improved since the care of Christopher Clunis. Indeed, given the ease with which communication can now take place, it is disappointing to note how reluctant the professionals involved in Donna's care were to talk to each other.

- 16.87 The Independent Investigation Team is also concerned about the impact which Donna's inclusion on the IAPTs service waiting list had upon other services within the Trust. It appeared to act as a barrier to Donna's presentation being considered reflectively as it appeared that there was a view that the 'outcome' of IAPTs involvement was necessary before other action was taken notwithstanding the fact that the length of the IAPTS waiting list was preventing this from happening. The Independent Investigation Team understands from information given to the Trust's Internal Investigation Team that there is now a vehicle in place to allow an individual to be 'moved up' the waiting list as a result of clinical need which is a positive development following Donna's care.
- 16.88 The Independent Investigation Team is concerned that, in its opinion, there remains the question as to the possibility that the lack of knowledge of staff working within the Trust may have contributed to the creation of barriers in that staff appeared unaware of what services within the Trust could provide and ; as has been demonstrated earlier in this section, clinicians and patients alike remained unclear as to the exact nature of services afforded by various limbs of the service. In addition, the staff did not appear to fully understand the relationship between services and whether care could be provided concurrently. This echoes a concern recently voiced in the CQC report published October 2017<sup>53</sup>.

#### **Comment Five: Accessing services**

A number of the difficulties which Donna experienced in accessing care arose because a key service which she required was experiencing resourcing issues at the time. As a result, patients faced a significant wait for care as a result of lengthy waiting lists. However, once a patient has been placed on a waiting list a commitment has been given to provide treatment within a reasonable period of time.

It appears that the approach which was adopted to the ongoing management of the IAPTS waiting list was flawed as it focussed on the service and was not viewed from the perspective of those who wished to access care some of whom were facing significant challenges due to the nature of their presentation which led to referral to the service.

When there is a 'shortage' in NHS provision, it is likely that some patients will seek care from the private sector. When Donna sought to investigate this route, further confusion and delay occurred to her gaining access to NHS services. In addition, it appears to the Independent Investigation Team that information did not flow between NHS providers and private sector organisations.

#### **Recommendation Four:**

The introduction of IAPTS services led to the recruitment of skilled professionals from other parts of NHS services in order that this new service could be staffed

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<sup>53</sup> CQC report published 31 October 2017.

which inadvertently reduced provision for individuals with some conditions or complexities whose care is best provided elsewhere.

In addition, the introduction of electronic record keeping led to increased clinical time being spent on note keeping, therein placing significant time pressures on clinicians.

1. Commissioners should consider conducting an impact assessment prior to the commissioning of 'new' services in order to establish the potential impact upon existing services in terms of staffing and recruitment in existing services.

#### **Recommendation Five:**

Donna's care demonstrates the difficulties which are presented to patients when a waiting list is lengthy. Included in the management of service waiting lists should be the consideration of the likely impact upon individual patients and their carers in particular:

1. It is recommended that the Trust considers whether an IT solution could be adopted which manages patients' need for information about their inclusion on waiting lists.
2. The Trust should review the manner in which it communicates with the patients of its psychological therapy services who are awaiting access to the service in order to ensure that the use of reverse opt-in processes is avoided.
3. Staff are appropriately trained to provide accurate information in response to queries about Trust services, likely waiting times and other sources of assistance.
4. The Trust to undertake an audit of correspondence produced in relation to waiting list management in order to determine whether all written communications reflect aims and ethos of the service and seeks to promote a positive engagement with potential service users which encourages a sense of hope.
5. The Trust should develop a protocol to provide guidance about information sharing in relation to the situation where a patient is receiving care from the private sector.



## 17 JUNCTURE FOUR: APPOINTMENT OF A CARE COORDINATOR

- 17.1 This report has made reference to the failure to apply a reflective approach to Donna's presentation and also the difficulty which she encountered when she attempted to access Trust services. Reference has also been made in this regard to a failure to apply the CPA. One significant feature of the CPA is the appointment of a care coordinator.
- 17.2 Donna did not obtain access to a care coordinator during her care by the Trust. This omission meant that Donna was left without support following a very serious uncompleted suicide attempt indicating a 'crisis' in her mental health, despite her eligibility for CPA as defined in the Trust's own CPA Policy.
- 17.3 Role of a care coordinator in MAP team according to Trust Policy:
- 17.4 The MAP Operational Policy in place at the time of Donna's care stated:
- "Role of the care coordinator*
- Care coordinators are responsible for ensuring that all data, such as risk assessment, child risk screens, and HoNos ratings for the service users on their caseloads is up to date. They should also ensure all cases are clustered and that the diagnosis is entered on EPJ.*
- Care coordinators are responsible for drawing up a care plan in partnership with the service user and ensuring that this is followed and updated as needed.*
- The majority of service users within the MAP service are not on CPA, but the care coordinator, together with the team manager and the MDT should identify those service users who should be on CPA. This applies particularly to complex cases where a number of agencies are involved and those cases where there are safeguarding concerns".*
- 17.5 Allocation of care coordinators by MAP East:
- 17.6 During the course of the Independent Investigation, it became clear that during the period of Donna's care the MAP East Team were facing significant resourcing issues as a result of significant caseloads.
- 17.7 During the course of the interviews held by the Independent Investigation Team, MAP Trainee Psychiatrist 1 provided some insight into some of the pressures which were being experienced by MAP at the time. He stated:
- "I mean, there was a pressure because the care coordinators were overwhelmed with patients. And it was difficult for them to see their regular clients because of the volume of new assessments they had to do".*
- 17.8 Further, at the Inquest into the death of Donna and Zaki, MAP Consultant Psychiatrist 1 stated that there were 8.5 care coordinator staff for MAP at the time, and that 30 – 35% of SLAM outpatients were allocated a care coordinator.

He stated that in his opinion, as a result of resource issues, the care coordinators struggled with managing their own caseloads in addition to performing all associated administrative tasks, such as manning phones all day.

- 17.9 In response to the challenge which the MAP East Team was facing at the time, it is clear that the team developed a number of maladaptive procedures and processes which were designed to 'relieve' the pressures which they were facing. The procedures were not fully documented and therefore sat outside the Trust's clinical governance framework. One such informal process related to the allocation of an 'interim' care coordinator which determined the 'level' of input from that individual that the patient could expect.
- 17.10 The expectation of an 'interim' care coordinator was that they would provide a reduced level of intervention to individuals who were to receive a 'seven day follow up' and new assessments. The appointment of a care coordinator has resource implications for services. The creation of the role of an 'interim' care coordinator appears to have been an attempt to address the issue of capacity faced by the care coordinators.
- 17.11 Appointment of a care coordinator in Donna's case:
- 17.12 On 17 December 2012, following Donna's uncompleted suicide attempt in Rotherham, CPA was mentioned in Donna's records for the first time. There are significant conflicts in the evidence available to the Independent Investigation Team as to the issues which were discussed at that consultation.
- 17.13 The evidence supporting the discussions relating to the appointment of a care coordinator is not clear. What is certain was that the need for a care coordinator was discussed between clinicians involved in Donna's care on 17 December 2012 but also, significantly was never actioned, as, whilst the evidence regarding even 'informal allocation' is conflicted at best, in the view of the Independent Investigation Team, at no point was Donna formally allocated a care coordinator.
- 17.14 Donna's mother's evidence is clear and has been consistent throughout the course of the legal proceedings which followed her daughter and grandson's death. She maintains that Donna was not offered care co-ordination at any point in her care.
- 17.15 The Trust's Internal Investigation Report states that at the end of the duty assessment on 17 December 2012 conducted by Registered Mental Health Nurse 1, Donna agreed to a short period of non-medical care coordination from Registered Mental Health Nurse 1 while she waited for IAPTS sessions to begin. Donna's mother, who was present at the meeting is clear that no 'short term' care coordinator was offered. This appears to be at odds with the interview which was conducted with Registered Mental Health Nurse 1, which suggests that the conversation which took place about care coordination took place between Trainee Psychiatrist 1 and Registered Mental Health Nurse 1 after Donna and her mother had left the appointment. This version of events would accord with the information recorded in Donna's records.

17.16 Registered Mental Health Nurse 1 at inquest confirmed that she believed that Donna would benefit from care coordination and went to speak to Trainee Psychiatrist 1 about this on 17 December 2012. Evidence given by Registered Mental Health Nurse 1 at inquest was clear in that she was of the view that she could not have been the care coordinator because she was going on leave and also because she had a 'huge' case load.

17.17 The Coroner asked Registered Mental Health Nurse 1 the following question:

*"So what did Trainee Psychiatrist 1 say about who was going to be the care coordinator?"*

17.18 Registered Mental Health Nurse responded in the following terms:

*"He cannot make that decision; it's something we have to discuss. We can discuss it but it's something that needs to be taken further to the meeting that if I say that I feel that she needs a care coordinator that the team after me made that decision, the reason why the client needs a care coordinator, if she would've benefited from having a care coordinator, it's something we have to decide in the team".*

17.19 The Coroner then asked;

*"Were you involved in any meeting or decision about whether she should have a care coordinator, and if so, who that should be?"*

Registered Mental Health Nurse 1's response was as follows:

*"Apart from my conversation with Trainee Psychiatrist 1, no, because I went on leave".*

17.20 It was put to Trainee Psychiatrist 1 in evidence that as far as she was concerned Registered Mental Health Nurse 1 was never appointed as a care coordinator.

17.21 Trainee Psychiatrist 1 responded as follows:

*'I spoke to Registered Mental Health Nurse 1 in the corridor and she agreed from mid-January, if necessary when she's back from holiday she can be care coordinator.'*

17.22 The Coroner then put the following to Trainee Psychiatrist 1:

*"she told me that as far as she was concerned she was never appointed as a care coordinator for DO. Do you disagree with her?"*

17.23 Trainee Psychiatrist 1's response was *"I disagree with that, yes".*

17.24 Evidence given at Donna's inquest and indeed submitted to the Internal Investigation suggested that the appointment of care coordinators would normally take place during the team meetings with the appointment of an individual not present at the team meeting being confirmed in an email if they were not present.

In light of this, a further concern for the Independent Investigation Team is the difference in understanding of the situation represented in Trainee Psychiatrist

1's entry dated 17 December 2012 in relation to this point, which states that Registered Mental Health Nurse 1 is to be Donna's care coordinator from "mid-January".

- 17.25 Registered Mental Health Nurse 1 records do not make reference to her appointment. This is a matter of concern because one of the purposes of CPA is to make it clear who is responsible for the provision of care. Trainee Psychiatrist 1 undertook some tasks, but not others, such as scanning documents in to the electronic records. Further examples in this regard include the failure to follow up DNA's and the referral to Social Services regarding Zaki. In Donna's case, it was not at all clear who was doing what, which is a matter of concern. Had a CPA meeting been held, this would have been much clearer.
- 17.26 Notwithstanding the confusion about whether or not Registered Mental Health Nurse 1 had been appointed as a short-term care coordinator and whether she was aware of that appointment, the SUI reports that Registered Mental Health Nurse 1 went on leave shortly after the consultation with Donna on 17 December 2012 and did not follow up on the plan when she returned from leave. This confusion was further exacerbated by the fact that Registered Mental Health Nurse 1 did not respond to a later email from the IAPTS service Lead enquiring as to the identity of Donna's allocated care coordinator.
- 17.27 No request for care coordination was made to the team meeting (where allocations would be routinely made).
- 17.28 There remains the question as to the reason why Donna did not have a care coordinator or even an appointment for discussion of a care coordinator two months after the issue was raised on 17 December 2012. There was no evidence of correspondence from any care coordinator, either in the form of telephone calls, emails or letters to Donna.
- 17.29 On 17 January 2013 in an email to MAP Consultant Psychiatrist 1 and the MAP Team Manager he stated:
- "I also considered if she should have a care co-ordinator... I won't be here in to raise the issue of a care co-ordinator myself at the team meeting Monday, hence this email".*
- 17.30 Accordingly, it appears that Trainee Psychiatrist 1 knew that the appointment of a care coordinator should be discussed at the Team meeting and that a care co-ordinator had not been appointed on 17 January 2013. However, there is no evidence to suggest that this request was followed up or actioned. Trainee Psychiatrist 1 went on annual leave shortly after 17 January 2013 and there was no handover of cases between Trainee Psychiatrist 1 and his replacement. It is also known the MAP East Team Manager was absent from the Team from 18 January 2013. There is no evidence that suggests that Donna's care was discussed at any subsequent team meetings.
- 17.31 The Independent Investigation Team is of the view in light of Paragraphs 17.11 to 17.32 above that the system for allocating care coordinators was

deficient in that it lacked clarity and did not have 'fail safes' in in order to highlight the failure to appoint a care co-ordinator.

17.32 Benefits of having a care coordinator:

- 17.33 As has been mentioned at Juncture 3, SLAM services were, by virtue of their funding and organisation difficult to navigate and access. Despite the commendable efforts of Donna's GP in primary services, and with persistent and relentless effort from her mother, Donna nonetheless suffered from the absence of a single point of contact within SLAM to guide her through the Trust's complex organisational structure. Such an individual could have acted to mitigate the impact of the 'barriers' which arose such as the failure to provide Donna with accurate information about what services such as the HTT could provide her.
- 17.34 Such an individual would have also given Donna a designated point of contact within SLAM, as opposed to her closest equivalent, her GP who was naturally, outside of SLAM and, as a result, did not have a comprehensive understanding of the complex web of services within SLAM.
- 17.35 However, the most significant benefit of having a care coordinator in relation to the care of an individual such as Donna is that Donna would have had an opportunity to meet regularly with her care coordinator. A care coordinator is expected to support the patient and try to build a positive relationship to work in an open, engaging and non-judgemental manner to explore the individual's worries and how anxiety might be impacting on their life.
- 17.36 A series of 'judgements' were made by clinicians largely based upon 'self-reports' by Donna throughout her contact with services about the severity of Donna's anxiety and whether any improvement had been experienced. In addition, each contact which Donna had was dealt with as a separate assessment and not as part of the same process. The Independent Investigation Team could not find any evidence of clinicians working across boundaries, or indeed any level of curiosity about the views of other clinicians either in the NHS, such as Rotherham, nor indeed the private sector.
- 17.37 Had a care coordinator been involved in Donna's care, a more 'evidence based' approach to assessing her levels of anxiety could have been achieved. For example, the Hospital Anxiety and Depression Scale (HADS) is a reliable self-rating scale that measures anxiety and depression in patients in both hospital and community settings and is used within SLAM. HADS is a psychological screening tool which can help in the assessment of the symptom severity of anxiety disorders and depression. It can be repeated at various intervals to help decide if the treatment offered is working effectively. This screening tool could have been used to better inform clinicians in relation to Donna's self-reports of her levels of anxiety. It is not clear to the Independent Investigation Team why a tool such as HADS was not utilised in Donna's care. The tool which was used in Donna's care was the 'SAD Persons' scale. This is discussed more fully at Paragraph 14.20.
- 17.38 The care coordinator can also advise upon different ways to manage the patient's anxiety levels (self-management strategies). Most importantly, the care

coordinator could assess the impact of any changes made to better manage the anxiety and monitor and review the need for specialist psychological therapy or supporting medication. This aspect of the role would have had particular relevance to Donna as she was unable to access psychological therapy which is recognised as a first-line treatment for anxiety.

17.39 One of the main goals in the treatment of GAD is to help the individual achieve personal changes that reduce anxiety and distress. This involves developing an understanding of the specific causes and triggers for anxiety for that individual and learning how these can be effectively managed to reduce symptoms and achieve better control of the condition. Without regular access to a care coordinator, delivery of this key treatment goal would have been very difficult to achieve for Donna.

17.40 Notwithstanding the clinical benefits this could have brought to clinicians involved in Donna's care and treatment, psychologically, it may also have given Donna a sense of security and reassurance, which in turn, may have diminished, if even only slightly, her obvious sense of growing hopelessness as time went by.

17.41 In addition, such an individual may also have been of clearly enormous assistance in relation to the ability of the services involved in Donna's care to share information, particularly that relating to risk and safeguarding issues and any potential issues with engagement. MAP Consultant Psychiatrist 1 at the inquest of Donna and Zaki stated in this regard concerning an apparent failure by Donna to attend an appointment:

*"I think, what would be expected is if she were not to attend an appointment, then one of the admin staff would put an event on, highlighting that someone would have been DNA'd. If we had any acute further risk concerns at that stage, we may consider calling the patient to find out what's going on, but I think there was a presumption there, and there was a lack of clarity that we felt that she was care coordinated, even if she were not to attend appointments, she would be seen by the care coordinator".*

17.42 Trainee Psychiatrist 1 subsequently suggested that Donna should have a care coordinator in an entry in Donna's records dated 17 January 2013. However, it was recorded in Donna's notes that her allocation of a care coordinator was not related to "genuine risk issues".

17.43 The Independent Investigation team is concerned about this reference as it suggests that a further 'informal rationing' process may have been applied towards the allocation of care coordinators which concentrated solely on 'risk'. Risk is only one of the features of the CPA, which in turn, is only one aspect of the role of a care coordinator.

17.44 The Independent Investigation Team is aware that the Trust has reviewed its policies and procedures considerably since the time of Donna's care. Donna would now be referred initially to the Assessment and Liaison Service. The Trust has provided the Independent Investigation Team with the following information in this regard:

*“The assessment and liaison service provides a gateway service into secondary mental health services within the Croydon district. Service users are engaged at the point of referral, followed by assessment to understand what services and treatments could be provided to better manage their situation, this may involve being referred onto another service who can manage treatment more effectively. Service users can be expected to have a 12 week assessment and stabilisation before being discharged back to primary care (i.e. GP), but should the needs be more complex and require further involvement, a referral will be made to other services. This includes home treatment prior to possible admission”.*

**Comment Six:**

The MAP East Team had developed a number of maladaptive processes in relation to care coordination possibly in response to the difficulties which the Team was facing due to resources.

It appears that Donna was viewed as an individual who had access to other resources which some other services users did not have. She was, for example, able to obtain CBT on a private basis.

This appeared to obscure the need which Donna had for care coordination. In particular, her care was fragmented as she unsuccessfully tried to navigate the complexity of Trust services.

Donna was seen by a number of clinicians. This lack of consistency led to a potential loss in clinically relevant information without a designated individual to ‘pull’ the information together in order to afford clinicians a ‘full’ picture of Donna and her needs. It also caused a lack of clarity in relation to who was responsible for aspects of Donna’s care most notably in the organisation and follow up of appointments made on behalf of Donna.

Crucially, Donna was denied a support mechanism who could monitor her condition following a significant uncompleted suicide on 14 December 2012.

### **Recommendation Six – Accommodating the needs of all service users:**

The Independent Investigation Team has had an opportunity to consider the Operational Policy adopted by the Assessment and Liaison service. Whilst the Independent Investigation Team recognises a number of positive features which would have benefited Donna such as the allocation of an individual who would have been responsible for her care from the outset and a tightening of some discharge procedures, the Independent Investigation Team does continue to have some concerns.

It appears to the Independent Investigation Team that the processes may have been built around an individual who has a psychotic illness or personality disorder. The procedures are relatively supportive of individuals with such a presentation. However, the Independent Investigation Team is unclear as to how an individual presenting in the same manner as Donna would benefit from the reflective provisions set out in the Operational Policy for example.

That there are also provisions that clarify the responsibility to scan documents into the Electronic Patient Journey System ('ePJS') is clearly a positive step by the Trust and would have been a significant benefit in Donna's care. However, the Independent Investigation Team is concerned that this change has not become embedded into current practice. The CQC raised this concern in the following terms:

*"The Trust must ensure that a consistent approach is used to complete risk screens and risk assessments on the patient records system so they contain the necessary detail to be used by all care professionals<sup>54</sup>".*

In addition, there are a number of points within the operational policy where there is a lack of clarity. For example, it is unclear what process would apply to a referral from the Home Treatment Team.

Accordingly, it is recommended that the Trust review the Operational Policy: PMIC Assessment & Liaison Service (November 2016: Version 5) in order to ensure that all process noted within the policy are clear and accommodate the needs of all groups of service users.

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<sup>54</sup> CQC report published 31 October 2017, page 13.



## 18 JUNCTURE FIVE: SLAM'S FAILURE TO RECOGNISE THE SIGNIFICANCE OF, AND ACT UPON 'THE ROTHERHAM INCIDENT'

- 18.1 This report refers to a failure to implement the ethos of the CPA in relation to Donna's care. Notwithstanding this overarching failure, the Independent Investigation Team is of the view that Donna's uncompleted suicide attempt on 14 December 2012 constituted a juncture in Donna's care, notwithstanding the earlier failures to apply a reflective approach to her diagnosis as part of a structured review and risk assessment.
- 18.2 Uncompleted suicide 14 December 2012:
- 18.3 During a visit to Rotherham in December 2012, Donna made a very serious (albeit unsuccessful) suicide attempt, the significance of which was clearly recognised by extremely concerned local services, and yet, not recognised by the relevant SLAM services upon her return to Croydon after the event.
- 18.4 It is the opinion of the Independent Investigation Team that suicide attempts are strong risk factors for future completed suicides. A previous suicide attempt is a major risk factor for a future suicide attempt, resulting in an increased risk of death by suicide compared with those who did not make an attempt.
- 18.5 The 'Rotherham Incident' represented a very serious and clear warning sign that, if it had been recognised as such and actioned by SLAM, it may have taken the treatment that Donna received in an entirely different direction. The Independent Investigation Team considers that it was neither recognised, nor actioned.
- 18.6 The uncompleted suicide:
- 18.7 The assessment form completed by the mental health professional in Rotherham<sup>55</sup> following Donna's overdose and suicide attempt recorded;
- "DO came to stay with a friend in Rotherham on 11<sup>th</sup> December to give her a break from her son whom she has been struggling to care for due to her agitation. He would be looked after by DO's mother back home in Croydon. DO's mother explained separately that this was also necessary to give her and her husband a break as they could not cope with DO's mood and behaviour, described as being constantly demanding of their attention, permanently seeking reassurance, at times hostile and physically threatening, if for instance she wasn't given a cigarette when she wanted one (been smoking up to 50 a day). DO is said to have made numerous threats of suicide to her mother, picking up a knife and threatening to cut herself with it if her demands were not met. Apparently the friend in Rotherham found DO's company equally challenging and it was during this stay that DO took the overdose".*
- 18.8 Donna's mother states that On Wednesday 12 December 2012, Donna travelled to Rotherham to visit a friend living there with the intention of getting out of

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<sup>55</sup> 'Mental Health Patients Clinical History' form, Rotherham, Doncaster and South Humber NHS Foundation Trust, 16 December 2012, page 1.

London to take a break from things. Her friend had herself suffered from anxiety. Donna's mother has informed the Independent Investigation Team that Donna's friend did not realise the extent of Donna's deterioration at this time. She did not take Zaki with her. On the evening of Thursday 13 December 2012, Donna told her friend that she was "*feeling suicidal*", and early on the morning of Friday 14 December 2012, Donna's friend found her in an unconscious state following an overdose of prescribed medication.

*"We were not a safety factor on 14 December 2012...we were doing our very best we supported Donna but we couldn't make her better..."<sup>56</sup>*

18.9 The intervention of Rotherham NHS Foundation Trust:

18.10 At 10.54, Donna was taken to the Accident and Emergency department at Rotherham Hospital. Donna was unconscious on arrival. The team treating her were unable to confirm what she had taken but suspected a mixed overdose of Pregabalin and Promethazine. Donna was admitted to the intensive care unit for observations due to a low Glasgow Coma Scale (GCS) score<sup>57</sup>.

18.11 Donna was referred to the local mental health crisis resolution team (part of the Rotherham access team for assessment by intensive care unit team) and was assessed by a local crisis resolution worker, who was also an Approved Mental Health Professional (AMHP) on 15 December 2012. The same day, Donna's GP called MAP seeking assistance with "*the management*" of Donna following notification of Donna's suicide attempt from Donna's mother.

*"...We travelled to Rotherham and left Zaki with my [other] daughter. I was so relieved to see Donna, I was shocked and appalled at the terrible state she was in, this is what the previous months had been building up to, Donna was in complete despair crying and asking "Why did they wake me up? I didn't want to be woken up"...it broke my heart to hear this, Donna has a loving family who supported her and our Zaki she doted on. With her illness she wasn't able to look after Zaki what would we do without her, what Zaki would do without his mum..."*

18.12 The Rotherham assessment:

18.13 The Rotherham AMHP obtained a detailed mental health history of Donna and summarised her presentation as "*severe anxiety with possible depression*" with "*ongoing risks associated with impulsivity*". The depression was considered difficult to determine because of the predominant features of anxiety, and whilst no active suicidal ideas were present, there were noted "*ongoing risks to self-associate with impulsivity*".

18.14 The Independent Investigation Team considers the Rotherham incident to be of considerable significance in relation to the treatment of Donna. At the time of admission, Donna was an individual who had been 'involved' in one capacity or

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<sup>56</sup> Information provided to the Independent Investigation Team by Donna's mother.

<sup>57</sup> The GCS is a neurological scale which aims to give a reliable and objective way of recording the conscious state of a person for initial as well as subsequent assessment.

another with five SLAM secondary mental health services for almost five months, and was no further forward in terms of diagnosis, treatment, or access to service. However, her uncompleted suicide attempt marked a clear deterioration in her condition.

- 18.15 The Rotherham Team clearly identified and highlighted the possibility of depression, and the *“ongoing risks to self”*. The authority of the Rotherham insight is compounded by the fact that this was not simply the diagnosis of one solitary clinician, but in fact, two separate services, the liaison team initially upon first admission, and then their crisis team the following day.
- 18.16 The Rotherham assessment was also significant in that it represented a ‘reassessment’ of Donna, and therein, a potentially excellent point at which to reflect upon Donna’s presentation and explore the nature of her illness. The team in Rotherham also had had the benefit of assessing Donna at a point when she was very ill.
- 18.17 The intention of the Rotherham Team was to return Donna back to Croydon for reassessment by a local crisis team. The Rotherham crisis team documented that they were concerned and felt that Donna needed intensive home treatment. In addition, advice was provided for Donna’s family concerning how formal admission might be arranged under mental health legislation in the event that Donna’s care and safety could not be managed at home.
- 18.18 As has been referred to in paragraph 16.38 of this Report, the recommendation which Rotherham made for Donna was *“referral for urgent assessment, and recommending input to stabilise anxiety”*.
- 18.19 The Rotherham recommendation:
- 18.20 The AMHP at Rotherham recommended a referral for Donna to have an urgent assessment by the HTT in Croydon to stabilise Donna’s anxiety immediately upon her return home. This recommendation was duly faxed to Trainee Psychiatrist 1 at MAP.
- “We thought we had won the lottery at long last someone had properly diagnosed Donna and she was going to get the treatment she urgently needed...”*
- 18.21 It is the view of the Independent Investigation Team that the Rotherham AMHP clearly felt that *“intensive”* support was necessary. The Independent Investigation Team has referred to the difficulties which Donna had in accessing services and in particular, HTT at paragraph 16.30 of this report.
- 18.22 As above, whilst both Registered Mental Health Nurse 1 and Trainee Psychiatrist 1 were aware of the suicide attempt in Rotherham prior to their subsequent interactions with Donna, neither pursued the referral any further.
- 18.23 It is of grave concern to the Independent Investigation Team that the MAP Team staff had no awareness of who first received this referral, as is the fact that the

MAP Team notes make no reference to that referral. This resulted in a significant amount of new and potentially relevant clinical information concerning Donna being lost to those who subsequently became involved in her care and treatment.

- 18.24 Trainee Psychiatrist 1 confirmed at Inquest that the referral from Rotherham did come to Tamworth Road, and that he had seen it in the manager (at the time's) office. When asked by the Coroner at Inquest whether he had seen the Rotherham discharge letter of 16 December 2012, addressed to him, at the time, Trainee Psychiatrist 1 confirmed that he "*definitely saw something*", but could not remember which document he saw. He stated that he "*probably*" would have seen it. When asked if he had seen the actual assessment, Trainee Psychiatrist 1 stated that he could not recall, but did not refute that he was aware of Donna's overdose in Rotherham.
- 18.25 HTT could have offered significant benefits to Donna's care at this time. Donna could have been visited and potentially reviewed possibly as often as 3 or 4 times per day. This would have allowed for a greater understanding of Donna's presentation including her relationships, not least the relationship which she had with her son. The knowledge that someone would be attending would have provided greater information to guide the choices which were made in relation to her medication and its subsequent impact. The attendance of the HTT can also provide useful feedback and allows the introduction of occupational therapists and social workers into the care of the individual.
- 18.26 Psychologically, the Independent Investigation Team is of the view that the introduction of HTT would have been more likely to make Donna feel that she was being taken seriously and would also have allowed for her family and carers to be supported. It may also have allowed for the establishment of a therapeutic relationship where the HTT was able to build upon the information which Donna provided to clinicians, rather than having to explain her situation each time she approached services.
- 18.27 Discharge and return to London:
- "...Travelling home on Sunday 16 December 2012, although Donna kept repeating she didn't want to have woken up I told her she had a second chance she was going to get the treatment to help her get better none of this was registering she said she couldn't cope any more she didn't want to wake up, this was very frightening and distressing to hear, where had my daughter gone she was a shell of herself. [Donna's sister] brought Zaki home, Donna went to bed and that's where she stayed to the following day..."*
- 18.28 On 16 December 2012, Rotherham discharged Donna into the care of her mother and they returned to London so that Donna could be cared for in her home environment. The next working day, Monday 17 December 2012, Donna's GP made an urgent referral call to MAP for assessment of Donna's suitability for HTT, pursuant to the Rotherham recommendation. Donna was seen the same day by an experienced mental health nurse, RMHN MAP Nurse 1 at MAP. The fact that Donna was seen so promptly was an element of good practice. The assessment conducted by MAP Nurse 1 is considered more fully at Paragraph 18.44.

18.29 The MAP Consultation of 17 December 2012:

18.30 Suicidality is one of the most important problems that mental health professionals deal with. Suicide attempts are common. In 2012, there were 5,981 suicides in the UK, but the number of attempted suicides is much higher.

18.31 The Rotherham AMHP sent a fax on 16 December 2012 to the MAP Team. Prior to sending this fax, the Rotherham AMHP had contacted SLAM to confirm that the Trust operated a Home Treatment Team. This is an element of best practice.

18.32 The Rotherham AMHP's covering letter to his report states:

*"In view of the degree of her anxiety and risk of further impulsive overdose I would recommend input be arranged as a matter of urgency".*

18.33 This fax included a report which stated:

*"NEEDS SUMMARY*

*Assessment: DO presenting with severe anxiety, probable depression also although difficult to determine with predominant features of anxiety. Constantly seeking reassurance, fixed belief that cocaine use has done irreparable damage to her mental health. No active suicidal ideation at assessment but ongoing risk of impulsivity.*

*Recommendation: Liaison with Intensive Home Treatment Team in her own locality, referral for urgent assessment and recommending input to stabilise anxiety. DO discharged from Rotherham Hospital to care of her mother. Mother (Nearest Relative) advised about mental health legislation and how to access formal assessment process with a view to admission if felt DO's care and safety cannot be managed at home".*

18.34 The Rotherham AMHP also wrote to Donna's GP on 17 December 2012, setting out details of the outcome of Donna's assessment by the Rotherham Access Team. This letter included the Rotherham AMHP's contact details.

18.35 During the course of the interviews conducted by the Independent Investigation Team it was stated by Trainee Psychiatrist that:

*"you know, she's taken an overdose, but all the other patients have taken overdoses as well or tried to hang themselves or jumped off piers or drunk litres of pesticides or other things".*

18.36 Contact with Rotherham:

18.37 There is little, if any, information contained within Donna's records on 17 December 2012 that confirms the actions taken by the MAP Team to establish the clinical significance Donna's suicide attempt in Rotherham which led to her admission to ICU. A telephone conversation with the Rotherham AMHP would have been very beneficial in this regard. However, what is clear is that the MAP

Team were aware that the team of mental health professionals who assessed Donna following her suicide attempt in Rotherham were of the view that Donna should receive home care. Equally, Donna's GP was also concerned that Donna should receive this type of care.

18.38 Contact with GP:

- 18.39 Donna's GP contacted the MAP Team on 17 December in order to arrange an urgent appointment for Donna. Donna's GP was aware of the serious nature of Donna's suicide attempt. Donna's GP records include the following entry in respect of 17 December 2012:

*"mother has expressed a desire for pt to be treated with the crisis at home team where psychiatrist come to your house and review you daily. I have explained I am not aware (sic) of this service but will discuss with Psych Team.*

*...called and discussed with Registered Mental Health Nurse 1 Trainee Psychiatrist 1 is in clinic situation explained and he has said he will call me back".*

- 18.40 There is no record of any subsequent call between Trainee Psychiatrist 1 and Donna's GP on 17 December 2012. In addition, there is no record of any member of the MAP Team contacting Rotherham AMHP to discuss Donna or the Rotherham Team's findings and concerns in order to obtain further details of the Rotherham Team's assessment of Donna. This is a matter of significant concern

18.41 Duty System:

- 18.42 As has been discussed in section 12, staff working within the MAP East Team had an average caseload of 30+ cases when the recommended level at that time was between 20 and 25 cases. Further information about the pressures which the MAP East Team faced can be found at Chapter 12.

- 18.43 The Duty system was the process which related to the allocation of cases within the MAP East Team at the time of Donna's care. Team members undertook duty on a half day or full day basis during the week. One team member was on duty at a time. This task was carried out in addition to the established case load of the member of staff who was on 'duty'.

- 18.44 In addition to their core duties, care co-ordinators were expected to play an active part in the Duty system. Registered Mental Health Nurse 1 gave evidence to the Internal Investigation that she would be spending one day a week engaged in the Duty System.

- 18.45 The Duty system was known to be a concern of the management of the MAP Team as early as August 2012. Evidence given by a senior manager to the Internal Investigation Team described the situation in the following terms:

*"It is very busy. They have to take phone calls and walk-ins and deal with referrals and GP's. It is one of the areas where the team feels overwhelmed".*

- 18.46 The MAP East Team had expressed concerns about the duty system. At around

the time of Donna's care, the MAP East Team had put forward a possible solution that additional admin support would be provided to allow for calls to be answered. However, this solution was not accepted and instead it was subsequently proposed that teams would be split into assessment and treatment and an additional team member was recruited.

18.47 On 17 December 2012, Registered Mental Health Nurse 1 was on 'duty'. It was in this capacity that she met Donna and her mother. Registered Mental Health Nurse 1's recollection was that Donna was one of three patients which she saw on 'duty' that day. At the time when she met with Donna, Registered Mental Health Nurse 1 informed the Internal Investigation Team that she was not up to date with her mandatory training, although she was unsure as to which aspects of her training were not up to date. The reason which she gave the Internal Investigation Team for this was that *"the Team is just too busy"*<sup>58</sup>. This is a serious concern for the Independent Investigation Team because it indicates significant time pressures that staff were operating under.

18.48 In a report to commissioners dated 22 May 2013, the Trust provided the following information to commissioners concerning the steps which the Trust was taking in this regard:

*"Additional dedicated HR support (0.4wte) has been provided to Croydon services to assist team managers in improving staff performance for example, sickness absence and meeting mandatory training requirements. A number of staff have been subject to formal performance management and disciplinary action".*

18.49 Consultation with Registered Mental Health Nurse 1:

18.50 Registered Mental Health Nurse 1 had not previously been involved in Donna's care. She did however, have access to the ePJS system.

18.51 The evidence given by Registered Mental Health Nurse 1 at the inquest into the deaths of Donna and Zaki was that she had been contacted by Donna's GP who was seeking advice on Donna's management. According to Registered Mental Health Nurse 1's inquest evidence, Donna's GP was concerned about prescribing medication to Donna following her uncompleted suicide in Rotherham. Donna was seen by Registered Mental Health Nurse 1 as part of the duty system.

18.52 Donna was provided with access to the MAP East Team later that same day. The speed at which Donna obtained access to the MAP East Team on this occasion is an element of good practice.

18.53 During the course of evidence given at Donna's inquest, Registered Mental Health Nurse 1 described the reason for the consultation in the following terms:

*"she's not sleeping and the medication that she has been prescribed with is not really effective, it's not working..."*

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<sup>58</sup> Trust Internal Investigation interview 8, 9 May 2013.

*...the anxiety is something that led to taking the overdose in the first place because she want to get better..."*

18.54 During the course of her evidence, Registered Mental Health Nurse 1 confirmed that she had not contacted Rotherham in order to obtain any detail surrounding Donna's overdose. In evidence, she stated *"If I have more time I should do that"*. Registered Mental Health Nurse 1 subsequently described herself as being *"too busy"* whilst undertaking 'duty' to contact Rotherham services.

18.55 In addition, in evidence given at Donna's inquest Registered Mental Health Nurse 1 confirmed that she had not reviewed Donna's records in relation to her attendance at A&E on 7 December 2012 following Donna's attempts to put a knife to her throat. When asked about this, Registered Mental Health Nurse 1 stated:

*"If I had looked properly, I would have seen that. At that time, my priority was because I have other clients before her and after her, so my priority is to deal with the crisis. Since the GP has called me and made clear what the needs are"*.

18.56 Registered Mental Health Nurse 1 went on to state *"duty is the crisis it's not a full assessment"*. As is noted in Donna's records, RMHN 1 has not documented the full context of Donna's overdose in Rotherham, stating simply that Donna had been to A &E. RMHN 1 did not contact Rotherham for any details of Donna's uncompleted suicide.

18.57 Registered Mental Health Nurse 1 did however establish that Donna's uncompleted suicide in Rotherham was 'impulsive' in nature. Donna cited Zaki and her mother as being protective factors.

18.58 Registered Mental Health Nurse 1 was concerned about the possibility of Donna taking a further overdose. She 'managed' this risk of further overdose by ensuring that Donna's medication was given to her mother. Registered Mental Health Nurse 1 stated that *"I think that reduced the risk to low"*. The Independent Investigation Team would not agree with this opinion in light of the issues highlighted at Paragraphs 18.45 to 18.48 above which confirm that a full assessment had not been carried out and therefore a comprehensive picture of the risk which Donna presented at that time would not have been obtained. Furthermore, even if the risk of overdose of medication had indeed been managed, or at least, reduced by this step, the underlying risk of suicide (by other means, such as the knife referred to in paragraph 18.55 above), had not. Donna's eventual suicide was not as a result of overdose.

18.59 Involvement of Consultant Psychiatrist 2 and Trainee Psychiatrist:

18.60 MAP Consultant Psychiatrist 2 was not a member of the MAP East Team. However, on 17 December 2011, MAP Consultant Psychiatrist 1 was on annual leave and as a result, MAP Consultant Psychiatrist 2 was 'covering' his duties.

18.61 Neither Trainee Psychiatrist 1 nor MAP Consultant Psychiatrist 2 saw Donna on 17 December 2012. Consequently, the changes which were made to Donna's medication, were not made through direct observation of the patient, nor through



multi-disciplinary consideration of her care in accordance with the CPA. However, Registered Mental Health Nurse 1 did discuss her concerns about Donna with both Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 2. All discussions about Donna were conducted through Registered Mental Health Nurse 1. The reason why MAP Consultant Psychiatrist 2 made no entries in Donna's records nor had any direct contact with Trainee Psychiatrist 1 to discuss the case is unclear.

- 18.62 Trainee Psychiatrist 1 was involved in Donna's care on 17 December 2012. The records made by Registered Mental Health Nurse 1 stated:

*"Case was discussed with MAP Consultant Psychiatrist 2 and he suggested that Trainee Psychiatrist 1 to switch Pregablin to Olazepine (sic) + Citalopram and prescribe Clonazepam for short term use".*

- 18.63 Trainee Psychiatrist 1 made the following entry in Donna's records in relation to this attendance by Donna;

*"message relayed from Registered Mental Health Nurse 1, MAP Consultant Psychiatrist 2 advises*

*1 switching Pregabalin to Olanzapine 5mg mane 7.5-10 mg nocte  
2 adding Citaloprm or Escitalopram for anxiety  
3 Clonazepam as an absolute emergency".*

- 18.64 Evidence given by Registered Mental Health Nurse 1 to the Internal Investigation Team was as follows:

*"So the team consultant wasn't there and Registered Mental Health Nurse 1 had spoken to the covering consultant and he advised Registered Mental Health Nurse 1 to get the SHO to prescribe medication and Registered Mental Health Nurse 1 thought that DO needed so Clonazepam [sic] to take the edge off the Olanzapine".*

- 18.65 Whilst it is documented that Registered Mental Health Nurse 1 discussed Donna's care with MAP Consultant Psychiatrist 2, the detail of the discussions which were undertaken were not documented at any stage in Donna's notes by MAP Consultant Psychiatrist 2. In addition, it appears that MAP Consultant Psychiatrist 2 did not discuss the changes which were to be made to Donna's medication with Trainee Psychiatrist 1.

- 18.66 Donna's records indicate three changes to her medication regime on this occasion. This in itself indicates a level of complexity. Whilst on the surface, these changes may appear reasonable, the changes were made without apparent regard to the information contained in the Rotherham report and the concerns which the Rotherham Team had for Donna.

- 18.67 The Independent Investigation Team notes that relevant to the need for Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 2 to discuss the changes which were made to Donna's medication regime on this occasion was the fact that Olanzapine is not licenced for anxiety disorders. The rationale behind the

prescription of olanzapine is not clear from Donna's medical records.

- 18.68 The Independent Investigation Team recognises that there may be instances where clinicians conclude for medical reasons that an unlicensed use of a medicine is necessary to meet the needs of a patient. GMC advice in this situation includes the following:

*"You should also consider discussing the options with colleagues or experts and getting advice from them on the appropriateness of the treatment".*

- 18.69 In these circumstances given the relatively junior position of Trainee Psychiatrist 1 within the Team and in view of the lack of clarity surrounding the prescription of olanzapine, the Independent Investigation Team believes that such changes would have been best made during 'face to face' contact between the Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 2, or indeed following a structured review of the patient who was in clinic at the time.

- 18.70 It is not clear from the evidence which is contained in Donna's medical records why such a meeting or review did not take place, given that Registered Mental Health Nurse 1, Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 2 were within the building at the time. However, it appears from the evidence which was available to the Independent Investigation Team that MAP Consultant Psychiatrist 2 was undertaking a clinic at this time. On the evidence, it appears that Trainee psychiatrist 1 did not raise the issue because Registered Mental Health Nurse 1 was not back from leave until mid-January.

*"I spoke to [Registered Mental Health Nurse 1] in the corridor and she agreed from mid-January, if necessary when she's back from holiday she can be care coordinator<sup>59</sup>".*

- 18.71 Description of HTT Service:

- 18.72 Registered Mental Health Nurse 1 was asked in an interview with the Internal Investigation to how she would describe home treatment. Her response was as follows:

*"They would take patients who are bed blockers and they can visit at home and give the patient medication....they talk to the patient too<sup>60</sup>".*

- 18.73 On this basis, and in the absence of any other evidence to the contrary, the Independent Investigation Team will infer that her explanation of HTT to Donna would have been made in similar terms.

- 18.74 Donna's mother's account given to the Independent Investigation Team of the description of the HTT service given to Donna and herself was as follows:

*"we explained what had happened in the last 48 hours she informed me there were no home treatments at Croydon. All they could offer was supervision of*

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<sup>59</sup> Trainee Psychiatrist 1's evidence at Inquest.

<sup>60</sup> Internal Investigation interview 8, 9 May 2013.

medication<sup>61</sup>".

- 18.75 Donna's GP notes for 17 December 2012 record the following;

*"Discussed hx with mother this am, as abot (sic) Pt now at home. Was given a few tablest (sic) of temazepam to sleep. Pt requestin (sic) medication to help calm her down. Declined at present I will call Map East team and discussed on going mx options. Mother has expressed a desire for pt to treated with the crisis team where psychiatrist come to you (sic) home and review you daily. I have explained I am not awar (sic) of this service but will discuss with Psych team..."*

*...Called and discussed with MAP Nurse 2, Trainee Psychiatrist 1 is in clinic situation explained and he has said that he will call me back"...*

- 18.76 It was a finding of the Internal Investigation performed by the Trust that:

*"the investigators were concerned that the full spectrum of home treatment team interventions were not discussed with Mrs DO and her mother to allow them to make an informed decision about referral to the team".*

- 18.77 Notwithstanding the conflict of evidence between the Trust and that given by Donna's mother, as has been discussed in section 16, the Independent Investigation Team is concerned that the description of HTT which was provided to Donna and her mother indicates a lack of understanding of the HTT service within SLAM at that time and the benefits it could offer.

- 18.78 Further, as has been shown throughout the report, it is the opinion of the Independent Investigation Team that this is a further example of some limbs of the Trust and indeed local GP's lacking an awareness of the services actually provided by the organisation, as well as the views expressed at the Focus Groups, and referred to in section 22 of the Trust staff involved in the Independent Investigation's 'Focus Groups'.

- 18.79 Registered Mental Health Nurse 1's note of this consultation states:

*"I discussed role of HTT with her and if she would like to be referred. She said she is capable to take medication without HTT support. However, she agreed to have care coordinator that she will be able to talk to when feeling anxious while waiting for CBT via IAPT..."*

*Case was discussed with [MAP CONSULTANT 2] and he suggested that Trainee Psychiatrist 1 to switch Pregabalin to Olazepine+Citalopram and prescribe Clonazepam for short term use.*

*See entry from Trainee Psychiatrist 1.*

*Plan*

*2/52 of above mentions prescription*

*She was reminded of pathway to service if in crisis.*

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<sup>61</sup> Taken from Donna's mother's written recount of events, provided to the Independent Investigation Team by letter of 19 November 2014.

*Mother will dispense medication.  
She will use distraction technique if fail she will use Prn Clonazepam”.*

18.80 Donna’s records made by Trainee Psychiatrist 1 on 17 December 2012 state:

*“Patient deemed not suitable for HTT.*

*MAP Consultant Psychiatrist 2 advises:*

*1 switching Pregabalin to Olanzapine 5mg mane 7.5-10 mg nocte  
2 adding Citaloprm or Escitalopram for anxiety  
3 Clonazepam as an absolute emergency*

*Plan*

*1 I will review at 1pm 31 December  
...Citalopram 10mg for 1 week then 20 mg for 1 week Olanzapine 5mg bd (patient  
has already stopped pre-gabalin)  
Clonazepam 0.5 mg bd/prn  
[Registered Mental Health Nurse 1] to be care co ordinator from mid January”.*

18.81 Discussions concerning appointment of a care coordinator:

18.82 When asked about whether Donna was asked whether she would like a care coordinator, Registered Mental Health Nurse 1 stated the following during the course of her evidence at Donna’s inquest:

*“When she declined the role from Home Treatment Team, I then discussed the case of having a care coordinator with DO and she was quite happy to have one and I told her what a care coordinator does. They don’t have capacity to see clients everyday but they can see the client once a week or maybe fortnightly, depending on the client’s needs while waiting for IAPTS”.*

18.83 Donna’s mother is very clear and consistent in her evidence provided to the Internal Investigation Team, Independent Investigation Team and at inquest that that the appointment of a care coordinator was not discussed during the consultation with Registered Mental Health Nurse 1. Donna’s mother’s recount of events to the Independent Investigation Team is that at no time was the availability of HTT mentioned, nor was it described as being available via CMHT. DO’s mother’s recollection is also that neither the provision of a care co Ordinator, or the availability of medication via the HTT was mentioned. Notwithstanding this significant difference in evidence, it is unclear to the Independent Investigation Team how, at this stage, the provision of a care coordinator alone, who would see Donna potentially once a week, would have addressed Donna’s needs which were highlighted in the Rotherham Report which was not the subject of consideration or inquiry by Registered Mental Health Nurse 1.

18.84 It is the view of the Independent Investigation Team that, at this stage, and following the recommendations made in the Rotherham report, a visit with a care co-ordinator once a week was insufficient to address Donna’s needs, by virtue of the fact that a more intensive response required following the events in

Rotherham.

- 18.85 As above, whilst both Registered Mental Health Nurse 1 and Trainee Psychiatrist 1 were aware of the suicide attempt in Rotherham prior to their subsequent interactions with Donna, neither pursued the referral any further.
- 18.86 It is also unclear why neither Trainee Psychiatrist 1 nor Registered Mental Health Nurse 1 took Donna's 'consent' to having a care coordinator to the next meeting of the MDT. In this regard, Registered Mental Health Nurse 1 stated about whether Trainee Psychiatrist 1 could take a decision about care coordination for Donna. She stated:
- "He cannot make that decision; it's something we have to discuss. We can discuss it but it's something that needs to be taken further to the meeting. If I say that I feel that she needs a care coordinator that the team after me made that decision, the reason why the client needs a care coordinator, if she would've benefited from having a care coordinator, it's something we have to decide in the team".*
- 18.87 It is unclear from Donna's notes the rationale behind the changes which were made to Donna's medication nor indeed what conditions were being addressed. In particular, it is unclear how the changes in medication would have addressed the concerns highlighted by the Rotherham Team and in particular, the *"probable depression"* highlighted by the Rotherham Team.
- 18.88 An additional concern is that a number of simultaneous changes were made to Donna's medication in that Citalopram was added, Pregabalin was switched to Olanzapine. In addition, Clonazepam was added *"as an absolute emergency"*. This would have created a difficulty in subsequently establishing which medication was responsible for any changes in Donna's presentation which could potentially have caused clinicians difficulties in relation to Donna's longitudinal care.
- 18.89 Crucially, it is also unclear why home treatment was deemed unnecessary from a clinical perspective. During the course of the inquest into Donna's death, Registered Mental Health Nurse 1 explained that changes made to Donna's medication would require 14 days to take effect. Consequently, an appointment with Trainee Psychiatrist 1 was made on 31 December 2012 in order that any such changes could be assessed. Whilst on the surface, this suggestion may appear reasonable, this decision fails to take account of the information which was contained in the Rotherham advice concerning urgency. It also failed to recognise the fact that there was sufficient complexity in Donna's presentation which required the medicine regime outlined at paragraph 18.61 above.
- 18.90 Administration:
- 18.91 The Independent Investigation Team is also concerned that the comprehensive discharge summary prepared by Rotherham AMHP was not entered into Donna's electronic records at this time. The SUL prepared by the Trust states:

*“The discharge letter from Rotherham Doncaster and South Humber Foundation Trust, Crisis Resolution Team was not loaded onto ePJS although East Croydon MAP team doctor confirmed that he had seen this letter”.*

18.92 Whilst Trainee Psychiatrist 1 has confirmed that he had seen the Discharge Summary, the failure to upload it to the electronic record system meant that it was not available to other clinicians who would later come into contact with Donna.

18.93 The MAP East Team Manager was asked at inquest how correspondence such as that received from Rotherham would be uploaded onto the ePJS system. His response was as follows:

*“Generally, if it was directed specifically to the doctor in question then the doctor would receive the letter and either he himself or one of our admin secretaries would upload it onto the (inaudible). It was generally one of the admin secretaries who would have done that. They would’ve scanned on a copy”.*

18.94 This response reveals a lack of clarity in the process adopted by the MAP East Team at the time which is a significant concern. The impact of the failure to upload the information from Rotherham cannot be overstated. The description of Donna’s uncompleted suicide attempt which is recorded in the entry dated 17 December 2012 in Donna’s electronic record omits key information relating to the event including the fact that the overdose which she took was sufficient to necessitate her admission to ICU. This information is relevant in relation to the assessment of risk. The entry made in Donna’s records on 17 December 2012 simply states:

*“reported that she presented at A&E yesterday following overdose of her prescribed medication”.*

18.95 The Operational Policy in place in the MAP Team at the time of Donna’s care provides the following insight in relation to the responsibility for ensuring that information relating to patients is complete. It states:

*“Care coordinators are responsible for ensuring that all data, such as risk assessment, child risk screens, and HoNos ratings for the service users on their caseloads is up to date. They should also ensure all cases are clustered and that the diagnosis is entered on EPJs”.*

18.96 Donna did not have an appointed care coordinator throughout her care. This issue is more fully dealt with in Juncture 4 of this report. However, it is clear that the impact of the absence of a care coordinator impacted upon all levels of Donna’s care as it was very unclear who was responsible for aspects of her care such as loading an important document onto the ePJS system or indeed ensuring that Donna’s entry on ePJS was ‘open’.

18.97 A further concern for the Independent Investigation Team which arises from the consultation which took place on 17 December 2012 was the lack of any accurate risk assessment which underpinned the plan which was completed in relation to Donna’s ongoing care particularly in relation to the *“probable depression”* noted

by the Rotherham Team. Notwithstanding the conflict in evidence given at Donna's inquest between Donna's mother and Registered Mental Health Nurse 1 about whether the issue of care coordination was in fact discussed at this consultation, it was clear that in any event, care coordination could not commence until mid-January.

- 18.98 As above, whilst both Registered Mental Health Nurse 1 and Trainee Psychiatrist 1 were aware of the suicide attempt in Rotherham prior to their subsequent interactions with Donna, neither pursued the referral any further.
- 18.99 Given that Donna would not be seen again by the MAP East Team until 31 December 2012 following a very serious incident which required Donna to be cared for in ICU, the Independent Investigation Team is of the view that a risk assessment should have been carried out to ensure that Donna did not pose a risk to herself or indeed others in the intervening period when she remained on an IAPTs waiting list and did not have access to the support of a care coordinator. Indeed, as has been stated in section 9 of this report, information from Rotherham suggested that Donna as a result of her presentation had become "*at times hostile and physically threatening*" towards her mother and partner.

#### **Comment Seven:**

This is a significant juncture in Donna's care where her care could have been directed differently.

Despite a thorough assessment having been undertaken by clinicians in Rotherham, the conclusion of which was that Donna required input from mental health services on a daily basis, the MAP Team put in place a package of care which involved changes in medication but provided no support in the community and no access to a mental health clinician for a further two weeks. In addition, the Rotherham assessment which included new and clinically relevant information was not placed in Donna's electronic records to make it available to those who would subsequently be involved in her care and treatment.

Whilst a care coordinator may have been discussed, care could not to be delivered by that individual until four weeks following Donna's suicide attempt which had caused her admission to ICU. It is not clear how Donna was to access an alternative to this support which had been deemed necessary by the Rotherham Team until this time as this decision was not the subject of a CPA or MDT review. This is a particular concern given that it was unclear at this time as to when Donna might be able to access 'talking therapies' through IAPTs.

The Independent Investigation Team is of the view that the MAP took no account of the events in Rotherham without further analysis of Donna's presentation, or investigation into other potential diagnoses which could have been considered given Donna's presentation. Accordingly, an urgent assessment and appropriate follow up as requested by Rotherham was not conducted.

What is particularly striking, is the failure to contact Rotherham and the reliance on an assessment which had been done by the MAP Team on 16 November 2012 notwithstanding the fact that Donna had presented to A & E on 7 December 2012. It appears that this omission was a feature of the 'time' pressures which were experienced by practitioners undertaking 'duty' at that time.

As a result, the 'judgements' which were reached did not appear to members of the Independent Investigation Team to be based upon all of the clinical information which was available about Donna at that time.

The clinical assessment made by the team in Rotherham was not accorded the weight it deserved when set against the very limited assessment conducted by MAP on 17 December 2012. Trainee Psychiatrist 1, in conjunction with a senior colleague decided on a course of action which did not appear to recognise how Donna's condition was evolving.

In particular, it is not clear why there was a need for MAP to review the decision of the Rotherham Team that a referral to HTT was indicated. Rotherham AMHP fell within the category, who, had he been in SLAM, would have requested an assessment by the HTT to determine whether Donna met their service criteria. His referral would still have necessitated an assessment by HTT within SLAM. It is unclear therefore why MAP conducted a review in these circumstances. In interview, Trainee Psychiatrist 1 stated:

*"at the time it felt like here was somebody who was quite dramatic... that she would sort of make threats when she didn't get her way.*

*...And she has said to me...what I want is help. I don't really want to kill myself".*

The purpose of multi-disciplinary working is to enhance clinical quality, by integrating a range of professional perspectives.

In this case, a service in a different geographical location reached an independent decision about Donna which was that she required home treatment and that her needs and the risk of impulsivity that she posed should be managed. In addition, advice had been provided to Donna's family concerning how formal admission might be utilised if it was felt that Donna's care and safety could not be managed at home.

However, MAP placed little or no weight upon this assessment relative to its own views upon Donna's presentation.

In Donna's case, there was a sharing of information, but there was no integration of that information. As a result, new clinically significant information was not factored in to her care, as the label of 'dramatic' appears to have directed a response towards her care. Consequently, a chance to engage Donna with a view to gaining a better understanding of her illness was lost.

The recommendation from Rotherham did not generate an appropriate review by the MAP East Team. Had the HTT team been afforded an opportunity to review



Donna, they could have reached an informed decision about whether Donna could have benefitted from their service. This could have reduced the work load of MAP East Team and ensured that the aims and function of the service were properly explained.

The Trust has provided the following information to the Independent Investigation Team:

*“the Trust’s systems have been updated. All HTT referrals, including those from outside of the Trust, are made through central Acute Referral Centre (ARC) who triage and assess. The current HTT operational policy is clear that it will accept referrals from outside of the Trust from Mental Health Professionals outside of the trust”.*

The CQC report published in October 2017 stated as an “area for improvement”;

*“The Trust must ensure that risk assessments and risk management plans are always completed and reviewed after changes in patients’ circumstances and risk events, and stored where other staff can find them easily<sup>62</sup>”.*

#### **Recommendation Seven – Audit of complaints against trainees:**

The Independent Investigation Team recognise that significant work has been undertaken since the care and treatment of Donna in order to improve and strengthen the supervision of trainees within the Trust.

In order to ensure that the learning from the care and treatment of Donna in relation to the supervision of Trainee Psychiatrist 1 has been established, the Independent Investigation Team recommends that an audit be undertaken by the Trust of the following:

1. An audit of the complaints made against trainees to establish any trends in order to support the needs of trainees involved and the training provided by the Trust in general.

The Independent Investigation Team recommends the introduction of a protocol for supervisors as to how to respond to a complaint about a trainee whether made through the formal complaints process or otherwise. The Trust should audit the implementation and use of the protocol 6 months after its introduction.

#### **Recommendation Eight – Audit of Efficiency:**

As mentioned above, the CQC found in their inspection of July 2017;

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<sup>62</sup> Page 15

*“The Trust must ensure that a consistent approach is used to complete risk screens and risk assessments on the patient records system so they contain the necessary detail to be used by all care professionals<sup>63</sup>”.*

The Independent Investigation Team recognises the considerable amount of work completed by the Trust including the reconfiguration of services and the introduction of the single point of access. However, in order to ensure that the learning from the care and treatment of Donna has become embedded in the Trust’s current practice, the Independent Investigation Team recommends that the Trust conduct an audit of the effectiveness of the receipt of information from out with the Trust in order to determine the action taken by the Trust in response to such a referral.

## 19 JUNCTURE SIX: COMPLAINT MADE ON 31 DECEMBER 2012

- 19.1 This consultation constitutes a 'Juncture' in Donna's care for two reasons;
- 19.2 Firstly, this appointment presented Trainee Psychiatrist 1 and MAP services with a further chance to consider Rotherham's assessment and review Donna's care and treatment following the events of 14 – 15 December 2012 in light of the *"probable depression"* noted by Rotherham, and formulate a plan directed towards that condition.
- 19.3 At interview with the Independent Investigation Team, Trainee Psychiatrist 1 conceded that he *"did not speak to Rotherham about the overdose, and that in retrospect, this could have been helpful"*.
- 19.4 Secondly, the complaint made by Donna's mother during the course of the consultation afforded the Trust an opportunity to review Donna's treatment in order to determine whether patient centred care was in fact being delivered.
- 19.5 Consultation on 31 December 2012:
- 19.6 When Donna and her mother raised the Rotherham incident and made reference to the recommendations which had been made, they were advised that continuing to wait for IAPTS CBT and medication was the only help available. Dissatisfied with this assessment, Donna's mother informed services that she was going to make a complaint.
- 19.7 During this follow up appointment however, Trainee Psychiatrist 1 telephoned his supervisor MAP Consultant Psychiatrist 1 (mid appointment) to discuss Donna's case. MAP Consultant Psychiatrist 1 agreed that in his opinion, MAP was already offering Donna everything they could, based upon the information provided by Trainee Psychiatrist 1. Donna's mother has informed the Independent Investigation Team that, on her recount of events, she cannot recall this telephone conversation taking place. MAP Consultant Psychiatrist 1 did not have access to the Rotherham Report, but was aware that there had been an incident in Rotherham. Donna's mother did make a complaint after this appointment. During the course of the consultation between Donna, her mother and Trainee Psychiatrist 1 on 31 December 2012, Donna's mother became distressed. The entry in Donna's records states:
- "Seen with mother, who states she will not leave the consulting room without a date for intensive psychological therapy, and if she does not get is she will contact her MP..."*
- "She wanted to make a complaint, and I said if she was unhappy she could make a complaint"*.
- 19.8 During the course of the Interviews conducted by the Independent Investigation Team, Trainee Psychiatrist 1 made it clear that he regarded the complaint made by Donna's mother to be about the length of time which it was taking to access care through IAPTS rather than being about the delivery of care by him.

19.9 It is clear that during the course of this consultation, Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 1 had a discussion concerning the plan which Trainee Psychiatrist 1 intended to implement.

19.10 It is also clear from the comments that upon reflection, MAP Consultant Psychiatrists 1's views about Donna's presentation recognise that Donna's presentation could have been reframed to include the possibility of depression. The stepped-care model for patients with depression which provides a framework in which to organise the provision of services and support, differs from that which applies to anxiety.

19.11 It is not clear what information was imparted to MAP Consultant Psychiatrist 1 by Trainee Psychiatrist 1. Donna's records are sparse in this regard. Comments made to the Independent Investigation Team in interview, provide some limited insight into Trainee Psychiatrist 1's views about Donna's presentation:

*"you're sort of presenting it as a really complicated case which maybe should have gone to the consultant, the way that you're presenting it. But all the patients are quite complicated. All of them had tried to – most of them had tried to kill themselves, I'd say".*

19.12 At the time of Donna's care, Trainee Psychiatrist 1 had just commenced his specialty training in psychiatry. Six years of specialty training are required as part of the training for a qualified doctor to become a psychiatrist; three-year core training programme (CT1-CT3) and three years in a higher training programme (ST4-ST6). Trainee Psychiatrist 1 was a CT 1 and was in his first of the two jobs six-month posts which this year required him to complete when he met with Donna. Trainee Psychiatrist 1 started his job with MAP East Team in August 2012.

19.13 MAP Consultant Psychiatrist 1 was responsible for Trainee Psychiatrist 1's supervision when he was working within MAP. His advice to Trainee Psychiatrist 1 in relation to Donna's presentation was reliant upon Trainee Psychiatrist 1's views and descriptions of Donna's presentation. MAP Consultant Psychiatrist 1 did not have access to the Rotherham assessment. In evidence given at Donna's inquest, Trainee Psychiatrist 1 admitted to seeing a letter from Rotherham but was unable to clarify when and was unable to recall the content of the correspondence.

19.14 It is clear that Trainee Psychiatrist 1 felt supported in his role and that MAP Consultant Psychiatrist 1 had confidence in his abilities.

19.15 It was made clear to the Independent Investigation Team during interviews which it conducted that timing was tight. MAP Consultant Psychiatrist 1 provided the following explanation of how appointments were scheduled for junior doctors at the time:

*"We basically staggered the time slightly so that they would start seeing someone before I started seeing someone so that there was this kind of half an hour opportunity to discuss.*

*...To be honest it was a bit squeezed. ..I think because I was also giving them regular supervision which I know doesn't always happen in mental health teams. I think anything that was carried over, if there was something urgent they would be able to speak to me that day, definitely. But you're right, the timetable was tight".*

19.16 Trainee Psychiatrist 1 advised the Independent Investigation Team that:

*"This is true, but in practice supervision was more fluid than this, and it would have been possible to have discussions with the consultant outside these times.*

*Regarding the key points regarding the level of responsibility and size and complexity of the caseload given to a doctor in the first months of their training, at the time I assumed this was normal and appropriate. ... I now have a different perspective".*

19.17 MAP Consultant Psychiatrist 1 also commented that:

*"In reference to having 10 minutes to discuss patients between the junior doctor and the Consultant, although there was a finite time to discuss cases, if a case needed more than 10 minutes to discuss this was facilitated. Cases were discussed in and out of supervision slots".*

19.18 At interview with the Independent Investigation Team, MAP Consultant Psychiatrist 1 stated that there was no policy in place for an 'audit' of supervisions of Doctors in Training, but that this *"would be a good idea"*.

19.19 There is an inherent risk in medical training across all specialties in that a medical supervisor is in many instances reliant upon the information which they receive from a junior colleague in order to advise about the best course of action for a patient and their care. If that information is for whatever reason incomplete or could be framed differently, then problems can arise including patient safety issues.

19.20 It is clear that on both occasions which Trainee Psychiatrist 1 saw Donna, it is recorded in his records that a discussion took place with MAP Consultant Psychiatrist 1 concerning her ongoing care. Details of the discussions including the flow of information between MAP Consultant Psychiatrist 1 and Trainee Psychiatrist 1 are not included in Donna's records. Equally, neither MAP Consultant Psychiatrist 1 nor 2 have made any entries concerning their views upon Donna in her medical records.

19.21 The Independent Investigation Team has not been provided with any records of Trainee Psychiatrist 1's discussions with his supervisor about Donna's care and treatment at his weekly supervision meeting.

19.22 In addition, there are no written records relating to any discussions which took place involving Donna at any Team or MDT meeting. The letters which Trainee Psychiatrist 1 wrote to Donna's GP on 9 January 2013 and 29 November 2012 following his two consultations with Donna, do not appear to copy his supervisor

in.

- 19.23 The Trust has provided the following statement of opinion regarding the level of supervision of Trainee Psychiatrist 1:

*“With regard to the supervision of the CT1 the internal investigation was provided with evidence that:*

- the team consultant provided regular supervision as well as an ‘open-door’ policy so that trainees could discuss their cases with him outside of the allocated supervision sessions.*
- Clinics were overseen by the team consultant and he could be, and was, consulted during clinics as referred to in the report”.*

*“The CT1 undertook three assessment/reviews of Ms DO and on each occasion he consulted a consultant colleague before concluding the review and the plans were discussed by the MDT shortly afterwards”.*

*“Therefore the Trust is confident that the level of supervision was appropriate. Furthermore we were assured that it would be entirely unremarkable for the CT1 doctor to undertake assessments of a patient presenting as Ms DO did with this level of supervision”.*

- 19.24 The Independent Investigation Team accepts that there is good evidence which suggests that Trainee Psychiatrist 1 was able to discuss Donna’s care with his supervisor during clinics which took place on 16 November 2012 and 31 December 2012 and indeed that MAP Consultant Psychiatrist 1 operated an ‘open door’ for his trainees. The Independent Investigation Team’s concerns about the level of interaction between Trainee Psychiatrist 1 and MAP Consultant Psychiatrist 2 on 17 December 2012 are more fully set out at Paragraph 18.57.

- 19.25 However, it is not clear from Donna’s records what information was included in these discussions and indeed the discussions which were undertaken in the MDT meetings as this information is not included in Donna’s medical records. The lack of a written record of these discussions is a cause for concern.

- 19.26 Further, whilst the means of supervision which was adopted in this case ostensibly allowed for input from MAP Consultant Psychiatrist 1, it contributed to care being provided to Donna as a series of ‘one-off’ consultations rather than care being delivered reflectively in response to Donna’s evolving clinical presentation. The Independent Investigation Team has not been provided with any evidence that Trainee Psychiatrist 1 and his supervisor discussed Donna as part of his supervision meetings or as part of a structured review of Donna’s care.

- 19.27 During the course of interviews conducted by the Independent Investigation Team, MAP Consultant Psychiatrist 1 made the following observation:

*“I think the thing with this lady, I think her anxiety was probably quite prominent but on reflection there was obviously some real depressive symptoms there as well. And I think perhaps our response was more around the anxiety side of it.*

*And even then it was quite disjointed”.*

19.28 Consultation: 31 December 2012:

19.29 During the course of the consultation on 31 December 2012, Donna’s mother was clearly attempting to advocate upon her daughter’s behalf and made a complaint about the delay which she was experiencing in receiving a key element of care for anxiety.

19.30 However, what is striking for the Independent Investigation Team was that MAP Consultant Psychiatrist 1 (Trainee Psychiatrist 1’s clinical supervisor) was conducting a clinic at the same time as Donna’s appointment; indeed, he had spoken to Trainee Psychiatrist 1 during the course of that consultation. In interview MAP Consultant Psychiatrist 1 stated:

*“I would have been available for appointments. But because of my own clinic, if you like, I was more stretched but I still had availabilities to see people on an urgent sort of basis if you like, and bring them in”.*

19.31 The question arises as to why MAP Consultant Psychiatrist 1 did not take this opportunity to discuss Donna’s concerns with Donna and Trainee Psychiatrist 1 at the point when the concern was raised or at a meeting arranged shortly afterwards. This would have provided both a training opportunity and an opportunity to review Donna’s care. It might also have provided a better way of dealing with Donna’s concerns and maintaining a positive clinical relationship with services.

19.32 During the course of the Independent Investigation, the Trust very helpfully provided the Independent Investigation Team with information which is provided to clinicians to assist them in their role as supervisors. Within this information is material which is intended to help supervisors support trainees who for whatever reason maybe struggling. It highlights the fact that there are some potential early warning signs. These include, complaints made by patients, poor records, inappropriate investigations and a failure to follow guidelines.

19.33 MAP Consultant Psychiatrist 1, in evidence given at Donna’s inquest and to the Independent Investigation Team, stated that he was aware that the SAD Persons Tool used by Trainee Psychiatrist 1 was not a tool which was authorised by the Trust. This was confirmed in a subsequent interview with Independent Investigation Team when it was said:

*“he used this SAD person’s score which is something that’s not kind of part of our usual assessment tool or anything like that. So I think it was slightly out of the ordinary that he would use that person’s score<sup>64</sup>”.*

19.34 MAP Consultant Psychiatrist 1 was on leave on 17 December 2012. He confirmed in interview that he did not have sight of the documentation provided to the Trust by Rotherham as it had not been entered onto the ePJS system. In

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<sup>64</sup> Independent Investigation Team interview with Consultant Psychiatrist 1, Maudsley Hospital, 23 February 2015.

this regard, the Serious Case Review of the Circumstances surrounding the death of Zaki published in January 2014 stated:

*“5.1.27 It is acknowledged that this was the CT1 psychiatrist’s first community mental health post and his supervision by senior colleagues was not sufficiently robust to highlight deficiencies in his note keeping which were identified by the SLaM Agency Reviewer. It was however noted in the SLaM Report that following this incident, CT1 psychiatrist ‘was able to rectify this deficit in record keeping’.”*

- 19.35 Further, MAP Consultant Psychiatrist 1 confirmed that he was aware that Donna and/or her family had made a complaint, albeit that Trainee Psychiatrist 1’s expressed view was at that time that the complaint related to the delay in receiving psychological therapy.
- 19.36 Finally, Donna had an appointment with Trainee Psychiatrist 1 on 17 January 2013. Instead, she attended A&E. A record of the entry made by Bank Nurse 1 is included at paragraph 21.30. It is clear that the impression which Bank Nurse 1 obtained was that Donna wished to be seen a doctor other than Trainee Psychiatrist 1 and took steps to convey this to Trainee Psychiatrist 1’s supervisor.
- 19.37 Given the very early stage which Trainee Psychiatrist 1 had reached in his specialist training, these issues could have been viewed as ‘early warning signs’ in relation to the care of Donna that there may have been an issue which would have necessitated a structured review of the patient’s care.
- 19.38 The arrangements concerning the supervision of Trainee Psychiatrist 1 are more fully set out at Paragraph 12.35.

**Comment Eight:**

Trainee Psychiatrist 1 was at a relatively early stage in his psychiatric training.

At this stage, Donna’s care had not been reviewed by a Consultant; and as a result, significant reliance was being placed on the clinical evaluation of Donna by a junior member of the MAP East Team. However, there were potential ‘warning signs’ that Trainee Psychiatrist 1 may have been struggling.

In order to ensure that there were no patient safety issues attached to the lengthy wait for CBT, Donna’s mother’s complaint could potentially have provided MAP Consultant Psychiatrist 1 with an opportunity to review Donna’s care in order to establish whether the delay in obtaining access to IAPTS could prove detrimental. It would also have allowed for consideration of whether an alternative framework to support Donna could be put in place whilst she awaited access to IAPTS.

It could also have provided a training opportunity for Trainee Psychiatrist 1 and potentially reduced the levels of distress experienced by Donna and her mother, which may have had an impact upon their on-going relationship with services, although this opinion may be speculative.



Instead, Donna's mother's complaint was directed for an 'organisational response' which meant that the matters giving rise to the complaint were not dealt with at an early stage which would have benefited Donna as well as those involved in her care.

One of the principles of good complaint handling is the idea of 'nipping the complaint in the bud'. This approach provides a better chance of resolution of the complaint prior to the escalation of the complaint to the point where an 'organisational response' is required and resolution is more difficult to achieve as the opportunity to influence the delivery of patient centred care is lost until the organisation has had an opportunity to determine the 'validity' of the complaint.

In addition, the Independent Investigation Team is concerned about what is, in its opinion, the disproportionate impact which the reference to a complaint had upon Donna's care as, in the opinion of the Independent Investigating Team, it appears to have acted as a 'barrier' to Donna's care when she subsequently approached other services within SLAM.

The most recent CQC report into the Trust, published October 2017, did state the following in relation to "listening to and learning from complaints";

*"Most patients know how to make a complaint. Staff responded to complaints appropriately, taking action as needed. Managers shared learning from complaints with their teams<sup>65</sup>".*

## 20 JUNCTURE SEVEN: ACTION TAKEN FOLLOWING DONNA'S ATTENDANCE AT A&E ON 17 JANUARY 2013

- 20.1 This is a juncture in Donna's care because following this attendance at A&E Donna had no further involvement with services.
- 20.2 Attendance at A&E on 17 January 2013:
- 20.3 When Donna attended A&E on 17 January 2013 following concerns raised by her sister, she was seen by Bank Nurse 1, a nurse in A&E. Bank Nurse 1 was working in the Croydon HTT at the time but undertook overtime shifts with the Psychiatric Liaison Team. Once again, Donna was faced with the distressing prospect of re-telling her story and in particular, the distress of her uncompleted suicide attempt in Rotherham.
- 20.4 The Internal Investigation Report states:
- "She was seen by a bank nurse as the PLN team were on an away day however the nurse had PLN experience".*
- 20.5 Bank Nurse 1 had access to Donna's records. Her conclusion was noted as:
- "Despite there not appearing to be any immediate risk to self DO is in distress and would benefit from an urgent medical review with a view to considering medications to help stabilise her with the help of CBT as she may be unable to fully engage in CBT until the anxiety lessons.*
- ...I also advised her that I would request an urgent OPA and for someone to contact her to provide some follow up".*
- 20.6 Bank Nurse 1 contacted Trainee Psychiatrist 1 later that day. A note made by Trainee Psychiatrist 1 states:
- "DO DNA'd her OPA today.*
- It appears her sister called an ambulance because she was worried about suicidality".*
- 20.7 Evidence given to the Internal Investigation Team was that Bank Nurse 1 was of the view that Donna was *"very anxious"*. However, the impression which was given was that there *"wasn't much risk... She was not actively suicidal and her son was a protective factor"*.
- 20.8 The Independent Investigation Team notes that Donna failed to attend an appointment with Trainee Psychiatrist 1 on 17 January 2013. However, the electronic patient record does not contain any indication that a patient appointment letter was ever generated in respect of this appointment. However, the appointment is referred to in a letter to Donna's GP dated 10 January 2013.
- 20.9 In Trainee Psychiatrist 1's letter to Donna's GP dated 10 January 2013, Donna

and her mother are described in the following terms:

*"Mother and daughter are exacerbating each others anxiety, neither appear to retain information well during consultation".*

20.10 The failure to send a letter confirming details of the appointment on 10 January 2013 when a letter was sent to Donna's GP may have contributed to Donna's failure to attend the appointment on 17 January 2013.

20.11 The Independent Investigation Team is of the view that it is necessary to use an approach that took account of the impact of Donna's anxiety and the difficulties which this could generate for Donna including the challenges which she might face in keeping appointments for whatever reason. Indeed, there may have been clinical relevance in Donna's expressions of *"not wanting to be around anymore"* made to her sister on 17 January 2013 and the fact that she had an appointment with MAP on 17 January 2013. Individuals with chronic suicidal ideation may be frustrated with the progress of interventions or treatment or use suicidality as a way of communicating distress.

20.12 Notwithstanding this, Bank Nurse 1 made the following entry in Donna's records on 17 January 2013:

*"Email sent to MAP East requesting follow up and assessment to be faxed to GP".*

20.13 Evidence given at Donna's inquest in relation to this email was that it was sent at 16.39 on 17 January 2013. The email was addressed to MAP Consultant Psychiatrist 1, it stated:

*"Please can you look up DO and offer her an urgent OPA and/or duty appointment in the meantime. There does not seem to be any immanent (sic) or immediate risk to herself but her family are concerned and I worry the risk will increase if she doesn't get any respite".*

20.14 There is an 'empty' entry in ePJS in respect of 22 January 2013. The only information relating to that entry is *"[MAP Consultant Psychiatrist 1] Croydon East Team"*. There is nothing in Donna's records to confirm what this entry relates to. However, evidence given by MAP Consultant Psychiatrist 1 at Donna's inquest stated that he responded to this request in an email at 17.06. This email was copied to a team administrator who was tasked with offering Donna an appointment. The email stated:

*"No problem (administrator) could we offer this lady an appointment with me on Tuesday 22 January at 11 am. At TRRC please. The lady booked in for that time has already been seen. We can also tell this lady to come to duty before then if she feels that she is in crisis".*

20.15 Despite this instruction, which is not referred to in Donna's records, an issue in itself, it is not clear whether this instruction generated an appointment letter and if so when. The evidence given by Donna's mother on this point is unequivocal

and is to the effect that no appointment letters were received.

- 20.16 There is no evidence in Donna's electronic records which would support the generation of an appointment letter on 17 January 2013. However, a letter was generated by MAP to Donna dated 21 January 2013 offering her an outpatient appointment on 29 January 2013 with MAP Consultant Psychiatrist 1 on 29 January 2013, some 12 days after her attendance at A&E and outside the 7-day follow up target. Donna did not attend this appointment. Evidence given to the Independent Investigation Team by Donna's mother was that Donna did not receive this letter. The letter was not copied to Donna's GP.
- 20.17 A further appointment (18 February 2013) is referred to in Donna's records in an entry made by Trainee Psychiatrist 1, but this does not appear to have been the subject of any letter or entry in the electronic record system. Accordingly, the Independent Investigation would question whether Donna was made aware of this appointment.
- 20.18 As is more fully set out at Paragraph 12.23 above, at the time of Donna's care, the Trust were aware that an issue faced by the MAP East Team was administrative support. However, it is a matter of concern that notwithstanding Donna's mother's contention that a number of letters concerning appointments were not received by Donna, there was no evidence that the Trust took any action to follow up the appointments noted in Donna's medical records. This is a significant concern for the Independent Investigation team.
- 20.19 It is clear that Trainee Psychiatrist 1 felt a great deal of responsibility in helping to support vulnerable people and was concerned to conserve NHS resources. However, it is also clear that he had ambivalent feelings about the cause of Donna's expressions of suicidality which may have caused him difficulties in maintaining a respectful and non-judgemental attitude towards Donna's presentation. In turn this may have created a barrier towards building a positive working relationship which kept Donna and her perspective central. Communicating respectfully is an important way of keeping the focus on the individual and their story, rather than thinking and responding in terms that may be misinterpreted and create a barrier to developing a positive working relationship in order to help support the person over time to make sense of a crisis and foster hope for the future.
- 20.20 There is considerable and unacceptable confusion surrounding the provision of a follow up appointment to Donna; potentially, this meant that the risk which she posed to herself and others was not supported by services.
- 20.21 What is clear however, is that Donna's medical records do not provide a 'full' record of events because emails were not copied into her records and therefore were not available on ePJS, nor were copies of letters which were purportedly generated included in her records. A care coordinator may have been valuable in avoiding this problem by ensuring both continuity of care as Trainee Psychiatrist 1 left the MAP East Team but also by ensuring that the administrative arrangements necessary to sustain and support the continuity of Donna's care were in place.

- 20.22 Further, had the complaint made against Trainee Psychiatrist 1 been recognised by his supervisor and/or indeed the Trust, then there is a possibility that Donna's non-attendance at any appointments which were offered would have invoked a different response.

**Comment Nine:**

By 17 January 2013, Donna had been seen by three different individuals at SLAM, as a result of Trainee Psychiatrist 1's rotation to another part of the Trust her care would have been transferred to MAP Consultant Psychiatrist 1. Potentially, this ever changing flow of clinicians places an added burden on clinicians and patients alike. People can feel distressed and disrespected when asked to continually retell traumatising events. This is a problem that clinicians often have little control over; the problem can however, be eased by good communication. In this regard, it is a matter of concern that Rotherham AMHP's letter was not entered into the electronic record system nor indeed was clinically significant information relating to Donna's admission to ICU included in the references to this incident in Donna's records.

Research suggests that people can feel a sense of embarrassment and failure mixed with relief following an uncompleted suicide. It is important that clinicians recognise this and acknowledge the confusing feelings and trauma that an individual may experience. How mental health professionals attempt to instil a sense of hope and encourage individual responsibility is crucial to how individuals subsequently engage.

The Independent Investigation Team is concerned that little recognition was given to the way in which services were communicating with Donna following her suicide attempt in Rotherham and in particular how services were communicating with her about her access to care. Equally, no consideration was given in relation to the risk which she posed, nor how her engagement could be secured.

Donna's records state that she was told by Bank Nurse 1 that she would be given an urgent out patient's appointment with the MAP Team. It was clear that Bank Nurse 1 felt that this appointment was necessary as a means to managing on going risk. Notwithstanding the lack of evidence surrounding which appointments were in fact issued to Donna and with whom, an issue arises as to whether the manner in which the Trust was communicating with Donna at the time arises. In particular, whether sufficient consideration was given to the level of anxiety which she was experiencing at the time.

In addition, Donna was not given any opportunity to comment or intervene in relation to the transfer of her care. Whilst it seems that Trainee Psychiatrist 1 and Donna had not established a strong therapeutic relationship, the transfer of Donna's care may at this stage have exacerbated Donna's lack of optimism that she could access meaningful help, inadvertently contributing to feelings of

hopelessness and impacting adversely upon the establishment of a future therapeutic relationship with services.

**Recommendation Nine - Communication with patients following uncompleted suicide:**

The Independent Investigation Team recognises the work which has been undertaken by the Trust in relation to strengthening its systems concerning DNA's. If viewed from a procedural perspective, this represents a positive change following the time of Donna's care.

However, the changes which have been made are procedural in nature. The Independent Investigation Team is concerned that the manner in which the Trust communicated with Donna following her uncompleted suicide in Rotherham did not encourage her to remain engaged with the service.

In order to strengthen hope, thereby aiding recovery in an individual who has experienced this type of traumatic event, clinicians must recognise their role in helping patients understand their experience in order to assist them to move towards recovery.

The Trust is required to implement a suicide awareness training programme for its staff which addresses the following elements of care:

- a) the need to create and preserve hope;
- b) assist people to work through suicide towards achievable recovery and growth goals;
- c) integrate suicide care into recovery care.

It is recommended that implementation of this recommendation is audited by the Trust 6 months after inception of the training programme in order to assess its effectiveness.

## **21 OPENNESS TOWARDS FAMILIES**

- 21.1 A further issue that arises in relation to Donna's interaction with SLAM services in the period July 2012 – February 2013 is that of the duty of openness.
- 21.2 The National Patient Safety Agency (NPSA) published guidelines in November 2009 for NHS organisations on 'Being Open', which describe the importance of open and effective communication with patients.
- 21.3 The NPSA's Being Open framework provided a clear set of principles describing how NHS staff need to communicate with patients, their families and carers when something goes wrong. This means that an open and honest culture must exist throughout an organisation.
- 21.4 Since the time of Donna's care, a statutory duty of candour has been introduced. This is of particular relevance in all NHS interactions with patients and their families since the Francis Inquiry. However, doctors have had a professional duty of candour for many years. The new statutory duty of candour was introduced for NHS bodies in England (trusts, foundation trusts and special health authorities) from 27 November 2014.
- 21.5 It is the view of the Independent Investigation Team that SLAM services in Donna's case did not always appear to adhere to the ethos of the duty of openness towards families, specifically in relation to a series of complaints made by Donna's mother against SLAM in relation to their care and treatment of Donna.
- 21.6 Donna's mother:
- 21.7 Donna's mother was, for all intents and purposes, acting in a capacity as Donna's 'carer', although she was not recognised as such by the Trust. Not only did Donna and Zaki live with Donna's mother, but Donna's mother attended each appointment with Donna during the relevant period, made numerous phone calls on her behalf, and sent many emails in an attempt to progress Donna's care.
- 21.8 Whilst Donna's GP worked extensively in advancing Donna's care, this was nonetheless done from outside of SLAM. As has been shown in this report, Donna was not allocated a care coordinator within SLAM, and as a result, had no one within the organisation marshalling or coordinating her care.
- 21.9 Donna's mother was therefore, the sole advocate attempting to advance her daughter's interests within SLAM (in the absence of a designated care coordinator). Unfortunately, it appears to the Independent Investigation Team that this voice was not lent sufficient weight by the Trust, not only from the perspective of Donna's 'carer', but also in relation to the openness in response which the Trust gave to the complaints which she made on Donna's behalf.
- 21.10 Donna's mother's 'complaint' letters to her MP:
- 21.11 On 17 December 2012, shortly after Donna's return to London following her

uncompleted suicide in Rotherham, Donna's family emailed their local MP<sup>66</sup>. The email included reference to the family's concerns about the care of Donna and her failure to be offered care in her own home. It stated:

*"we are a loving close knit family , but this is one thing we are out of our depth with, it took my daughter to do this and to travel five and a half hours by train to be told by someone this crisis for home is on offer , so why was it not offered".*

21.12 It also included information about Donna's position on the waiting list;

*"After a week we went back to the doctor who referred Donna back to Tamworth Rd to see Trainee Psychiatrist 1 who diagnosed Donna with severe anxiety, he said that prompt CBT & counselling was needed,he (sic) gave me an IAPTS number to ring, when I rang the women (sic) said was I having a laugh as there is a six month waiting list and Donna was 89 on the list".*

21.13 The family sent a further email to their MP on 26 December 2012 and again on 31 December 2012, following their follow up appointment at MAP, Donna's mother again emailed her MP, asking why *"Donna was unable to get any treatment"*.

21.14 This email was forwarded by Donna's MP to the Trust on 8 January 2013. The email included the following expression of concern about the consultation which took place between Donna and Registered Mental Health Nurse 1 on 17 December 2012:

*"when we arrived at Tamworth Rd we saw a duty nurse and her colleague, we were told there is no help only waiting for her CBT they were going to refer Donna that day we had then told them Donna was on the waiting list but she was number 86, they prescribed tablets for Donna and her colleague continued to tell us she should be grateful for a roof over her head as some people that visited the centre did not have one...*

*...the following day I rang Bethem (sic) to find out where my daughter was then on the list, a colleague told me she was near the top I asked how long this could be , I was then told 2 days's (sic), weeks or months...*

*We then had a letter two days later to say they had not heard from Donna to say she if she wanted to stay on the waiting list and they have taken her off the list, I then rang again to speak to someone and I passed them to Donna, who then told me they would put her back on the list at no 46. How can this be to be told you are at the top of the list and now you have gone back another three months.*

*I do hope the people I have sent this email to will be able to offer some help or explanation to why this has happened".*

21.15 Trust Response to complaints:

21.16 On 14 January 2013, the following response was received by Donna's MP from

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<sup>66</sup> 10.32, 17 December 2012.



the Trust:

*"I would like to apologise that Mrs O feels that her daughter was been passed from one service to another, this is not our intention. My understanding is that an assessment was carried out at Croydon University hospital and at this point it was determined that the community team were the best service to offer support..."*

*In terms of the treatment options, DO was seen by a psychiatrist within the service who carried out a comprehensive assessment and discussed the care plan with DO and her mother, the plan outlined medication that could be used as well as identifying crisis interventions should they be required over the Christmas period. The care plan also identified the need for psychological therapy, referrals have been made to both IAPTS (Improving Access to Psychological Therapy Service) and to CIPTS (Croydon Integrated Psychological Therapies Service). Unfortunately these services both have waiting lists which are longer than we would ideally like and it is likely that Mrs O will be placed on the waiting list for these services".*

21.17 Concerns about Trust response to Donna's mother's complaints:

21.18 The Independent Investigation Team has the following concerns about the response which the Trust provided to Donna's MP;

21.19 Firstly, the response does not address the specific concerns raised by Donna's family which questioned why Donna had not been offered care from the HTT or the reason for the change in Donna's position on the IAPTS waiting list.

21.20 Secondly, the response from the Trust is 'confused' in terms of the chronology of Donna's care, and erroneous in relation to the fact that Donna had already been placed on the IAPTS waiting list when the complaint to the Trust had been submitted by her carers. Indeed, the concern was the reason for the change in Donna's position on that waiting list.

21.21 Thirdly, the Trust response whilst providing an explanation, did not direct that explanation at Donna or her carer's but instead it was contained within the letter to their MP. In addition, the complaints did not generate any other contact with Donna or her clinicians in order to review her care or propose an action plan to address her actual concerns.

21.22 The Trust has provided the Independent Investigation Team with the following explanation for the approach which was adopted:

*"There is a statutory (sic) instrument that provides MPs with privileged access to clinical information avoiding the bureaucracy of the formal complaint process and ensuring a quick resolution. Emails received from the family by the local MP were forwarded to the Service Director for MAP on 17 December 2012 and 8 January 2013. The MP was contacted by the officer investigating the inquiry which is recommended practice The Service Director wrote personally to the MP on 14 January 2013 outlining the plans to manage Ms DO's care. As no further*

*correspondence was received either from Ms DO, her mother or their MP the matter was understood, reasonably, to have been concluded to their satisfaction”.*

21.23 As is noted in Paragraph 21.27, it is clear that Donna’s mother remained dissatisfied with care which her daughter was receiving and advised the Trust accordingly through discussions with members of its clinical team.

21.24 The Independent Investigation Team is of the view that the Trust’s response to Donna’s complaint constituted an ‘organisational response’ which may have complied with Trust protocols regarding response to complaints, but crucially it failed to address the issues which were at the core of Donna’s concerns. Further, if it had been explored, the complaint could potentially have been of benefit in the delivery of Donna’s care and in establishing a more favourable relationship with her carers.

21.25 As a result of these issues, the Independent Investigation Team is of the view that the Trust lacked openness in how it approached Donna’s complaints. It is the view of the Independent Investigation Team that the response could potentially be construed as being potentially misleading in that it states that she saw a ‘psychiatrist’, which may be seen to imply a fully qualified specialist, when in fact she had seen a ‘trainee’.

21.26 The ‘complaint’ against Trainee Psychiatrist 1:

21.27 At the MAP follow up appointment of 31 December 2012, Donna and Donna’s mother saw Trainee Psychiatrist 1. They informed Trainee Psychiatrist 1 that they were going to complain, in response to which Trainee Psychiatrist 1 said, *“So, if you’re unhappy, you should make a complaint”.*

21.28 The MAP record for that appointment recorded that *“seen mother who says she will not leave the consulting room without a date for intensive psychological therapy and if she does not get it she will contact her MP”.*

21.29 Later that day following the consultation with Trainee Psychiatrist 1, Donna’s mother contacted her MP once again because she *“was beside herself with worry for Donna”.*

21.30 The action taken by MAP Consultant Psychiatrist 1 in relation to this complaint has already been considered.

21.31 On 17 January 2013, Bank Nurse 1’s entry in Donna’s notes states that *“they are pursuing a complaint against CT1 (Trainee Psychiatrist 1) (East Croydon MAP)”.*

21.32 The Trust has responded to this concern in the following terms:

*“as far as the Trust is aware, no formal complaint was ever received in relation to this doctor.*

*Efforts were made to resolve concerns raised by Ms DO and her mother on 31 December 2012 in relation to the waiting list for CBT. ... He escalated the*

*concerns immediately to his supervisor to allow for reflection on the treatment options available and the options were then discussed with Ms DO and her mother.*

*If such initial attempts to resolve a complaint are unsuccessful it is entirely reasonable and consistent with Trust guidance to refer a complainant on to the formal complaints process – as was done in this instance”.*

- 21.33 Notwithstanding these comments, Donna’s medical records make it clear that on 17 January 2013, during the course of an attendance at A&E, it was recorded by Bank Nurse 1:

*“It was initially difficult to get to the bottom of why she was here today due to the anxiety both from DO and her mother. My impression following the assessment that she has come to try and get help and for her NHS funded CBT to be available sooner and to see another Dr as they are pursuing a complaint against Trainee Psychiatrist 1”.*

- 21.34 Bank Nurse 1 communicated her concerns about Donna to MAP Consultant Psychiatrist 1 and requested that he *“look up DO and offer her an urgent OPA and/or duty appointment in the meantime”.*

- 21.35 Further, an entry made by Trainee Psychiatrist 1 on 17 January 2013 includes the following:

*“she will also need her 7 day follow up, it’s not appropriate that its me, because apparently they are making a complaint against me”.*

- 21.36 As has been noted at paragraph 20.14, Trainee Psychiatrist 1’s supervisor, MAP Consultant Psychiatrist 1 responded to Bank Nurse 1 by email offering an appointment with himself.

- 21.37 The Trust has made the following response:

*“The account of a complaint against the CT1 on 17.01.2013 was in the context of a report from MS DO and her family. No formal or verbal complaint about the CT1 was received by the Trust”.*

- 21.38 The Trust’s current website states in relation to how a complaint should be made:

*“The best way to make a complaint is to speak to a member of staff who is involved in your care. If you do not feel comfortable talking to someone directly, you can ask for someone independent to help you. The complaints team can tell you more about this.*

*If staff have been unable to resolve your concerns and you want to make a formal complaint you can contact the Trust’s Chief Executive or Complaints Department”.*

- 21.39 This position would, in the opinion of the Independent Investigation Team, appear

to be at odds with additional information provided by the Trust, which states;

*“When a staff member is notified by any complainant that they have submitted a complaint the staff member will reasonably trust that the complaint is being investigated as part of the accepted process. There is no duty on the staff member to check on this process in fact it may be seen as interference with the process were a staff member to do so”.*

- 21.40 As has been stated, Trainee Psychiatrist 1 was at an early stage in his training. The consultation on 31 December 2012 in A&E was the first point at which it had become clear that Donna and her family were concerned about the care and treatment of Trainee Psychiatrist 1. Accordingly, this constituted a new complaint and should have been actioned as such in accordance with Trust policies. There was no evidence that any action was taken in this regard.
- 21.41 Despite his supervisor being made aware of a patient’s possible concerns about care in which he was involved, the Independent Investigation Team remains concerned that this issue was not followed up as a complaint, notwithstanding the fact that it was not communicated to the Trust in accordance with its formal procedures, procedures which may not have been made clear to Donna and her family at a time they were experiencing significant challenges.
- 21.42 As stated above in relation to the complaints which were made to Donna’s MP, neither Donna, nor her mother, received any acknowledgment of the complaint from the Trust either formally, or even informally. The reason for this was not established by the Independent Investigation Team. However, the explanation provided by the Trust set out at Paragraph 21.21 is relevant in this regard. No evidence was produced to the Independent Investigation Team that the Trust took any practical steps to address the concerns which were actually raised by Donna’s mother.
- 21.43 The significance of these complaints:
- 21.44 Complaints can be useful if, for no other reason than as a ‘spotlight’ for overwhelmed, busy service providers to recognise a warning sign in a particular area of its service provision and investigate that area further in the ‘here and now’ to see if the complaint is warranted.
- 21.45 Most complainants are hoping that their concerns are acknowledged quickly, their fears allayed, apologies provided, and that learning has been achieved. Donna’s mother made significant efforts to make a complaint in an attempt to re direct her daughters care. She had attempted face to face and written contact in an attempt to have her views heard.
- 21.46 This was not recognised by the Trust.
- 21.47 The response which she received was aimed at a ‘high level’; had anything more than a cursory review of her case been carried out on or around 31 December 2012 the following would have been clear:

- Lack of a care coordinator;
- Failure to follow up referral to Social services about Zaki;
- Failure to be included on ePJS;
- Failure to attend further appointments.

21.48 This in itself could have suggested that a review of Donna's care may be necessary or indeed action was required to ensure that Donna was able to engage with services.

21.49 However, what appears to have happened in this case is that Donna's mother's attempts to advocate for her daughter in order to gain access to services had the opposite effect and had an unnecessarily adverse impact upon her care. The Service Lead for Croydon IAPTs described what happened in the following terms:

*"I think understandably, her parents were trying desperately to get as much help as they possibly could for her. They fired out lots of letters in lots of directions; understandably, but actually, what happened was that created quite a lot of confusion".*

21.50 In the opinion of the Independent Investigation Team based on all of the evidence it has considered during the course of this investigation, there was a defensive culture operating by the Trust in relation to complaints, instead of a willingness to listen and learn when a complaint is received.

21.51 A Trust 'report to the Trust board'<sup>67</sup> as recently as December 2017 found based on the Trust's own internal audit for the year 2016/17, under the heading "Learning"<sup>68</sup>;

*"The Trust is not consistently meeting its Duty of Candor....An improvement plan is in place. The audit was presented to the Quality Committee November 2017; the committee will take a report on 2017 – 2018 data when available"<sup>69</sup>.*

21.52 Further, the Independent Investigation Team acknowledges that the CQC report published in October 2017 did find;

*"Staff knew and understood their responsibilities in relation to the duty of candour...staff understood the importance of transparency...were aware of their duty to inform patients when things went wrong...described incidents where they had informed patients and carers of mistakes and apologised..."<sup>70</sup>*

21.53 During the course of the Independent Investigation, the Independent Investigation Team was provided with a significant amount of material by the Trust which indicated a good understanding and the practical steps which must

<sup>67</sup> 'Q2 report Lessons Learned', SLAM REPORT TO THE TRUST BOARD: PUBLIC, 19<sup>th</sup> December 2017.

<sup>68</sup> At page 3.

<sup>69</sup> *Supra*, p3.

<sup>70</sup> Page 25

be taken to ensure that it was able to work with carers and share information appropriately. This is an element of good practice.

21.54 The Independent Investigation Team was provided with a copy of the *'Family and Carers Strategy 2015 to 2019'* together with a copy of the Guidance which was prepared for staff in relation to the Introduction of a *'Carers Engagement and Support Plan'* and which is dated 12 December 2016. This document reflects changes in the Care Act 2014 and is aimed at ensuring compliance with NICE and other practice guidance including the Triangle of Care.

21.55 The Independent Investigation Team was also provided with a *'Families and Carers Handbook'*. The Handbook provides carers and family members about 'Concerns or complaints'. It states;

*"Please tell us if you have any concerns or complaints. We want you and the person you care for to get what you want".*

21.56 The handbook then provides the following advice about how to complain and offers the following three suggestions; care coordinator, PALS or complaints team. As has been stated at Paragraph 15.10, the Trust is of the view that Donna was in an 'assessment phase' (although as mentioned, the Independent Investigation Team has no contemporaneous evidence in support of this). In either event, it is possible that an individual in this 'phase' would not have the benefit of a care coordinator.

21.57 That being so, the only recourse which a carer would have would be to direct a complaint towards PALS or the Trust complaints team. Neither option allows immediate access to those delivering care on a day to day basis, and both encourage an 'organisational response' to a complaint, rather than offering an opportunity to direct care at a practical level.

#### **Comment Ten:**

An effective complaints system provides essential feedback. It serves as a quick, cost-effective and efficient means of resolving complaints and improving service delivery. It also provides an assurance to service users that their complaints are being taken seriously and that they are being treated properly, fairly and impartially.

This requires a culture that recognises the complainant's right to complain and have that complaint taken seriously, not simply the availability of vehicles to promote a complaint to be made.

It also provides the mechanisms for complaints to be addressed in an efficient, fair and timely manner.

Management commitment should be shown by the provision of adequate resources, including training. Furthermore, the ability to acknowledge complaints should be seen as a strength rather than a weakness.

The Independent Investigation Team could not see any evidence of such a culture being present within the MAP service in relation to the complaints made by Donna's mother.

### **Recommendation Ten – Complaints Policy**

The Independent Investigation Team recognises that Donna's complaint dated 31 December 2012 was not fully addressed. In addition, in answering complaints, the Trust did not 'involve' Donna's mother in their response.

It is recommended that:

1. The Trust reviews its training requirements for individuals who are tasked with responding to complaints to ensure that the duty of openness is applied to all complaints in order to ensure that all elements of complaints are addressed accurately.
2. The Trust reviews its complaints policy to ensure that complaints are used as a vehicle to drive improvements in care.

### **Recommendation Eleven - Response to complaints about the care of patients treated by junior doctors:**

1. MAP Trainee Psychiatrist 1 was in an early stage of his clinical practice as a psychiatrist. The complaints made about the care of Donna by her mother would have given his clinical supervisor an opportunity to ensure that there were no patient issues involved in Donna's care as well as presenting a training opportunity for a junior doctor.
2. It is recommended that the Trust introduce a protocol regarding the response by the supervisor to a complaint involving the care of the patient being treated by a junior doctor. This protocol should include the following elements:
  - a) Highlight early warning signs that a trainee maybe struggling;
  - b) Early meeting with the patient or their carer and the supervisor;
  - c) The option to transfer care to another clinician.

## 22 RESPONSE TO INCIDENT BY HEALTHCARE PROVIDERS

- 22.1 It is hoped that this report has shown the principle failings in Donna's care, the areas in which SLAM services did not act and could have, and those in which, when they did act, they may have chosen a different pathway.
- 22.2 As part of the Terms of Reference, the Independent Investigation Team has been tasked with an analysis of the Trust's response to the tragic incident, comprising, amongst other things, a review of the Trust's internal investigation, performed in the aftermath of events, and a series of 'focus groups', to ascertain where, if at all, changes have been made since the event.
- 22.3 Revisiting the Trust's internal investigation:
- 22.4 The Independent Investigation Team acknowledges that there were positives to be taken from the internal investigation and lessons learnt such as;
- It is comprehensive in its scope;
  - It included the requisite expertise;
  - It makes tangible recommendations.
- 22.5 As mentioned above, the Independent Investigation Team is conscious of the ease with which 'hindsight bias' can enter into perceptions of events after the fact, and this has been borne in mind when considering the internal investigation.
- 22.6 The Independent Investigation Team also acknowledges that since the Incident, the situation in relation to service users such as Donna has changed on a national level; we now have the Care Act (2014), the Duty of Candour and revised national guidance on serious incident investigations.
- 22.7 However, the findings of the Independent Investigation Team are that the main areas not adequately addressed in the Trust's internal investigation were as follows;
- The failure to adopt a reflective practice in relation to Donna's presentation;
  - The actions taken by the MAP East Team in relation to the report prepared by Rotherham AMHP;
  - How the Trust interacted with Donna's family;
  - How Donna's mother's complaints were handled;
  - The impact of the organisational challenges being experienced by the MAP East Team;
  - In addition, the Independent Investigation Team was disappointed to note that a recommendation made by the Internal Investigation suggesting the use of telephone contacts to establish whether patients intend to remain on the waiting list was rejected on the basis of being impractical to implement without further information.



- 22.8 Views of individuals involved in Donna's care:
- 22.9 The Independent Investigation Team recognises that an action plan was produced by the Internal Investigation Team following the death of Donna and Zaki based upon its findings.
- 22.10 However, the Independent Investigation Team noted from the interviews conducted with clinical staff following Donna's death that a number raised their views about the difficulties which they experienced in relation to patients with anxiety. A number mentioned that they would benefit from additional training. However, this was not made the subject of a recommendation in the Internal Report. This is a matter of concern.
- 22.11 Openness with Donna's family:
- 22.12 The SUI includes a section entitled 'Being Open and Staff Support'. It states:
- "The investigation team had contact with [Donna's] mother, Mrs CO, throughout the investigation. She contributed to the terms of reference and provided valuable information to the investigation. She was informed of developments and any issues regarding the investigation process. The investigators plan to feed back the draft investigation report to [Donna's mother] before it is finalised".*
- 22.13 Information provided to the Independent Investigation Team by Donna's mother stated:
- "Following the SLAM investigation we received the SLAM report which we studied at some length and compiled a response with our comments. I wish to put on record that I was horrified at this report in regard to the errors and omissions made. I was offered an opportunity of a meeting which I declined".*
- 22.14 The Trust has provided the Independent Investigation Team with the following comment:
- "The Trust believes that the internal investigation team made every effort to engage with Ms DO's mother throughout the investigation process and during the finalisation of the internal report. Ms DO was kept fully informed throughout. Ms DO sent an email to the investigation team thanking them for their help and cooperation throughout the process".*
- 22.15 What is striking about the SUI is that there is no reference to any consideration of the 'valuable information' provided by Donna's mother, and in particular her account of Donna's care which she attended. Nor have her concerns been addressed, rather they have simply been highlighted in the footnotes of the report. Had the issues raised by Donna's mother been included in the internal investigation, the Independent Investigation Team believes that further learning could have been 'unlocked'.
- 22.16 The Trust has provided the following comment upon this concern;

*“the SLAM investigation team received input from Ms DO’s mother. The Trust’s internal investigation report was reviewed, revised and where they could not be reconciled with the facts a decision was taken to include them in the final report as footnotes to ensure that they were fully represented and footnotes entered”*

- 22.17 The Independent Investigation Team has been provided with a significant number of emails which confirm that the Internal Investigation Team did indeed have a significant amount of contact with Donna’s mother during the course of their investigation and footnotes were entered into the internal report reflecting Donna’s mother’s commentaries. However, the commentary which she provided could have generated a further level of inquiry, which in itself, could have provided learning, in addition to addressing Donna’s mother’s concerns.
- 22.18 For example, the SUI refers to four follow up appointments which were sent to Donna. The apparent conclusion was that in not responding to the appointments, Donna had ‘disengaged’ from services. Donna’s mother’s evidence to the Internal Investigation Team was that the letters were not received. Indeed, the Trust’s own records are inconclusive on this point. Consequently, the conclusion that Donna ‘disengaged’ cannot be established from the evidence which was available to the Internal Investigation Team. In the view of the Independent Investigation Team, it could be perceived that sending four appointments was not the most prudent course of action in that one method of communication may have failed, but the option to try another means, such as a phone call or email, to the patient or GP, may have proven more successful. Further investigation in this regard by the Trust could therefore have been indicated in order to unlock learning for the Trust.
- 22.19 A further significant example arises in relation to the information concerning Donna’s uncompleted suicide in Rotherham. Whilst the Report refers to the fact that the Rotherham correspondence was not loaded into the ePJS, the significance of this issue is not considered as means of gaining a better understanding of the incident and consequently Donna’s presentation.
- 22.20 In addition, the Independent Investigation Team is concerned about the fact that this could also have had an impact upon the level of distress experienced by Donna’s mother as a result of the investigative process which followed the death of her daughter.
- 22.21 Interaction with Donna’s family following Donna’s and Zaki’s death:
- 22.22 A further concern for the Independent Investigation Team is the approach taken by the Internal Investigation towards the practical arrangements surrounding the Trust’s meetings with Donna’s family.
- 22.23 During the course of the Internal Investigation, meetings were scheduled with Donna’s family around the time that discussions were also being held with the clinicians involved in Donna’s care. This led to a very traumatic ‘meeting’ in the ‘waiting area’ prior to Donna’s meeting with the Trust.
- 22.24 This situation has caused enduring concern to all of those involved in this

encounter.

22.25 The Trust has provided the following response to this concern:

*“The Trust accepts that there was an extremely regrettable incident around the scheduling of meetings with the internal investigation team. A fulsome apology was given at the time and measures put in place to ensure that such a meeting does not occur in future”.*

22.26 SLAM’s records:

22.27 As a final point in relation to the duty of openness in this case, the Independent Investigation Team discovered several documentary discrepancies in the records produced by SLAM in relation to Donna’s care. The discrepancies in the records relate to differences in the electronic versions of letters addressed to agencies such as Donna’s GP, the Coroner and the ‘paper’ copy of these letters which were sent.

22.28 In addition, it is clear that emails involving Donna’s care were not included in her records.

22.29 The Independent Investigation Team is concerned that as a result of the differences, a definitive version of Donna’s records does not exist. This is a matter of significant concern.

22.30 A further concern which the Independent Investigation Team has in this regard is in relation to a finding made by the Serious Case Review into the death of Zaki, which is more fully set out in section 19. This report, which was published in April 2015, refers to the ‘insufficiently robust’ supervision of Trainee Psychiatrist 1 in relation to his record keeping. However, this issue is not explored in the Trust’s Internal Report.

#### **Comment Eleven:**

The Independent Investigation Team found that a crucial piece of learning that must be taken from this incident relates to the way in which the families of victims are included and engaged with by investigating trusts, in accordance with the duty of candour and the developments as a result of the Francis Report.

This learning must not only be applied to dealing with families in the immediate aftermath of an incident, but also, in the process of, and way in which a trust proceeds to handle the execution and delivery of their internal investigation report.

#### **Recommendation Twelve – ‘Being Open’:**

The Independent Investigation Team recommends a Trust faced with a similar situation in future must treat the families of victims as individuals. As a result, the Trust must acknowledge the personal knowledge levels of the case itself.

The Trust must review its 'Being Open Policy' with a view to include guidance for internal investigation teams in relation to:

1. Demonstrate an understanding and sensitivity to the traumatic events family members with whom they will be have endured.
2. Arrangements surrounding meetings with families and carers following an incident are made with a view to minimising distress to all those involved.
3. Conflicts in evidence between must be explored in reports in order to demonstrate that the evidence given by family members has been taken into consideration.

22.31 Action Plan Resulting from Internal Investigation:

22.32 Following the Internal Investigation conducted by the Trust, an action plan was prepared for the purposes of implementing the learning derived from the care of Donna identified by the Internal Investigation.

22.33 The Trust has faced significant challenges in embedding some of the learning arising from this action plan.

22.34 The approach to embedding any change in an organisation must be holistic and systemic. All organisations are complex and dynamic systems, not simple and linear. As a result, a simple cause-and-effect approach to embedding change may not work. There are a number of organisational 'levers', such as recruitment, performance management, staff retention and training that are involved in embedding change.

22.35 A significant challenge for any organisation when attempting to make changes is the availability of resources. Relevant in this regard is the ongoing financial issues which are attached to the funding of mental health services in Croydon. The Independent Investigation note that the Trust is acting proactively and indeed effectively to improve recruitment and retention of staff which will have a positive impact upon its ability to embed change. It is also actively reviewing the manner in which it delivers services in Croydon in recognition of the challenges which it faces.

22.36 As has been shown in this report, the Independent Investigation Team has identified a series of what it considers to be 'gaps' in the Internal Investigation performed by the Trust, see for example paragraph 22.7 above.

22.37 It is the opinion of the Independent Investigation Team therefore, that as a result of those 'gaps' in the internal investigation, the ensuing action plan formulated by the Trust failed to encompass all of the learning which could have been derived from Donna's care.

22.38 Notwithstanding this, the Independent Investigation Team has assessed the

'Action Points' identified by the Trust in light of the information provided to it by the Trust during the course of this investigation.

22.39 COMMUNICATION OF AVAILABILITY OF TRUST SERVICES: LESSONS LEARNED 1

22.40 During the course of the internal investigation, Trust internal investigators spoke to Registered Mental Health Nurse 1 regarding the offer of Home Treatment to Donna.

*"The investigators asked the duty worker what her (sic) to describe the service provided by home treatment and she replied that they visit patients at home and give them medication. This incomplete explanation of the interventions offered by the Home Treatment Team in Croydon may have resulted in Ms Do and her mother misunderstanding the services offered and this was complicated by different terminology used by SLAM and by the mental health services in Rotherham".*

22.41 The following recommendations were made as a result of the Trust's Internal Investigation.

*"The investigators thought that a leaflet summarising the interventions provided by the Home Treatment Teams across the trust might have helped the duty worker explain what was available to Ms DO and her mother . Unfortunately the investigators could find no evidence of a service leaflets (sic) on either the Patient Information Service or Psychological Medicine website'.*

*Recommendation*

*The Psychological Medicine CAG works in partnership with the Trust Patient Information Service to provide an accessible leaflet describing the Home Treatment Team services across the Trust and the interventions they can offer".*

22.42 The Independent Investigation Team understands that a patient leaflet was introduced to address this concern. In addition, the Independent Investigation Team note that the Trust's website now contains a helpful description of Home Treatment for patients together with a useful video explaining the service. The description is as follows:

*'Home treatment is a way of helping people at home rather than in hospital. This can help to avoid the stress, anxiety and upheaval that can happen with a hospital admission. This can include daily or twice daily visits, and help with medication and sorting out practical matters such as accommodation and shopping'.*

22.43 Independent Investigation Team review of the Trust's progress in implementing their action plan

22.44 In the opinion of the Independent Investigation Team, in making this change, the Trust has acted appropriately to address one element of the problem which arose in Donna's case, in that she would now have had access to information in both a verbal and written format, confirming the services provided by the Home

Treatment Team. In doing so the action point from the internal investigation has been embedded.

- 22.45 However, the recommendation in the internal investigation and subsequent change pursuant to the action plan does not of itself, address the fact that questions remain as to the quality of information provided to Donna and her mother by MAP Nurse 2 in relation to the services offered by the HTT. As a result, all possible learning capable of being derived from Lessons Learned 1 has not yet, in the opinion of the Independent Investigation Team, been fully embedded.
- 22.46 The concern of the Independent Investigation Team is that the questions around the description of the Home Treatment Team by staff (and at the very least the lack of documentary evidence confirming what was offered) potentially indicates a lack of understanding on the part of Trust staff as to what the HTT could provide in order that this information could be accurately conveyed to patients. This issue was discussed at length in the Focus Groups convened by the Independent Investigation team as part of the investigation process.
- 22.47 Relevant Focus Group feedback:
- 22.48 The Independent Investigation Team recognises that a large organisation such as the Trust which provides services across four boroughs offering complex interventions, will have multifaceted interactions with different commissioners. This in turn can make the provision of a comprehensive list of services challenging, particularly given changes to the way in which services are provided by virtue of constant attempts to improve the quality of care delivered to patients. However, this lack of understanding of services presently available can adversely impact upon patient care if staff do not have an appropriate level of knowledge about individual services and their potential benefits
- 22.49 This is a challenge across the NHS. However, it is necessary for staff to understand the options available for patients to be able to provide complete and accurate information upon the services which are available.
- 22.50 Survey questionnaires sent out in advance of the Focus Groups conducted as part of the Independent Investigation suggested that 65% of respondents (who included Trust employees and stakeholders such as general practitioners), felt that understanding Trust services was “difficult” and “complex”. Similarly relevant in this regard is the lack of understanding expressed by Donna’s GP as to the nature of the HTT service available (see earlier in this report).
- 22.51 During the course of the Focus Groups, the problem was summarised as follows:  
  
*...“the Trust should be experts on what services are available, staff don’t educate themselves enough on what is available, but there is always change”...*  
  
*...“Really difficult to keep up – as soon as publish one set of data, the complexities in the service mean that things have changed. It is about understanding what’s available but also about relationships between the services across the CAGs and the 4 boroughs”...*
- 22.52 The issue was also highlighted in a recent CQC Report entitled ‘South London and Maudsley NHS Foundation Trust Community based mental health services

for adults of working age Quality Report<sup>71</sup>, published in October 2017. This report states in relation to “consideration of whether services responsive to people’s needs”

“We rated responsive as **requires improvement** because:

....There were barriers to effective patient movement along the care pathway.  
.....Patient transfers between teams were sometimes delayed because specialist teams lacked appropriate or sufficient staff, or staff were unclear about the referral criteria and thresholds of different teams”.

22.53 As a result, the CQC set out the following action which the Trust:

“**SHOULD** take to improve:

*The trust should continue to address barriers to effective patient movement along the care pathway. The trust should ensure that staff clearly understand their roles and responsibilities, clarify referral criteria and thresholds, ensure specialist teams can accept referrals, and support community staff to make more effective placement funding applications”.*

22.54 The Independent Investigation Team would concur with this recommendation made by the CQC in relation to this long-standing challenge encountered by the Trust.

22.55 INFORMATION SHARING WITH SERVICE USERS: LESSONS LEARNED 2

22.56 During the course of her care and treatment Donna was not provided with copies of correspondence or care plans relating to the care and treatment which she was given. This included copies of letters concerning her discharge from services such as that written to Donna’s GP on 13 November 2012.

*“The investigators found that there was poor awareness of the principles for sharing information with service users. Clinical staff confirmed that they were unaware that they have an obligation to give service user (sic) the option of being sent copies of correspondence , and the importance of documenting this choice on ePJS.*

*This was escalated to the service management with a suggestion that it could be highlighted to MAP team leaders as an early learning point”.*

*Comment from the Board Level Inquiry Panel*

*The panel concurred with the service management team’s disappointment that issues relating to the awareness and sharing of information with service users had arisen in this case. The panel were however pleased to hear that the operational policies across the four boroughs, within the CAG, had been revised.’*

22.57 Independent Investigation Team review of the Trust’s progress in implementing their action plan

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<sup>71</sup> Date of inspection visit: 17-20 July 2017. Date of publication: 31/10/2017.

- 22.58 The Independent Investigation Team notes that action was taken to escalate this “lesson learnt” to MAP team leaders as an early learning point. This is an element of good practice.
- 22.59 The NHS Plan 2000 made a commitment that patients/service users should be able to receive copies of clinician’s letters about them as of right. A working group convened by the Department of Health in 2001 set out the background to the initiative in a report dated February 2002. The DH subsequently issued “*Good Practice Guidelines*” in April 2003.
- 22.60 The principal aim of the DH policy was (and is) to improve communications between healthcare professionals and patients/service users and to increase patient/service user involvement in their care and treatment.
- 22.61 The provision of information to patient/service users to support their decision making in their care was a standard set by the NHS Litigation Authority in their ‘*Risk Management Standards 2013/14*’<sup>72</sup>. Trusts are no longer assessed against these standards, but they remain available to use to promote best practice.
- 22.62 The DH guidance relates particularly to letters, but the principles of sharing information can be applied to any documentation that refers to a patient. Care plans and discharge summaries are documents that should be copied to the patient/service user, provided the exemptions do not apply.
- 22.63 The ‘*Croydon Psychological Medicine and Integrated Care CAG (PMIC) Assessment Service Purley Resource Centre and Tamworth Road Resource Centre Operational Policy*’ was provided to the Independent Investigation Team during the course of this Independent Investigation. This document is dated November 2016. This policy refers to information-sharing with patients in the following manner:
- ‘All assessments should be shared with the GP in writing within five days of completing the assessment. The sharing of correspondence with service user should be agreed at the assessment, where appropriate’.*
- 22.64 ‘Correspondence’ is not defined in the policy. It is not clear to the Independent Investigation Team therefore, whether care plans or assessments would be covered by this instruction. There is no reference in the policy to the need to keep the service user’s decision under review, and no guidance is provided as to what is considered to be ‘appropriate’ in this context. The policy does not ‘sign-post’ users to other policies or documents where clarification of these issues or additional guidance could be obtained.
- 22.65 However, the Policy does state:
- ‘If a person is not seen after the assessment with the service, the plans and crisis management should be documented in the discharge letter to the GP, with the letter copied to the service user’.*
- 22.66 In relation to patients who have been assessed and identified as requiring treatment and care from the service it appears that the main vehicle for

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<sup>72</sup> Standard 6.2.



information-sharing is the patient's care plan.

- 22.67 The policy actively encourages information-sharing with patients through the provision of care plans and states:

*'Care plans are created collaboratively on the day of assessment and a copy given to the service user to take with them and a copy scanned under the care plan tab on ePJS.'*

- 22.68 No further guidance about the sharing of care plans with service users is given in the policy.

- 22.69 In a Quality Report published on 21 January 2016 prepared by the CQC following an inspection visit on 21-25 September 2015, the Trust was told by the CQC that they:

*"should ensure patients are routinely involved with developing their care plans and that this is recorded clearly on the records. Patients should be offered copies of their care plans and this should also be recorded".*

- 22.70 In a follow-up inspection visit conducted on 17 July 2017, it was noted:

*"Staff usually gave patients attending assessments with the A&L teams a care plan at the end of their assessment. We reviewed the records of 12 patients in the Croydon A&L team and found that nine of the 12 patients had a plan of care in place..."*

*...In the PR teams, records did not always make it clear if staff offered patients or gave them a copy of their care plans".*

- 22.71 In relation to 'patient feedback' the CQC noted:

*"Most patients told us that staff had given them a copy of their care plan and offered a range of options in respect of care and treatment. Patients felt they had been involved in decisions about their care. However, on many care plans, the involvement of patients was implied rather than explicit".*

- 22.72 As a result of its concerns the CQC stated that:

- 22.73 The trust should ensure that staff clearly record patient involvement in their care records and offer each patient a copy of their care plan.

- 22.74 The findings and results of the Focus Groups corroborate the reasonableness of this recommendation, made by the CQC aimed at improving information sharing in relation to this long-standing challenge encountered by the Trust.

### 22.75 ALLOCATION OF CARE CO-ORDINATION - LESSONS LEARNED 3

- 22.76 In the opinion of the Independent Investigation Team there were deficits in the systems for allocating care co-ordination. Although there was a great deal of goodwill within the team, there was a fragmented approach to the allocation of non-CPA care coordination in this instance, with no robust central process.

*"Recommendation*

*The service management takes steps to ensure that there is an effective and robust system for the allocation of non-CPA care coordination in the East Croydon MAP team that includes clear lines of responsibility for communicating requests for care coordination”.*

- 22.77 Following the care of Donna, the MAP East service was reconfigured in part in response to this concern. An overview of the services which replaced the team is as follows<sup>73</sup>:

#### **“Assessment & Liaison Teams**

*Assessment and Liaison (A&L) services are one of the main gateways into secondary mental health services. The teams provide a comprehensive health and social care assessment service to eligible service users between the ages of 18-65, who are experiencing moderate to severe mental health problems, as well as social problems that may be having a detrimental effect on their mental health.*

*Treatment following assessment might not always be provided by the team, so signposting to other trust services or providers will always be considered. Most of the patients seen will be provided with up to 12 weeks assessment and stabilisation before discharge back to primary care. In cases where needs are complex and require intervention beyond 12 weeks, referrals will be made to specialist treatment services. In cases where risk cannot be managed solely by the team or more intensive support and treatment is required, home treatment will be considered before admission to an inpatient facility.*

#### **Promoting Recovery Teams**

*Promoting Recovery (PR) teams are for people aged 18 and over and living in the London boroughs of Lambeth, Lewisham, Croydon & Southwark. This service is for people who have serious mental health concerns and need specialist support to help with their recovery. Evidence based treatments are provided by a team of professionals who include psychiatrists, social workers, psychiatric nurses, occupational therapists, psychologists and support workers.*

*Many people within the promoting recovery pathway have a number of professionals involved in their care and this is organised under the care programme approach (CPA)”.*

- 22.78 This model makes a distinction between CPA and non-CPA care coordination and addresses the concerns behind the action plan implemented following Donna’s care.

- 22.79 The Trust is currently reviewing this model, in part, due to financial pressures. The CQC stated in this regard:

*“Senior managers noted that the A&L model was approximately three years old, and was designed at a different time. The teams had been affected by a large increase in demand in the last year particularly in Croydon where there was a*

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<sup>73</sup> CQC report.

*gap between funding from commissioners, and the needs of patients. This had led the trust to fund a post in the Croydon A&L team themselves...The different models in use in different boroughs, for example the Lambeth hub, and Lewisham neighbourhood teams may have impacted on significant differences in performance between boroughs. The A&L model was due to be reviewed in August 2017”.*

22.80 In addition to the service reconfiguration noted above, a ‘zoning system’ was introduced by the Trust following the care of Donna. A benefit of this system is intended to improve non-CPA care coordination.

22.81 The zoning system was discussed at length in the Focus Groups. It was recognised that the system had been the subject of favourable comment by the CQC. In its latest report entitled ‘*South London and Maudsley NHS Foundation Trust Community based mental health services for adults of working age Quality Report*<sup>74</sup>’, published October 2017, it was stated:

*“The teams had a clear risk management system in place that used a traffic light system of red, amber and green to categorise risk to patients. The PR teams held zoning meetings regularly, between three and five times a week. At zoning meetings, the multidisciplinary teams discussed and reviewed the risks affecting individual patients, particularly those considered at higher risk. Higher risk patients included those categorised as red and amber, those held by the home treatment teams and those subject to safeguarding concerns. Staff discussed the plans and actions needed to keep patients safe and in the some teams updated individual risk assessment and management plans during the zoning meeting. The zoning meetings we observed were well organised and involved all members of the teams. This helped ensure all staff were aware of the risks across the team and immediate plans were in place to address concerns...”*

*....The Croydon A&L team, where there was a long waiting list, had created a sub team to track all referrals. Each day a staff member carried out telephone triage of referrals. This helped identify anyone in need of urgent assessment, and identify changes in priority. Staff did this by checking patient records to see whether any new information about them had become known. Staff moved patients identified as a higher risk up the waiting list”*

22.82 Independent Investigation Team review of the Trust’s progress in implementing their action plan

22.83 The Independent Investigation Team welcomes these changes in practice. The benefits of the zoning system were said by participants at the Focus Groups to be;

- gives teams focus.
- Supports team-based approach.
- feeds into supervision and appraisal of staff.

22.84 The benefits of the zoning system were summarised by an attendee as follows:

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<sup>74</sup> Date of inspection visit: 17-20 July 2017. Date of publication: 31/10/2017

*“There are examples where we know that things including policies are really clear but staff can’t adhere to that. Zoning shows that if there is a risk it is brought to the team’s attention – leading to shared responsibility”.*

- 22.85 There were ways that the zoning structure at the time could be enhanced. In particular, it was recognised that the system at the time which involved the use of a white board to ‘display’ information, including ‘DNA’s, should be formalised in order that a record could be kept of the information displayed on the white board. An excel-style database was however maintained. Focus group attendees were of the view that a significant enhancement would be the system could be linked to ePJS. The Independent Investigation Team recognise that there would be resource implications attached to this modification.

#### **22.86 LESSONS LEARNED 4: ‘DNA’s’**

##### **22.87 Recommendation**

*“It is recommended that the CAG executive assure themselves that an effective system for following up on DNA appointment (sic) has been implemented by East Croydon MAP”.*

##### **22.88 Independent Investigation Team review of the Trust’s progress in implementing their action plan**

##### **22.89 Response to an individual’s failure to attend an appointment:**

- 22.90 The Trust have reviewed their response to a DNA and have made a number of improvements. Evidence given at the inquest of Donna and Zaki was as follows:

*“The expectation response is very much dependent on what the risks are, and what collateral information we know about the service user. So if there is issues of high level of risk, responses could be at a higher level, if for example, there could be multiple reasons for a DNA; the appointment is forgotten, maybe the person hasn’t quite been able to make it for various reasons, but the expectation would be that contact would be made as soon as possible just to establish that they’re okay and to see what intervention they want, or what they want us to do, do they want another appointment”.*

- 22.91 As has been stated, the East Croydon MAP has been reconfigured. The Croydon Assessment and Liaison Service is currently holding approximately 1,300 cases and has 850 people waiting. The average number of referrals is between 200-300 per month<sup>75</sup>. DNA management is therefore a clinical, and indeed, operational issue for the service.

*“In the Croydon A&L team, the percentage of patients not attending for appointments varied between 7% and 17% in the six months to June 2017. The team sent text message reminders to patients, five days and again at two days before their appointment in an attempt to reduce the numbers of people who did not attend. They also over booked appointments in anticipation that some people*

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<sup>75</sup> Board papers, 19 September 2017.

would not attend. Other teams used telephone and text reminders to encourage attendance<sup>76</sup>”.

- 22.92 At the Focus Groups, the issue of DNA’s was discussed from a risk- management perspective. The key feature of the current approach to DNA’s is the use of the ‘zoning system’ which is designed around alerting staff to a DNA and then implementing an appropriate response.
- 22.93 The zoning system allows for a speedy discussion of an appropriate response to a DNA. All assessments (except relating to a crisis) for the week are put on a team whiteboard so that clinicians can discuss at a multi-disciplinary meeting whether patients attended or DNA, in order to ensure that an appropriate action plan was put in place. This could include an opt-in letter, but for anything urgent, it could include a telephone call or a doorstep attendance.
- 22.94 The Independent Investigation Team recognises the improvement in the response to a DNA arising from the zoning system. However, the DNA process set out in the Operational policy<sup>77</sup> which is in place would benefit from additional clarity as to who is responsible for highlighting a DNA to the multi-disciplinary team across the ‘categories’ of DNA’s.

## **22.95 LESSONS LEARNED 5: SAFEGUARDING**

- 22.96 The internal investigation report stated;
- “It is evident that her family were included in the assessments but there were missed opportunities to fully and meaningfully assess the family’s role as a protective factor to both MS DO and her son”.*
- 22.97 The Independent Investigation Team’s concerns about the Trust’s failure to investigate the relationship between Donna and Zaki is more fully set out elsewhere in this report.
- 22.98 The internal investigation report went on to state that:
- “Trust services need to improve their focus on the Think Family mode<sup>78</sup> within assessments and risk assessments. This is particularly relevant when assessing the protective function of families. These assessments whilst including families need to include individual assessments to inform practice. Within the Think Family agenda staff should also be mindful of partner agencies with which information could be shared”.*

### *Recommendation*

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<sup>76</sup> CQC Report, 2017.

<sup>77</sup> Operational policy<sup>77</sup> of the Croydon Psychological Medicine and Integrated Care CAG (PMIC) Assessment & Liaison Service Purley Resource Centre & Tamworth Rd Resource Centre

<sup>78</sup> The Cabinet Office (2008). Think Family: Improving the life chances of families at risk. [http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/social\\_exclusion\\_task\\_force/assets/think\\_families/think\\_family\\_life\\_chances\\_report.pdf](http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_family_life_chances_report.pdf)

*Think Family model is in place in Southwark and is discussed in Level 3 Safeguarding Children Committee in terms of best practice. Nevertheless awareness is inconsistent and there is a requirement to be systematically rolled out throughout the Trust as a model. This will be raises (sic) as an agenda item at the next Trust Safeguarding Children Committee.*

*Board Level Inquiry Comment*

*The panel concurred with the service management view that the 'Think Family' was merely one of the possible approaches and that this model was not as universally adopted as suggested in the recommendation. The panel agreed that the Trust Safeguarding Committee consider the WEB 10414 structured investigation report and review all the recommendations in this case.*

- 22.99 The 'Family and Carers Strategy: 2015 to 2019' issued by the Trust includes the following statement of principle made by the Trust:

*"As an organisation we will:*

*Work towards family and carer inclusive services and implement the recommendations of the document, Think Family: Improving the life chances of families at risk (Cabinet Office 2008)".*

- 22.100 The Trust's work towards compliance with this statement will be assessed in a Final 'benchmarking exercise', scheduled to occur between June - September 2018. The Trust website also provides access to the Trust's Safeguarding Policy. The policy came into effect on 1 September 2015 and has a review date of July 2018. The policy was considered on 9 July 2015 by the Safeguarding Children Committee and refers to the 'Think Family' Model. No changes were required by the Committee on this occasion.

- 22.101 The Trust's Safeguarding Policy is comprehensive and gives the following guidance to practitioners:

***"Recognising abuse and neglect***

*Many features may lead you to be worried about the welfare of a child and the following list is not exhaustive. Their presence is not proof that abuse has occurred but must be regarded as an indicator of the possibility of harm. The context of the situation and information from others will help you decide how to proceed, including whether or not to refer to local authority children's social care services (LA CSC). If in doubt, discuss in your team with your supervisor/team manager, contact your borough/CAG child protection Lead and or LA CSC*

***4.1.2 Observations about a child***

***4.1.3 Observations about a parent***

***4.1.4 Observations about the relationship between child and parent / carer***

#### **4.1.5 Observations about engagement of the child or family with services**

#### **4.1.6 Other**

- 22.102 Independent Investigation Team review of the Trust's progress in implementing their action plan
- 22.103 The Independent Investigation Team recognises that this list is specifically stated to be "non-exhaustive". However, the Independent Investigation team notes that the categories of observations make no reference to the 'family' unit in which the child lives. The vast majority of families are a source of strength and protection. However, observations about the family environment may constitute indicators for the possibility of harm, and as a result, raise safeguarding issues are not included. In Donna's case for example, whilst Donna's mother was able to look after Zaki, Donna's mother had a full-time job and Zaki was cared for by a full-time childminder until January 2013, and after that, one day per week onwards
- 22.104 The issue of safeguarding was dealt with at some length during the Focus Groups. Participants raised the practical difficulties which could arise regarding communication with other services. What was apparent was the determination of practitioners to obtain support from other organisations, despite the difficulties which they faced on occasion.
- 22.105 However, the responses received at the Focus Groups indicated that where interfaces existed between different services, practical differences in communication arose. A lack of understanding of the function and role of organisations at the "coal face" was mentioned. The difficulty caused by the fact that the Trust covers four boroughs is a complicating factor, as is the interface between the CAG's within the Trust. In addition, differences in the lines of accountability were cited. Tensions in relation to budgetary matters were also raised.
- 22.106 The sense of frustration was summed up by one participant as follows:
- "If you've got safeguarding issues, you just keep going until you get it right and get the information you want".*
- 22.107 The view of participants appeared to be that this was a problem which could be tackled by identifying the individuals in each organisation who had the practical knowledge to make meaningful contacts, possibly at management level, to ease the communication difficulties.
- 22.108 The Independent Investigation Team recognises that the Trust is aware of this and has undertaken work to find the information and make the necessary contacts to mitigate the consequences of the barriers created by different service 'boundaries'. The Multi Agency Safeguarding Hub ('MASH') team improves links with other relevant team managers. The importance of this work cannot be overstated.

22.109 The Independent Investigation Team recognise that in Croydon, there has been an increase in resources attaching to safeguarding, and new posts have been created. These individuals act as a conduit between mental health services and children and families' services about referrals. This has had a positive impact and has reduced the possibility of a referral not being followed through.

22.110 The 'zoning' system also allows for a better response to potential adult or child safeguarding issues. This was explained at Donna's inquest in the following terms:

*"So we have the zoning system which looks at the level of risk and need for an individual, so where there is a child protection issue, we would see that as a significant issue and they would be zoned as red. If it was ongoing child and need issues, or there had been previous prior child protection issues but they are being resolved, we would hold that person with amber just so we are making sure that we're thinking THINK family".*

#### **22.111 LESSONS LEARNED 6**

22.112 This action point related to information-sharing between IAPTs and the central Trust database. The 'concern' underpinning this recommendation was expressed by the internal investigation team as follows:

*"IAPT notes and information are recorded on a separate data base from ePJS, the central Trust database. This makes it difficult for teams to have a clear picture of what was happening in IAPTs and how a service user presentation (sic) to one team might impact on an assessment conducted by another".*

22.113 Accordingly, the following recommendation was made:

#### ***"Recommendation***

*The investigators recommend that all team members should have access to this information".*

22.114 During the course of the interviews conducted by the Independent Investigation Team, the team was advised that the IAPT team can now view the Trust ePJS system, and the MAP teams could view IAPTus.

22.115 Independent Investigation Team review of the Trust's progress in implementing their action plan

22.116 Accordingly, the Independent Investigation Team concludes that this recommendation has been implemented.

#### **22.117 LESSONS LEARNED 7: IAPT 'OPT-IN' SYSTEM IN RELATION TO DNA'S**

22.118 The Trust Internal Investigation stated:

*"IAPT should review their process of closing cases when there is no response to a single opt-in letter as this may inadvertently disadvantage vulnerable service*



*users and lead to missed opportunities to support and engage those in need of the service”.*

22.119 The recommendation which was made was as follows:

*“IAPT consider using telephone contacts to establish that people on the waiting list still require a service as this is more direct and inclusive. It is also a familiar method used in the triage process”.*

22.120 Independent Investigation Team review of the Trust’s progress in implementing their action plan

22.121 This recommendation made by the Internal Investigation Team was not implemented. The Internal Investigation states:

*“Board Level Inquiry*

*The panel were of the view this recommendation should be omitted from the report as it was not considered achievable”.*

22.122 Waiting Time for Psychological Therapies:

22.123 In relation to the management of waiting lists, the following information was provided by the Trust at the inquest of Donna and Zaki.

*“We do try to implement waiting list initiatives, we always check if people might be at that particular point be suitable to go to IAPT, we provide a group interventions whilst people are waiting, for example, mindfulness interventions, so we are trying to work with the resources that we have to manage the waiting list. As said we’re having the discussion with our commissioners about this”.*

22.124 However, the “CROYDON IAPT SERVICE: OPERATIONAL POLICY Developed October 2010- Sept 2011 Updated June 2017” was reviewed as part of the Independent Investigation.

22.125 The Policy confirms that individuals can self-refer to the service and provides the following description of the service:

*“Croydon IAPT*

*The Croydon IAPT Psychological Therapies and Wellbeing Service provides psychological therapy for adults with mild to moderate depression and anxiety. It is a wave 3 site in the national Improving Access to Psychological Therapies Programme (IAPT). The service is provided by South London and Maudsley NHS Foundation Trust, and was commissioned for one year in the first instance while the service was retendered. The previous service provided by the Priory Healthcare group closed in December 2010, and the current IAPT service inherited a very large waiting list. As a wave 3 site, the Croydon IAPT service is smaller than wave one and two sites, and is under-resourced to meet demand in Croydon”.*

22.126 It gives the following guidance in relation to waiting list management:

*“PART 7: WAITING LIST MANAGEMENT AND CASE ALLOCATION*

*At times when the waiting list is longer for some venues than others, we will write to patients waiting advising them of this and asking them to let us know if they are able to attend other venues.*

*We will routinely write to people who have waited for more than 2 months since telephone triage and apologise for the wait, and explain that they are still on our waiting list. We hope to run a waiting list drop in clinic and helpline, plus online and peer support groups”.*

22.127 The service operates a strict attendance policy. There are several points in the IAPTs pathway where a patient can be discharged if the service does not receive a response from the patient.

22.128 Whilst it is clear that the service works hard to maximise its resources in very difficult circumstances, in applying a strict ‘DNA’ policy where communication may be a single telephone or text message, the policy does not take cognisance of, or indeed address, the risk of the disadvantage which this could have upon vulnerable service users and which was highlighted by the Trust’s internal investigation.

22.129 This has the potential to lead to lost chances to support and engage those in need of the service, particularly those who self-referred and have no GP who may be contacted. This is a matter of concern given that a DNA can result in a patient being discharged or re-entered onto a lengthy waiting list but at a less advantageous position according to the IAPT Operational Policy.

## 23 CHANGES IN PRACTICE

- 23.1 During the course of the Independent Investigation, it became clear that the Trust had instigated a number of changes in the manner in which the services provided by MAP East Team were delivered. A number of these changes would have benefited the care and treatment afforded to Donna. This has had an impact on the recommendations which the Independent Investigation have considered it necessary to make
- 23.2 Financial issues:
- 23.3 A significant topic discussed by the focus groups conducted by the Independent Investigation Team was funding in relation to Croydon. The feeling at that time was as follows:
- Funding is determined by the local commissioner.
  - Funding is delivered through CAGs. If you are in Croydon and you are given that financial envelope, that is what you must work with.
  - There is discrimination – Croydon gets less funding
  - The Trust was attempting to keep pace with the flux in population and diversity was working to develop collective solutions to those problems.
- 23.4 Despite a level of optimism expressed at the Focus Groups about an increase in funding being available, this has not in fact been delivered. The Independent Investigation Team noted at the Focus Groups that there appeared to be an “acceptance” of a post code lottery concerning the funding of services in Croydon.
- 23.5 On 19 September 2017, a paper entitled “*Overview of Working Age Community Mental Health Services in Croydon*” was submitted to the Trust Board which provided an overview of the continuing challenges faced by Croydon community adult mental health services. The paper included the following points:
- *‘The Borough of Croydon has historically been categorised as a suburban, out of London Borough. However, its demographic, economic and social characteristics are similar to inner-London Boroughs, including; the largest overall population when compared to other Boroughs; the largest children and young people’s population of other Borough’s; the highest proportion of Black Asian and Minority Ethnic Groups; and some of the most deprived areas in London. A challenge for the Borough has been a nearly 10% increase population over a ten-year period, and its transient population (Croydon Observatory,2012).*
  - *Croydon SLAM services have historically been chronically underfunded when compared to Lambeth, Southwark and Lewisham. Since 2010, external reviews have reported that the overall mental health spend does not meet the needs of population, which was reported in the findings in an Ernest and Young review in August 2017.*
  - *A reduced level of Adult Mental Health model funding was invested in 2015, to include additional resources for Croydon IAPT. However, due to Croydon CCG’s funding gap and being placed in special measure in 2016, a significant*

*amount of the original investment was withdrawn as part of the 'Croydon Bridge'.*

- In Quarter 1 of 2016-17 it became apparent that the CCG could not meet its proposed mental health spend for that financial year. Following mediation between the Trust and Croydon CCG, it was agreed that plans were required to bridge the gap in the original spend, which became the 'Croydon Bridge'. This impacted on a raft of services.*
- In the current financial year, this funding gap has not been corrected and there has been further disinvestment in Croydon IAPT.*
- Mitigations are in place to manage these challenges, but a medium to long term solution is required to ensure safe and sustainable service delivery within a limited financial envelope.*
- The Trust is working with commissioners about the problems, but it appears unlikely that there will be sufficient resource in the health economy to address these challenges.*
- It is important that the Trust ensure that the CCG include mental health services in the propose transformation programme to develop integrated services.*

23.6 The paper states:

*"Going forward, there is no evidence of additional resource being made available from the health economy. Therefore, we need to consider whether there is a case for reviewing the existing model to fit with the current financial envelope.*

*The current challenges in Croydon require senior leadership from each CAG, usually at service director level, to engage senior commissioning managers about the challenge, with the support of the senior contract and finance personnel. We believe that we are seeking ways to support the commissioners to make informed decision regarding mental health services in Croydon".*

23.7 Reconfiguration of the service:

23.8 At the time of Donna's care, the model which the service operated was a community mental health team which accepted patients for assessments, but which also provided ongoing care.

23.9 The Trust has now separated the treatment element of care i.e. ongoing care, requiring care coordination, from referral and assessment. As a result, the duty system has been abolished, leading to clarity in the roles of professionals and accordingly, an improvement in service delivery.

23.10 There are now two teams.

23.11 The assessment team accepts referrals from primary care or any other potential stakeholder who wants to make a referral. This team has a dedicated team manager and nurses and doctors working within that team.

- 23.12 An individual who is newly referred will be screened by this dedicated service. They will have an assessment which may, in appropriate cases, lead to the offer of up to twelve weeks interventional stabilisation. If at any point during that time it is felt that the individual requires a greater level of intervention, then they would be referred to the treatment team which includes access to care coordinators.
- 23.13 However, as is clear from the report entitled 'Overview of Working Age Community Mental Health Services in Croydon which was considered by the Trust Board on 19 September 2017 the changes in systems put in place following the care and treatment of Donna are facing significant challenges and significant elements of the 'postcode' lottery recognised at the Focus Groups persists. In particular, the impact upon the *Assessment and Liaison Team* was identified as
- *Current waiting times exceed the Trust standard for waiting with average time for an urgent appointment standing at four weeks and routine appointments up to 18 weeks.*
  - *As of the date of the report the waiting list stands at 750 patients.*
  - *Low level need was being referred to the service (clusters 1-3) by primary care and through safeguarding concerns.*
  - *The service has 50% less consultant psychiatrist time and approximately 3WTE less community practitioners when compared to other SLAM Boroughs but experiences the same level of demand.*
  - *As mitigation QI is used to review the waiting list to delivery patients in accordance with NICE stepped care. The service has also refined its systems for triaging need in accordance with evidence-based practice. In addition, 2 WTE community practitioners have been agreed to support the issues with the waiting list and to allow for new systems to be put in place. Consultant time with the Trust is being reviewed.*
- 23.14 An aspect of Donna's care which was considered to be good practice and is referred to above was the speed at which she was able to gain access to the MAP East Team. It is disappointing therefore that the service is now facing these additional challenges.
- 23.15 Following the completion of the CQC inspection in July 2017<sup>79</sup>, the CQC rated community-based mental health services for adults of working age provided by the Trust as 'requires improvement' for reasons which included the following:
- *Patients referred to the Croydon assessment and liaison (A&L) team were not being seen within trust target timescales. This left some of them waiting up to 18 weeks for an assessment, thereby increasing chances of deterioration and putting them at greater risk of avoidable harm.*
- 23.16 The CQC also stated in relation to Trust' governance:
- *"We rated this domain as good, despite the core service having three domains that were rated as requires improvement. This was because service managers were aware of the issues we found relating to risk assessments and care plans, and working to address them. They had also*

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<sup>79</sup> Report published 31<sup>st</sup> October 2017.

*taken proactive steps to address long waiting times in the Croydon A&L team, and regarding delays in Mental Health Act assessments.*

- *Items on the psychological medicine and integrated care (PMIC) CAG risk register relating to the A&L teams included, managing the financial challenges faced by Croydon Clinical Commissioning Group, high vacancy levels, disaggregation (separation back to the local authority) of social workers”.*
- *It is important that the Trust ensure that the CCG include mental health services in the propose transformation programme to develop integrated services.*

23.17 The CQC also stated

*‘Senior managers noted that the A&L model was approximately three years old and was designed at a different time. The teams had been affected by a large increase in demand in the last year particularly in Croydon where there was a gap between funding from commissioners, and the needs of patients. This had led the trust to fund a post in the Croydon A&L team themselves;*

- *It is important that the Trust ensure that the CCG include mental health services in the propose transformation programme to develop integrated services.*

23.18 The CQC noted the impact which the difficulties faced by staff in Croydon was as follows

*“Staff in teams worked well together and supported each other. All staff reported feeling well supported by their immediate managers and enjoyed their work. However, some staff in Croydon expressed feeling demoralised and stressed, and did not feel the trust listened to or consulted staff on changes to the services”.*

- *It is important that the Trust ensure that the CCG include mental health services in the propose transformation programme to develop integrated services.*

23.19 Improvements in Access to care coordination:

23.20 As has been shown throughout this report, the Independent Investigation Team had a concern with the mechanism for managing the IAPTs waiting list, and the length of the list itself in relation to Donna’s interaction with services. Further, in relation to allocation of a care co-ordinator, in the event that an individual requires care coordination, they would be moved to the treatment part of the service.

23.21 The Trust gave the following evidence at inquest in this regard:

*“In terms of reiterating the systems that we have in place, anybody who would require care coordination who are coming from the assessment and liaison team, or coming from outpatients would need to be discussed with an MDT, and it is the team manager’s responsibility .. to make sure that person is allocated. If they are absent they will nominate a senior practitioner within the team who will take responsibility for the allocations”.*

23.22 In relation to the allocation of cases to a care coordinator, a record is now kept of requests for care coordination, and this is examined at a number of forums, including regular team meetings, and a process for checking that a request has been actioned exists. The Independent Investigation Team was encouraged to note that the allocation of cases is now a feature of the supervision system. The Trust provided the following information at inquest in this respect:

*“in supervision the supervisor will go onto the electronic patient records and will review the caseload of a particular worker. So say for example, they’re seeing 20 people, the team manager will know exactly who they’re seeing and who else ought to be allocated to them, so there’s quite a clear system for knowing that people have been allocated to the right part of the team”.*

23.23 Changes in Team Meetings:

23.24 Evidence given by the Trust at Donna and Zaki’s inquest set out the improvements which have been made with regard to the recording and referral to team meetings:

*“In terms of clinical team meetings which involve multiple MDT discussion, what happens within the team is that they are, there is a form that’s completed per service user that’s discussed. What happens in that form is that the reason why they’ve been brought up for discussion, what the decision is in relation to that discussion, and what the rationale is, that is then scanned onto the persons electronic record as per discussion. What also happens is routine discussions, so we’d make sure that we try to discuss everybody who is currently care coordinated, so when the discussions been made and that’s been written up, a date will be set when the next review is within the multi-disciplinary team discussion”.*

23.25 Improved communication between services within SLAM:

23.26 The Independent Investigation Team notes that there has been an improvement in communication within Trust services in that the IAPTS has access to the electronic records generated by Trust, relevant teams within the Trust also have access to IAPTS records.

23.27 Focus Groups:

23.28 As part of its Terms of Reference, the Independent Investigation Team convened a series of ‘Focus Groups’ in order to evaluate the learning that Trust had taken from the incident.

23.29 A number of the issues discussed at the Focus Groups have already been referred to earlier in this report.

23.30 A further issue which was discussed was the issue of electronic medical records. Many Independent Investigations comment upon the problems created by poor record keeping systems. This is a particular concern with regard to information contained in ‘paper’ records. It is clear that the Trust has made a substantial investment in the electronic system which it now operates. This has significant benefits in terms of ease of communicating patient data. However, this in itself has created a resourcing issue, in that there is a significant time element for

practitioners to transpose the information required in the records when populating the new system.

- 23.31 A significant part of the discussions relating to the ongoing challenges which the Trust faces was in relation to the difficulties which have been experienced in recruitment, partly due to the difference in pay scales between inner and outer London. This difficulty had historically led to an increased dependence on locums. Indeed, a number of locums were involved in Donna's care. Recruitment campaigns have had a degree of success. However, this challenge is also ongoing.
- 23.32 The Independent Investigation Team note that recruitment and workforce developments is a regular matter discussed at Board Meetings and has been the subject of a proactive management response which has led to positive changes including less reliance on locums, which has had some success.
- 23.33 The Independent Investigation Team recognises that recruitment, training and development of staff also has a direct impact upon the ability of an organisation to embed change in its culture and practice. Difficulties which the Trust has historically in this area faced may have impacted adversely upon the Trust's ability to embed the learning from Donna's care and treatment.



## 24 GLOSSARY OF TERMS

- **Anxiety** - A state of apprehension and psychic tension occurring in some forms of mental disorder.
- **Beck Depression Inventory** - The Beck Depression Inventory (BDI) is a 21-item, self-report rating inventory that measures characteristic attitudes and symptoms of depression.
- **Bulimia** - A habitual disturbance in eating behaviour mostly affecting young women of a normal weight, characterised by frequent episodes of grossly excessive food intake followed by self-induced vomiting to avert weight gain.
- **Citalopram** - Citalopram is an antidepressant medicine prescribed to treat depressive illness and panic disorder including fear of wide open spaces (agoraphobia) or crowds.
- **Clonazepam** - Clonazepam is used to treat certain seizure disorders (including absence seizures or Lennox-Gastaut syndrome) in adults and children. Clonazepam is also used to treat panic disorder (including agoraphobia) in adults.
- **Cognitive Behavioural Therapy (CBT)** - Cognitive Behavioural Therapy is a type of talking treatment that focuses on how thoughts, beliefs and attitudes affect feelings and behaviour, and teaches coping skills for dealing with different problems.
- **Depression** - Condition of general emotional dejection and withdrawal; sadness greater and more prolonged than that warranted by any objective reason.
- **Diazepam** - Diazepam affects chemicals in the brain that may be unbalanced in people with anxiety. It is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms. It is sometimes used with other medications to treat seizures.
- **DNA** – ‘Did not attend’.
- **Escitalopram** - Escitalopram is used to treat depression or generalised anxiety disorder. It works by restoring the balance of serotonin, a natural substance in the brain, which helps to improve certain mood problems.
- **Glasgow Coma Scale (GCS)** - The Glasgow Coma Scale provides a practical method for assessment of impairment of conscious level in response to defined stimuli.
- **‘GSH’** – Guided Self-Help [therapy].

- **Hospital Anxiety and Depression Scale** - The Hospital Anxiety and Depression Scale (HADS), a self-assessment scale, was developed to detect states of depression, anxiety and emotional distress amongst patients who were being treated for a variety of clinical problems.
- **Interpersonal Behavioural Therapy** - Interpersonal therapy focuses on the interpersonal relationships of the depressed person. The idea of interpersonal therapy is that depression can be treated by improving the communication patterns and how people relate to others.
- **“MP”** – Member of Parliament.
- **Neurosis** - A functional disorder in which feelings of anxiety, obsessional thoughts, compulsive acts, and physical complaints without objective evidence of disease, in various degrees and patterns, dominate the personality.
- **Olanzapine** – an antipsychotic medication used to treat schizophrenia and bipolar disorder. It is usually classed with the atypical antipsychotics, the newer generation of antipsychotics. Appears to have slightly greater efficacy in treating schizophrenia, particularly the negative symptoms, and a lower risk of causing movement disorders than typical antipsychotics.
- **Pregabalin** - Pregabalin is used for treating fibromyalgia, nerve pain caused by certain conditions (e.g., shingles, diabetic nerve problems, spinal cord injury). It is also used in combination with other medicines to treat certain types of seizures.
- **Promethazine** - Promethazine is used to treat allergy symptoms such as itching, runny nose, sneezing, itchy or watery eyes, hives, and itchy skin rashes. It also prevents motion sickness and treats nausea and vomiting or pain after surgery. It is also used as a sedative or sleep aid.
- **Psychotherapies** - The treatment of psychological disorders or maladjustments by a professional technique as psychoanalysis, group therapy, or behavioural therapy.
- **Symptomatology** - The collective symptoms of a patient or disease.

## 25      **APPENDICES**

- Appendix 1 - Terms of Reference of the Investigation
- Appendix 2 - Team Membership
- Appendix 3 - Methodology
- Appendix 4 - Chronology

## **Appendix 1 – Terms of Reference**

### ***“5. Core Terms of Reference for Independent Investigations under HSG (94) 27***

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

- Review the trust’s internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- Review the progress that the trust has made in implementing the action plan.*
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user’s first contact with services to the time of their offence.*
- Compile a comprehensive chronology of events leading up to the homicide.*
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.*
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.*
- Examine the effectiveness of the service user’s care plan including the involvement of the service user and the family.*
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.*
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
- Consider if this incident was either predictable or preventable.*
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.*
- Assist NHS England in undertaking a brief post investigation evaluation.”*

## **Appendix 2 – Team Membership**

### **Janet Hawthorne LLB (Hons)**

Janet Hawthorne is an experienced regulatory lawyer. She has considerable experience of Healthcare Law working on both sides of the medico legal divide.

Janet has held the position of Legal Director of a national regulator. She has represented a variety of regulatory bodies and individuals in front of disciplinary tribunals such as the General Medical Council and HPC regulated individuals.

In addition, she has extensive experience of the practice and procedure relating to performance management and investigation both in the healthcare and financial services sectors. She is a former head of the Investigations Department of Lloyds of London. Janet has extensive risk management experience gained in the insurance sector and healthcare sectors.

Janet has experience of performing Mental Health Homicide reviews and has experience of the unique legal issues which can be thrown up such as whistle blower protection and confidentiality. On a practical level Janet has undertaken several complex investigations within the NHS and is able to put her risk management and governance experience gained across a variety of sectors to good use in the healthcare investigations which she performs. Janet can work with clinicians to facilitate investigations which deliver a transparent audit trail which can sustain public and legal security.

Janet is an accredited mediator.

### **Dr Keith Linsley**

Dr Linsley presently holds the post of Consultant Psychiatrist Adult and Community Psychiatry with a special interest in liaison. Dr Linsley has been a consultant psychiatrist since 2000 and prior to this he practised as a liaison psychiatrist and psychotherapist. Dr Linsley works with the Service Developments and Wider NHS Involvement, within this role Dr Linsley is the sole responsibility for the inpatient unit assessing patient safety and imposing discharge procedures. Dr Linsley plays an active role in the 'Self Harm Service' throughout County Durham. In addition, Dr Linsley pursues research and publication in suicide prevention with extensive experience in presenting and providing training to psychiatrists. In 2005 Dr Linsley was awarded the NE NHS Innovations Award for developing Suicide Risk Management Training. Dr Linsley has assisted the police in investigations involving murder/suicide.

### **Mr Anthony Ashton**

Mr Anthony Ashton trained and worked as both a Psychiatric and General Nurse and practiced as such from the mid-1970s until themed- 1990s when he undertook group-analytic training with the Institute of Group-Analysis.

Having graduated as a group-analyst in 1996 he has worked in that capacity within two mental health trusts (in Wakefield and in Middlesbrough): This role involves assessing referred patients for suitability for psychodynamic psychotherapy, undertaking consultations with referrals where the most suitable treatment is not clear, providing psychodynamic psychotherapy via group-analysis and supervising and teaching trainees.

He has an interest in organisational dynamics within teams and units within the NHS and has both received and delivered training in this field.

In 2002 Mr Ashton undertook a one-year course at the Cassel Hospital (West London Mental Health Trust) called management and Leadership in Mental Health services which was designed and delivered by Ms Vega Zagier Roberts (the co-author of 'The Unconscious at Work') and Ms Fransesca Cardona: Both of these trainers studied at and work from the Tavistock Institute of Human Relations in London and are highly experienced practitioners of organisational consultancy with the NHS.

Consequent to this training Mr Ashton has delivered similar training to many teams and training courses.

### **Appendix 3 - Methodology**

1. The Independent Investigation Team gathered documentary evidence, including policies and procedures from the Trust.
2. A list of documents reviewed is set out below:
  - a. Documentation supplied by Zaki's family
  - b. Zaki's General Practitioner records
  - c. Inquest Transcripts and documentation
  - d. Private Practitioners records
  - e. Trust - internal reports and supporting documentation
  - f. Trust - internal policies and procedures
  - g. Trust records including:
    - i. CMHT Records
    - ii. Crisis Resolution and Home Treatment Records
    - iii. IAPT Team Records
3. We interviewed individuals including staff 'on the ground', senior managers and members of the Board of Directors of the Trust.
4. We spoke to Donna and Zaki's family.
5. Focus groups were established to gather valid knowledge of the service and those who use it.
6. An initial draft report was produced.
7. Individuals who were the subject of actual or perceived criticism in the Report were afforded an opportunity to comment upon the criticisms and provide additional information. The Trust was also afforded an opportunity to comment upon the draft report.
8. The Report was submitted to NHS England.