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

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



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# 1 Executive summary

1.1 NHS England, London commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr J. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] The terms of reference for this investigation are given in full in Appendix A.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

## Offence

1.5 Mr J had described Miss K as his girlfriend to professionals during 2014, and said they had met through an internet site. His most recent discussion about her was in September 2014 when he said she was becoming more distant. This was not explored in any depth by professionals, and it was disclosed at the inquest in October 2015 that Miss K was not his girlfriend, and in fact felt harassed by Mr J.

1.6 Mr J killed Miss K with a hunting knife in Ilford on 31 October 2014, before fleeing after being seen. Shortly afterwards he ingested cyanide and was found dying in a nearby street an hour and a half later with Miss K's blood on his feet. An inquest into Miss K's death in October 2015 concluded that Miss K was unlawfully killed and Mr J died by suicide.

1.7 We would like to express our condolences to both families. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr J.

## History

1.8 Mr J was 27 years of age at the time of his suicide. He had previously studied medicine for two years but left this in 2010.

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[1] *NHS England Serious Incident Framework March 2015.* https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidents.* https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

1.9 In 2010 he started retraining as a personal fitness instructor and had applied to work in a London council leisure centre.

1.10 He did some voluntary work as a market researcher and fitness instructor, and received income support. In 2014 he trained as a security officer and a forklift driver. Mr J lived in the family home with his mother and brother and sisters.

1.11 His first admission to a mental health hospital was in Spain in July 2008 following arrest for making noise and failing to pay for his hotel. He was subsequently under the care of East London NHS Foundation Trust (to be referred to as the ELFT or the Trust hereafter). He was detained under Section 2[3] of the Mental Health Act 1983 (MHA) and admitted to Crystal Ward Psychiatric Intensive Care Unit (PICU), Newham Centre for Mental Health on 3 October 2008 following two arrests on two consecutive days. He was diagnosed with bipolar disorder and prescribed medication, which he was reluctant to take. He was discharged from Section 2 by a First Tier Tribunal on 21 October 2008. A week later family members called the police expressing concern about his mental state; he had been smashing up items in the home and was aggressive to family. Mr J was brought to the PICU by police. On 28 October 2008 he was detained under Section 3[4] MHA. Initially Mr J was angry and aggressive, demanding to be let out and tried to forcibly open ward doors.

1.12 He was discharged in December 2008 and referred to Newham South East community mental health team (CMHT). Assessment was arranged in December 2008 with Early Intervention Service (EIS) but Mr J did not attend. He was seen on 7 January 2009 but was not accepted by EIS due to his diagnosis of bipolar disorder.

1.13 Mr J took an overdose of GBL (gamma hydroxybutyrate) in August 2009 and was seen by a liaison psychiatrist in Newham University Hospital.

1.14 This was regarded as a serious suicide attempt, and he was referred to the Trust Home Treatment Team (HTT). Although Mr J did not keep all appointments, he appeared to be taking his medication, and remained in contact with HTT staff. By 26 August he had still not been allocated a care coordinator by the CMHT, and had been seen weekly by HTT staff. It was agreed to discharge him from HTT care on 31 August 2009 to await allocation by the CMHT which was 'promised as soon as possible'.

1.15 Mr J was seen by the clinical psychologist Dr E on 12 August 2009, and a care coordinator (CPN1) was allocated in October 2009. A Care Programme Approach (CPA) review meeting was held by Newham South East CMHT on 27 November 2009, the agreed care plan was to continue with medication, meet with the care coordinator regularly for support, monitoring of mental state, compliance and identification of risk, care

[3] *Section 2 of the Mental Health Act is Admission for assessment for up to 28 days.* https://www.legislation.gov.uk/ukpga/1983/20/section/2
[4] *Section 3 of the MHA is Admission for treatment, for up to 6 months.* https://www.legislation.gov.uk/ukpga/1983/20/section/3

coordinator to arrange three monthly medical reviews and six-monthly CPA reviews.

1.16 Mr J was admitted to a mental health hospital in France in June 2010 during a holiday, after being involved in two road traffic accidents. His mother travelled to France to bring him home. On June 24 2010 he was detained on Section 3 MHA, after being arrested in the West End for 'pickpocketing' and following a woman. At arrest he became violent & police sprayed him with CS spray.[5] He was incoherent and was referred to the mental health nurse attached to the police station, who interviewed him. He stated he had been sent by Allah and had been having "mind sex" with the woman he had been following, and he was intimidating to the escorting custody nurse.

1.17 He was discharged on Section 17A MHA Community Treatment Order (CTO) [6] on 19 October 2010 and the conditions suggested were: residence at a designated address, compliance with depot, compliance with lithium[7], submission to blood tests for lithium. This was due to expire on 18 April 2011, and was rescinded on 4 April 2011 after a period of stability. By April 2011, Mr J was no longer prescribed depot medication, and was maintained on lithium and risperidone, and the confirmed diagnosis was bipolar affective disorder (ICD10:F31.17).[8]

1.18 Mr J's last admission to Newham Centre for Mental Health was in March 2012. The CMHT received several phone calls from Mr J's brother on 26 March 2012, expressing concern about his mental state; he had been agitated, not sleeping and breaking things at home, and threw his bed out of the window.

1.19 Mr J was detained by the police on Section 136 MHA[9] and then on Section 3 MHA on 27 March 2012 on Emerald Ward. His father as next of kin reported that Mr J had done a lot of damage to the house, and was reported to be happy for his son to be detained for treatment.

1.20 Discharge under a further CTO was agreed to take place on 29 May 2012. He was to continue on risperidone depot 50 mg every two weeks, with a reducing dose of oral risperidone 3 mg, and sodium valproate,[10] to be reviewed. The mandatory conditions of his CTO were explained to him by a social worker; these were:

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*[5] CS spray is a peripheral sensory irritant. In most cases spraying will result in the subject's eyes being forced shut, a burning sensation on the skin around the eyes and face, when inhaled their breathing may be affected. In most cases this action will be sufficient to render a subject incapable of continuing an attack. CS comes from the surname initials of its US inventors, Ben Carson and Roger Staughton. From "Guidance on the Use of Incapacitant Spray". Association of Chief Police Officer of England, Wales & Northern Ireland, May 2009.*

*[6] Section 17 A is a supervised community treatment order. http://www.legislation.gov.uk/ukpga/1983/20/section/17A*

*[7] Lithium Carbonate is the medication most commonly used to treat bipolar disorder. Lithium is a long-term method of treatment for episodes of mania, hypomania and depression. http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Treatment.aspx.*

*[8] International Classification of Diseases: http://www.icd10data.com/ICD10CM/Codes/F01-F99/F30-F39/F31-/F31.70*

*[9] Section 136 MHA- police powers re mentally disordered persons found in public places. http://www.legislation.gov.uk/ukpga/1983/20/section/136.*

*[10] Sodium valproate is sometimes used to treat episodes of mania and as a long-term mood stabiliser. http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Treatment.aspx*

- To meet with his care coordinator, psychologist and Responsible Clinician (RC) as requested.

- To remain compliant with prescribed medication, receiving his depot and oral medication regularly.

- To accept random urinary drug testing.

1.21 Mr J continued to see the care coordinator (CPN1) and saw Dr E (clinical psychologist) weekly and attended a bipolar disorder support group.

1.22 CPA review took place on 13 May 2013, (but entered on 2 August 2013) with Dr F, CPN1 and the GP in attendance along with Mr J. The CTO was due to expire on 15 May 2013.

1.23 Dr F discharged him from the CTO on 17 May 2013. Mr J continued to attend the wellbeing clinic regularly for his depot medication of risperidone 37.5 mg, and told CMHT staff that he was feeling well, and had no psychotic or depressive symptoms. Mr J continued to see Dr E weekly, and discussion was around occupying his time and applying for jobs. He was noted to be unrealistic in his plans, for instance planning to borrow a large sum of money to open his own gym and then attract customers.

1.24 On 14 October 2013 Dr F's junior doctor requested by letter that the GP reduce his risperidone depot to 25 mg, to keep sodium valproate at 1300 mg, procyclidine 5 mg twice daily and to do a blood test for plasma levels, and 'A medical review was planned with Dr F for 3 months' time, noting that Mr J had requested to stop the depot injection and take oral risperidone, and this would be considered if he remains mentally stable.

1.25 In February 2014 his psychiatrist changed to Dr D, and he was first seen in April 2014. At a pre CPA meeting with CPN1, possible follow up in outpatients with Dr D rather than through a care coordinator was discussed, as Mr J was still giving 'assurance' about adherence to oral treatment.

1.26 A CPA review on 16 April 2014 with Dr D and CPN1 noted his bipolar disorder was in remission, and he was currently prescribed risperidone depot 25 mg every two weeks, sodium valproate 1300 mg at night, and procyclidine 5 mg twice daily. Dr D noted that he was seeing Dr E fortnightly, he was doing well, looking for jobs, with no major mood swings. Mr J denied any use of alcohol drugs, was not psychotic or suicidal and was described as fully compliant with medication. The plan was: to stop the depot and start risperidone tablets, 2 mg for three days, 4 mg thereafter. CPN1 was to monitor, with a progress review in three months to consider whether care coordination was still needed.

1.27 On 12 May 2014 Mr J's GP notified Dr D that Mr J had not picked up his prescription for sodium valproate since November 2013. He was seen by Dr D and CPN1 for urgent review. Mr J stated he had been taking his friend's tablets, said he was not psychotic or suicidal. He said he had no

side effects and no problems, and was continuing to see Dr E regularly. He was asked to arrange for his blood valproate levels and a liver function test from his GP, and given the forms to use. The next review was to be arranged by CPN1.

1.28 On 2 September 2014 Mr J attended his last psychology session with Dr E, and it is recorded that Mr J said he was doing well, had finished his fork lift truck course but not managed to get a job yet due to lack of experience. He was again encouraged to contact the employment specialist. There had been previous discussion about Miss K, whom he referred to as his girlfriend. At this time Mr J said his relationship with Miss K had become more distant however he did not seem troubled by this, and said it may be better to stop the relationship as it was not going in the direction he wanted. Mr J was noted to say he felt he had benefitted from therapy and had a better understanding of himself. He was very happy to be off the depot and said he planned to ask Dr D to reduce his medication further.

1.29 A CPA review meeting on 15 October 2014 was attended by Dr D and Mr J only. Mr J said things were going well, despite not being able to get a job with forklifts, and was planning to return to pursuing a career in fitness. He said he was fully compliant with medication, including the full dose of sodium valproate. He was keen for his medication to be reduced, and after discussing the risk of relapse, it was agreed to reduce the risperidone to 2 mg a day. He said he does not smoke, drink or take drugs, and said he had a blood test a few months ago, 'including valproate levels'. Crisis plans were discussed, and he said he felt prepared to take on responsibility for his wellbeing, including picking up on relapse signs. He denied any suicidal ideas, delusional thought content or mood fluctuations. He was said to be cognitively intact with good insight. The plan was for risperidone to be reduced to 2 mg daily, the GP to forward the latest valproate levels, discharge from care coordination, and book into outpatient clinic, to receive an appointment 'in due course'. On 21 October 2014 Mr J was sent an outpatient appointment with Dr D for 9 April 2015.

1.30 There are no further CMHT contacts, until the police contacted the Trust on 31 October 2014, stating that Mr J had been found collapsed, and a female known to him had been stabbed in the street, who later died of her injuries. Mr J also died on 31 October 2014, after admission to hospital.

## Internal investigation

1.31 The Trust commissioned the investigation immediately, and it was completed on 9 February 2015, which was within the expected time frame of 60 days. It was given executive approval by the Trust Medical Director on 3 March 2015. The lead author is an honorary consultant psychiatrist for the Trust, and she was assisted by a consultant psychiatrist, from a neighbouring directorate.

1.32 Three care delivery problems were identified:

- the decision to discharge [Mr J] from CPA was inappropriately risky, and the naivety of the final set of care plans in 2014 did not seem to involve a true assessment of risk, which would have needed to involve collateral information from his family and girlfriend.

- lack of contact between CMHT staff and the family members and girlfriend despite the fact that he lived in the family home and had posed risks to the family at times of previous relapse.

- There was no evidence that the care co-ordinator had seen the patient at least monthly. On the progress note section of the electronic patient record, he did not record any entries of contact with the patient after 30 June 2014, there are retrospective entries however.

1.33 One service delivery problem was identified:

- the opinion of the review panel was that this case represents an example of the multi-disciplinary team, patient and carers not working together according to the accepted practice of CPA.

1.34 The internal report concludes that it was predictable that [Mr J] would be at risk of relapse should he become noncompliant with medication. The lack of engagement with his family and the high risk discharge strategy could be seen as increasing the likelihood of relapse. Given his history of suicidal behaviour it was said to be predictable that he may become suicidal on relapse, but that it would not have been possible to predict that he would commit a homicide.

1.35 The internal report made one recommendation, which summarised the concerns about safe systems of delivery of care in this team:

- The processes and systems of governing a person's care within Newham CMHT South East should be reviewed to include the following:

- The role and duties of care coordinators.

- Decision making around psychological input.

- The use of the traffic light system in determining case discussion within the MDT.

- MDT involvement with carers and family members of service users.

1.36 We were supplied with the most up to date action plan, which had been revised and updated on 18 August 2016. It was noted in an update on 3 March 2015 that the recommendations in this action plan were overtaken by the restructure of the community teams in Newham during 2015 and 2016.

## Independent investigation

1.37 The investigation was carried out by Carol Rooney, Head of Investigations for Niche, with expert advice provided by Dr Huw Stone, consultant forensic psychiatrist. Kate Jury, Partner, Niche conducted an overarching review on the structure and effectiveness of organisational governance processes, both now and at the time of the incident.

1.38 This independent investigation has drawn up on the internal process and has studied clinical information, and policies. The team has also interviewed staff who had been responsible for Mr J's care and treatment. We have not been able to speak to either family.

1.39 We have provided a review of the internal investigation and associated action plan, including oversight by NHS Newham Clinical Commissioning Group of the improvements required.

## Conclusions

1.40 The inquest in October 2015 concluded that Miss K was unlawfully killed, and Mr J died by suicide.

1.41 The Trust's internal investigation acknowledged that there were a number of care delivery problems in Mr J's care, and an overarching service delivery problem of the multi-disciplinary team, patient and carers not working together according to the accepted practice of CPA.

1.42 Our investigation concurs with this as a summary, and we have added more detail in relation to the terms of reference.

1.43 We have however reviewed the systems and processes that are now in place which govern people's care in the Newham South East Community Recovery Team. We consider that it is clear that the Trust has learnt lessons and implemented changes that have greatly improved the oversight of the quality of care.

1.44 It is our view that the homicide of Miss K and the death of Mr J were neither preventable nor predictable. There were no recent indications that Mr J presented a grave risk of harm to others, and he did not appear to be relapsing when he was seen by his psychiatrist two weeks before the homicide.

## Recommendations

1.45 This independent investigation has made six recommendations for NHS services to address in order to further improve learning from this event. The recommendations are grouped in priority order as follows:

- Priority One: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

- Priority Two: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.

**Priority One**:

**Recommendation 1:**

The Trust must provide assurance that

- Section 117 aftercare arrangements are carried out, and that
- there are structured arrangements in place to ensure that the administration and monitoring of CTOs is carried out to meet best practice guidelines.

**Recommendation 3:**

The Trust and NHS Newham CCG should develop guidelines for the integrated care and treatment of bipolar disorder across primary health and secondary mental health services, which includes guidance for GP's action with regards to uncollected prescriptions in patients under secondary mental health care.

**Recommendation 5:**

The Trust should provide assurance that the clinical risk assessment policy is applied consistently in community teams, and ensure there are systems to in place to monitor its application.

**Priority Two:**

**Recommendation 2:**

The Trust should provide assurance that the Health Records policy is being implemented in community teams.

**Recommendation 4:**

The Trust should ensure that NICE guidance 'Bipolar disorder: assessment and management' is implemented and monitored.

**Recommendation 6:**

The Trust should provide evidence that spiritual and cultural issues are effectively considered, assessed and incorporated into care plans.

## Good practice

1.46 Recovery focussed care plans using 'DIALOG+'[11] have been introduced, which are intended to provide service users with an individualised and understandable care plan which reflects their concerns and priorities. We saw samples of these and read feedback from service users and spoke to staff who had appreciated the change in approach.

1.47 The consultant psychiatrist in the Newham South CRT attends local GP practice meetings to foster communication with the mental health team, and is readily available to GPs for advice about patients.

1.48 Formal feedback by letter was provided to the GP who was involved in the investigation.

1.49 Contact was maintained with families after the event, and the investigator met with families at the inquest; and arranged communication with the victim's family in their native language.

1.50 Support and briefings were provided for staff post event, and as part of the investigation process.

1.51 It is clear that this is an organisation which has and continues to have a focus on governance, safety and effectiveness. The Trust is a front runner in quality improvement (in partnership with the Institute for Healthcare Improvement) and has a dedicated strategy to ensure that at least 10% of all staff are trained in quality improvement practices.

[11] *DIALOG+ is a therapeutic intervention that improves the communication between a health professional and a patient and, through that, outcomes of mental health care. It combines assessment, planning, intervention and evaluation in one procedure http://dialog.elft.nhs.uk/*

# 2 Independent investigation

## Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[12] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[13] The terms of reference for this investigation are given in full in Appendix A.

2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

2.3 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

2.4 The investigation was carried out by Carol Rooney, Head of Investigations for Niche, with expert advice provided by Dr Huw Stone, consultant forensic psychiatrist. Kate Jury, Partner, Niche conducted an overarching review on the structure and effectiveness of organisational governance processes, both now and at the time of the incident (reflecting on substantial service changes since the date of incident in 2014).

2.5 The investigation team will be referred to in the first person plural in the report.

2.6 The report was peer reviewed by Nick Moor, Partner, Niche.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[14]

2.8 Access to relevant records was obtained through the Trust Caldicott Guardian.[15]

2.9 As part of our investigation we met with:

- Borough Director, Newham;
- Clinical Director for adult mental health, Newham;

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*[12] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

*[13] Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

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

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

- Consultant psychiatrist for Mr J;
- Clinical psychologist for Mr J;
- Honorary consultant psychiatrist – internal report author;
- Associate Director of Assurance;
- Team Leader, Newham South East Community Recovery team (CRT);
- Clinical Lead Nurse and care coordinators, Newham South East CRT;
- Associate Director of Quality, NHS Newham Clinical Commissioning Group (CCG);
- Telephone interview with Mr J's GP from Tollgate Medical Centre;
- Telephone interview with the Director of Corporate Affairs; and
- Email correspondence with the Associate Medical Director & Consultant Psychiatrist in Psychotherapy.

2.10 The care coordinator (CPN1) had left the Trust by the time this independent investigation was commissioned. We attempted to make contact with CPN1 at the last known address but received no response, and we were unable to make contact through the NMC as they do not appear on the live register.

2.11 A full list of all documents we referenced is at Appendix B.

2.12 We have adhered to the Salmon and Scott principles as outlined below:

"The Salmon Process' is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1966 Royal Commission on Tribunals of Inquiry. The Salmon Report set out general principles of an adversarial process for conducting an inquiry, similar, in essence, to what may be expected in a court of law. However, it was recognised by Lord Justice Scott, during his 1992 inquiry into the sale of arms to Iraq, that it is not practicable or appropriate in all cases to conduct an inquiry with a full adversarial process. Whilst recognising that it is proper that all witnesses must be able to adequately present their evidence, and have access to legal advice if required, it is not necessary to allow a full process of examination and cross- examination by legal counsel in order to achieve fairness in the course of proceedings. In many cases, the financial and logistical implications of such a process would have a significant detrimental impact on the ultimate aim of the inquiry; to reach conclusions on the issue under consideration."

2.13 The draft report was shared with NHS England, the Trust, NHS Newham Clinical Commissioning Group and Tollgate Medical Centre. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

## Contact with the victim's family

2.14 The victim's family live abroad, and contact was attempted by NHS England through the police family liaison officer and a translated letter was sent, but no response was received.

2.15 Further letters have been sent, and there has been no response received.

## Contact with the perpetrator's family

2.16 Contact for the perpetrator's family was made by writing to them at the last known address, but we did not receive a response.

2.17 We have followed up with further letters but have had no response. We have attempted to make contact through professionals who are known to the family, but with no response.

## Structure of the report

2.18 Section 3 provides background information about Mr J's personal life.

2.19 Section 4 sets out the details of the care and treatment provided to Mr J. We have included a chronology of his care at Appendix E in order to provide the context in which he was known to services in Newham.

2.20 Section 5 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.21 Section 6 examines the issues arising from the care and treatment provided to Mr J and includes comment and analysis.

2.22 Section 7 sets out our overall analysis and recommendations.

2.23 A list of pseudonyms for the professionals involved in Mr J's care is at appendix C. A glossary of terms is at appendix D.

## The Homicide

2.24 Mr J killed Miss K with a hunting knife in Ilford on 31 October 2014, before fleeing after being seen. Shortly afterwards he ingested cyanide and was found dying in a nearby street an hour and a half later with Miss K's blood on his feet. An inquest into Miss K's death in October 2015 concluded that Miss K was unlawfully killed and Mr J died by suicide.

2.25 A note found on his person after his death stated: '*I loved her dearly but she gave me nothing but grief, now she has to experience the pain I did in*

*a physical way, she was too indifferent, too ambivalent ... now she has to pay the ultimate price'.*

# 3 Background of Mr J

## Childhood and family background

3.1 Mr J was 27 years of age at the time of his suicide. He was the third of five children, born in the UK of Nigerian parentage. His father and mother were separated at the time of the homicide/suicide.

3.2 He was born of normal delivery and was described by family as an energetic child, occasionally hard to discipline. He was reported by family to have left home temporarily at the age of eight after misbehaving, rather than face his father. Around this time there is a report of fire setting at school, and the only details in relation to this are that it was recorded as not a serious act of arson. It was noted that there was no history of abuse or neglect of any kind.

3.3 There were a number of moves in childhood, and at one time the family of six lived in a two-bedroom flat which his parents reported was difficult for everyone.

3.4 No problems were reported during schooling; he had friends and was not bullied. Although he truanted briefly during his GCEs, this was resolved, and he achieved A levels at Newham College.

3.5 The family moved to Hackney when Mr J was a teenager. Around this time the parents sought help from a local Pentecostal Church, as they had concerns about Mr J's sister's mental health. Mr J's mother had a strong faith, and the family were told the church could 'cure' her daughter of her mental health issues. The records note that the family said this church was like a 'cult', and dictated how members dressed and what relationships they had. It was reported by family that some members of the church were physically abused, although they themselves were not. The family stopped attending this church after seeking help for their daughter again and being turned away.

## Personal circumstances

3.6 Mr J gained a place to study a degree in medicine at Kings' College, London, but left this after two years in 2010. He had failed some exams and appeared to accept that he would require medical clearance to continue his studies.

3.7 In 2010 he started retraining as a personal fitness instructor and had applied to work in a London council leisure centre.

3.8 He did some voluntary work as a market researcher and fitness instructor, and received income support. In 2014 he trained as a security officer and a forklift driver.

3.9 Mr J had no full time employment, and lived in the family home with his mother and brother and sisters. Mr J was apparently named on the mortgage which was in arrears, and had significant credit card debt. He decided in 2012 to be taken off the mortgage and move out into supported accommodation, but later changed his mind.

## Relationships

3.10 Mr J had one significant relationship with a woman for three years, which was described as finishing in June 2008, due to distance in travelling to Wales.

3.11 Mr J described the victim Miss K as his girlfriend to family and professionals, but later information disclosed at the inquest indicated that she regarded it as a platonic relationship only, and that Mr J texted her frequently which she did not welcome.

## Contact with police and criminal justice system

3.12 The police have been involved in many of Mr J's hospital admissions. The first known contact with police was in Spain in July 2008, when he was removed from a hotel to a psychiatric hospital by police, after allegedly making noise and being unable to pay for his stay. The family reported that he was playing his guitar loudly and could not pay for the remainder of his stay, and was refusing to leave.

3.13 In October 2008 he was arrested on two consecutive days. He was initially arrested at a Porsche dealership on suspicion of fraud, when attempting to buy a car with a cheque made out to himself. CS spray was used to detain him, and he was noted by police to be 'manic' although subsequently released from custody by the forensic medical examiner.

3.14 He was arrested again the following day after throwing a child's scooter through the windscreen of a neighbour's car. Mr J's account was that he was attempting to borrow or buy the car back, as it used to belong to him. It appears that the neighbour had almost agreed to let Mr J use the car when his mother intervened, and Mr J became highly agitated. His father paid for the damage and he was not charged. He was highly agitated on arrest, stripped naked, telling police he was god. He was assessed and detained under Section 2 MHA, and admitted to the Newham Centre for Mental Health.

3.15 One week after his discharge from hospital, on 28 October 2008, Mr J was brought by police to the inpatient unit at Newham Centre for Mental Health. He had been removed from the family home after refusing to let his mother and sister leave, and being threatening towards them. He was subsequently detained on Section 3 MHA.

3.16 On 24 June 2010 he was again arrested after pick pocketing, where he took a can of coke from a woman's handbag in London. He told the arresting officer that he had been having *"mind sex"* with the woman he had been following. He was subsequently assessed and transferred to

hospital on Section 3 MHA. Just prior to this he had also been admitted to a psychiatric hospital for several days while on holiday in France with friends and was involved in a road traffic accident; at this time he had been reported missing by his family, and he was intimidating and violent on arrest, and police used CS spray to subdue him. He was subsequently assessed and transferred to hospital on Section 3 MHA.

3.17 In November 2011 Mr J was arrested with his brother and charged with fraudulently obtaining £12,000 prior to his involvement with mental health services. Both were convicted in July 2012, and Mr J received a one-year community order, was obliged to wear an electronic tag and to attend probation meetings.

3.18 On 26 March 2012 Mr J was detained by police on Section 136 MHA, after family reported that he had become very agitated, breaking furniture, and threw his bed out of a window. He was pacing up and down and started to take his clothes off when police arrived.

# 4 Care and treatment of Mr J

### July 2008 First admission

4.1 Mr J's first admission to a mental health hospital was in Spain in July 2008. Notes were not available and accounts of this time are reported by his family as that he was staying in a hotel and playing his guitar loudly, and was unable to pay for his stay. He refused to leave and was taken to a mental health hospital by police officers. He stayed for several days but no details of his presentation were available.

4.2 His family reported that he did not take the medication prescribed for him and did not seek any other medical attention after returning home. He was reported to be louder than usual, going out more, and tending to be argumentative. On one occasion he tried to convince his parents to get back together, and when his sister tried to intervene in the argument Mr J assaulted her, hitting her several times. His older brother and older sister reported that he had been violent towards his family, 'beating up' his sister (it is not clear which sister), and attempting to smash a guitar over his mother's head.

4.3 The week before the 3 October 2008 admission in Newham; Mr J tried to convince his mother that the devil did not exist because god is everywhere. To try to prove this he burned a £20 note. He later explained to ward staff that he felt at the time he needed to do something more extreme to persuade her. He placed some books and papers on the kitchen floor, soaked them in methylated spirit (which he had in his room) and set them alight. The family, including his 8-year-old sister, became distressed and had to evacuate the house. Mr J put the fire out himself. We found no evidence of any safeguarding alerts regarding this.

4.4 Mr J was arrested on 3 October 2008 and subsequently detained on Section 2 MHA, after two altercations with police. He had been overactive

and aggressive with police, and on admission was elated and aggressive and claimed he was god.

**ELFT care from October 2008**

4.5 He was admitted to Crystal Ward Psychiatric Intensive Care Unit (PICU), Newham Centre for Mental Health on 3 October 2008. He required an injection of intramuscular medication to help calm him. Mr J was aggressive again two days later, kicking ward doors and aggressive to staff. He claimed his arrest had been a misunderstanding, and said he had £100,000 cash on him to pay for the car he was trying to buy. He also claimed to be very successful at internet betting and to have won millions of pounds. His family clarified that he did not have this money, and bailiffs had been to the house to collect mortgage arrears. The mortgage was in his name.

4.6 Mr J remained elated, and attempted to minimise events prior to admission. He was very reluctant to stay in hospital and presented as grandiose, claiming that god had told him he was alright. He appealed against the Section 2 MHA, and his consultant psychiatrist advised against discharge.

4.7 A diagnosis of bipolar disorder was made, and information was shared with Mr J about the diagnosis, which he was ambivalent about. He was very reluctant to take medication and tried to insist that he was in control of his mental state and could predict that no relapses would occur. He was however anxious about the effect of his admission and diagnosis on his university course, and chose not to inform them at that stage.

4.8 Mr J was discharged from Section 2 MHA by the Mental Health Review Tribunal on 21 October 2008, and elected to leave that day. He was referred to the Home Treatment Team (HTT), whom Mr J met once, but he refused their offer of support. He was discharged on olanzapine 20 mg and lorazepam[16] 1 mg (for one week). The discharge summary sent to his GP notes in October 2008 that noted that “it is highly likely that if he is discharged he will not comply with the necessary treatment and as a result will become unwell”. The HTT offered Mr J an appointment but he declined.

4.9 On 13 November 2008 the treating consultant psychiatrist wrote a letter of concern to the president of the Mental Health Review Tribunal[17] (MHRT), and outlined the care plan that had been suggested by the care team, which was to give Mr J leave with HTT involvement to assess whether his engagement was real rather than just apparent, whilst guarding against the risk of deterioration. The consultant psychiatrist made the MRHT aware of his rapid deterioration and detention a week after discharge. A letter of acknowledgment was received form the MHRT on 21 November 2008, noting that it would be sent to the Tribunal judge for her consideration. There is no further correspondence about this.

[16] *Lorazepam is used to treat anxiety. https://www.evidence.nhs.uk/search?q=lorazepam*
[17] *Mental health review tribunal, now First Tier Tribunal. https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health*

4.10 Mr J was brought to Newham Centre for Mental Health by police officers on 28 October 2008 after his family called the police with concerns about his mental health. He was brought informally and was initially not detained. On arrival Mr J denied any problems and said he was 'free', his family had made everything up, and he wanted a solicitor before he would give any more information.

4.11 Further background information was obtained by the assessing doctor by telephoning Mr J's brother. His brother reported that Mr J's mental health had deteriorated significantly over the past week. All day he had been stating he is Jesus and being aggressive to family if they questioned him.

4.12 His brother stated that he was on the phone to his mother and Mr J told him to get off the phone because Jesus could not be allowed to speak to their mother. Mr J knocked the phone out of his hand and tried to punch him saying "I want to kill you" and attacked him, requiring three of his friends to restrain Mr J. His brother called the police and when they arrived Mr J was reported to behave normally. His brother did not give the police details then, or in their follow up call, because he said he was frightened and intimidated by Mr J.

4.13 Mr J was reported to be playing loud music at home and not sleeping for the past few days. His brother said Mr J had been driving in the Blackwall Tunnel with him and others in the car, and started driving towards oncoming traffic and when they expressed concern he threatened to kill them all by driving into a collision, and said "don't test Jesus".

4.14 In the same week Mr J began smashing up his bedroom, with his brother and a friend of his brother's present. When his brother tried to escape, Mr J chased him and dropped a heavy statue on his foot, shouting "you are all going to hell, you are going to die". His brother also said he had seen him outside shops screaming at people that they were "going to die" and said he was concerned that Mr J would assault someone.

4.15 On admission to the PICU Mr J denied all these issues and presented as quiet, but refusing to answer questions without a solicitor, and refused a physical examination.

4.16 The assessing doctors' impression was of a manic episode with psychotic symptoms, high risk to others (as reported by family) and with little insight into his need for treatment. He was detained on Section 4 MHA[18] and admitted to Crystal Ward PICU on 1:1 observations. Later that day he was detained under Section 3 MHA. Initially Mr J was angry and aggressive, demanding to be let out and tried to forcibly open ward doors. He was regarded as at high risk of violence to others, and was prescribed a course of intramuscular zuclopenthixol acuphase[19] 100 mg and lorazepam 1 mg.

[18] *Section 4 of the Mental Health Act 1983 is for admission for assessment in cases of emergency. http://www.legislation.gov.uk/ukpga/1983/20/section/4*
[19] *Clopixol Acuphase is a rapid acting antipsychotic injection. https://www.evidence.nhs.uk/search?q=clopixol+acuphase*

4.17 His presentation gradually settled over the following month, and he accepted medication, although his insight and understanding of his illness was regarded as superficial. His mother attended ward round on 16 December 2008 and was reported to be happy that he was being discharged back to the family home. It was noted that a referral had been sent to Newham Early Intervention Service (EIS), and if not accepted he would be referred back to the CMHT. He was discharged on 16 December 2008, and the GP liaison discharge form noted he had been referred to the Newham South East CMHT, and an EIS referral had been sent. His medication on discharge was olanzapine 15 mg, and sodium valproate 75 mg twice daily.

4.18 An assessment was arranged in December 2008 but Mr J did not attend. Email correspondence between the South East CMHT and the HTT on 24 December 2008 noted that the EIS assessment had been intended to serve the function of the seven day follow up, and he had not attended. The CMHT called him to try to arrange the seven day follow up visit, and although they spoke to his mother, they were unable to meet him.

4.19 Because he was not in fact 'open' to the CMHT, they requested that the HTT carry out the 7 day follow up, and they met Mr J who appeared well, but had not opened the letter from EIS. This was conveyed back to the CMHT, who requested by email that the EIS offer him another assessment, which was offered for 7 January.

4.20 On 7 January 2009 he was seen by the EIS consultant psychiatrist who informed the consultant psychiatrist at Newham Centre for Mental Health by letter that he was not accepted, because at that time the service was not accepting patients with a diagnosis of bipolar affective disorder. The EIS psychiatrist noted that Mr J had no current symptoms of mood disturbance or thought disorder, but that he was reluctant to take medication and would benefit from further work on insight.

## 2009

4.21 It appears that there was assumption that he would be taken on by the EIS, because there is a note entry on 2 January 2009 stating '*now referred to EIS, therefore close to CMHT'*. There are no clinical notes recording any contact with Mr J until after the referral in August 2009.

4.22 On 4 August 2009 Mr J was admitted to East Ham ward in Newham University Hospital after taking an overdose of GBL (gamma-butyrolactone).[20] GBL is a clear liquid solvent. It is a pro-drug for the illegal substance GHB, which means that the body naturally converts it into GHB. It is sold in the 'grey market', often as 'alloy cleaner' or 'rust remover'. He was found unconscious by his sister in the garden of the family home, and brought to hospital by ambulance.

[20] *GHB (gammahydroxybutrate) and GBL (gamma-butyrolactone), are closely related, dangerous drugs with similar sedative and anaesthetic effects. http://www.talktofrank.com/drug/ghb*

4.23 It was reported that he purchased the GBL over the internet and mixed it with four cans of cider before ingesting it. He was seen by the liaison psychiatrist and said he had intended to kill himself as he was fed up with the long wait to get better. He was referred to Newham Home Treatment Team (HTT) and assessed on the same day.

4.24 When he initially woke up he said he regretted being alive, but that changed to not presenting as suicidal on assessment by the HTT, and he spoke of looking forward to continuing his medical studies. He was noted to strongly regret his suicide attempt and was glad to be alive, and had no signs of thought disorder. He stated he now wanted to engage with services and concentrate on his studies, and saw his family as a protective factor. He had been discharged (in December 2008) with a prescription for olanzapine 20 mg but said he had not been taking it.

4.25 Mr J agreed that the HTT would visit daily to supervise medication, monitor mental state and risk to himself. The liaison psychiatrist prescribed risperidone[21] 2 mg and he was referred to the CMHT for the allocation of a care coordinator, and to have a medical review within 72 hours of his discharge from the hospital.

4.26 He was not at home for the first HTT visit on 5 August although his mother was at the home and expressed concern about him. He was however seen at home with his mother on 6 August 2009, and appeared mentally stable and said he had been taking medication. He was due to see the HTT psychiatrist on 11 August but did not attend. A joint visit was carried out on 12 August with HTT staff, CMHT staff and the HTT psychiatrist. It was noted that Mr J appeared mentally stable, with no signs of elation, thought disorder or suicidal ideas or intent. He talked of planning to return to his studies in September, and being aware that he needs to express his feelings. The agreed plan was to continue HTT support until the outcome of the referral to the CMHT was known. His risperidone was increased to 4mg daily on 7 August.

4.27 Although Mr J did not keep all appointments, he appeared to be taking his medication, and remained in contact with HTT staff. By 26 August he had still not been allocated a care coordinator by the CMHT, and had been seen weekly by HTT staff. It was agreed to discharge him from HTT care on 31 August 2009 to await allocation by the CMHT which was promised 'as soon as possible'. The medical review before discharge noted that he had no thought disorder, no mood disturbance, and no suicidal ideas or intentions. He had been given a month's supply of risperidone by Newham Hospital, and he was advised to collect a repeat prescription from his GP. His identified relapse indicators were aggressive/violent behaviour and risk to himself when unwell. He was allocated a care coordinator in October 2009.

[21] *Risperidone is an antipsychotic medicine, sometimes prescribed to treat episodes of mania or hypomania. http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Treatment.aspx*

4.28 A CPA review meeting held by Newham South East CMHT on 27 November 2009 was attended by the care coordinator, clinical psychologist, CMHT psychiatrist and Mr J. The agreed care plan was to continue with current treatment, meet with care coordinator regularly for support, monitoring of mental state, compliance and identification of risk, care coordinator to arrange three monthly medical reviews and six-monthly CPA reviews. In the section on 'carers', it is noted that there is no known carer, and therefore no need for a carers assessment.

4.29 The relapse warning signs identified were: non-compliance with treatment, elevated mood or low mood/depression, increased pressure/stress from demanding course work, re-engagement in internet gambling, increased thoughts of self-harm or suicide. His strengths noted were 'works well with professionals, aware he will need to remain compliant to avoid relapse and complete academic pursuit'. His aims were recorded as to 'remain well and achieve his dream of becoming a surgeon, and to maintain stability with the aid of medication'.

4.30 The consultant psychiatrist's medical review of 2 December 2009 notes that Mr J said he is feeling '100%', and had very good insight. At a CPA review meeting on 3 December 2009 the agreed plan was to maintain care coordinator contact, refer to psychology, maintain current medication and arrange the next CPA review for three to six months' time.

## 2010

4.31 CPN1 maintained contact with Mr J, and he was encouraged to contact psychology to make an appointment for an assessment. He arranged to see Dr E and was seen on three occasions by Dr E in March and April 2010 for assessment. It was agreed that Dr E would write an assessment report and arrange to meet to start treatment in the next couple of weeks. In late May Mr J presented as somewhat elated, and he maintained that he was taking medication and accepted a reminder to collect medication before going on a planned holiday to St Tropez in France with his brother and friends.

4.32 Mr J went to see his GP on 8 June 2010 with his mother for a mental health review appointment, and he informed the GP that he had recently been admitted to a mental health hospital in France. There had in fact been a call to the GP surgery from a psychiatrist in France earlier that week, saying he been involved in a car accident, was highly agitated and said he was not taking medication. He was apparently admitted for several days and given medication, which he stopped taking after he left. His mother came to France to bring him home.

4.33 The details of the brief admission in France, which were obtained through a later meeting with his mother, were that Mr J was in a minor car accident when driving, and a further accident when he grabbed the steering wheel because the other occupants did not agree with his religious views. The car collided with the barrier and was written off. His brother and friends who were in the car called the emergency services and Mr J was taken to a

mental health hospital. He recalled not taking any medication since his discharge in 2008.

4.34 The GP phoned the CMHT on 9 June and conveyed the details about the admission in France, and wrote to the CMHT psychiatrist on 8 June asking for an urgent review, because Mr J said he was not taking any medication.

4.35 CPN1 phoned Mr J following a discussion in the CMHT sub-team meeting. During the conversation he was noted to be guarded regarding details of his admission to hospital in France, then admitted he had not been truthful with staff about his previous compliance. It was agreed CPN1 would visit him at home, and he would be seen for a medical review on 28 June. CPN1 saw him at home on 16 June. Mr J was wearing a white Islamic gown and told him he was now called 'Mohammed Musa Al-Mahdi, and had converted to Islam two days earlier. He was described as conformational and slightly elated. Mr J said he had not taken medication since March 2010, despite telling staff he had been complaint. He was placed on 'Amber' at the sub-team meeting, and CPN1 had no further contact until he was informed of Mr J's arrest and detention on 24 June 2010.

4.36 Mr J was detained on Section 3 MHA on 24 June 2010. He was arrested in the West End for 'pickpocketing' and following a woman. At arrest he became violent & police sprayed him with CS spray. He was incoherent and was referred to the mental health nurse attached to the police station, who interviewed him. He stated he had been sent by Allah and had been having "mind sex" with the woman he had been following, and he was intimidating to the escorting custody nurse. A MHA assessment was requested, and he was detained under Section 3 MHA and he was transported to Emerald Ward, Newham Centre for Mental Health by police. He initially refused to wear the paper suit supplied by the police, then made an attempt to escape on arrival at the hospital. He was nursed in seclusion on Emerald Ward until transfer to Crystal Ward PICU the same day.

4.37 Mr J was initially treated with risperidone, and at a ward review meeting with his mother he was still elated, and was ambivalent about the diagnosis of bipolar disorder. He described his over activity and elation as being due to "spiritual power" and believed he could manage it without any interventions.

4.38 He was noted to be aggressive to staff when his needs were not met, requiring the use of 'as required' sedation. He was prescribed lithium carbonate 1000 mg at night, risperidone 2 mg, midazolam[22] liquid 5 mg twice daily and promethazine[23] 50 mg twice daily.

4.39 On 8 July 2010 Mr J asked the ward psychiatrist to call his academic supervisor at university. It was discovered that Mr J had been suspended from the course earlier in the year after failing two out of three papers in

[22] *Midazolam is used as a sedative. https://bnf.nice.org.uk/drug/midazolam.html#indicationsAndDoses*
[23] *Promethazine is sedating antihistamine, used as short term sedation. https://patient.info/medicine/promethazine-avomine-phenergan-sominex*

May 2010, but had been turning up to classes without permission. There was concern about the effects of his mental ill health on his studies and his potential future career. A decision was made that the university needed to discuss it further then would be back in touch with the mental health services, and contact details were shared. The university later conveyed that Mr J's studies had been suspended and although they would welcome him back he would be required to have clearance from occupational health and a GMC fitness to practice panel.

4.40 In early July 2010 he was effectively sleepless for several days and became highly disturbed and aggressive. He was placed in seclusion for two days and given rapid tranquillisation. He remained actively resistive to taking medication and was prescribed a course of intramuscular zuclopenthixol acetate along with his regular medication. At that time he was prescribed risperidone 2 mg twice a day, lithium carbonate 800 mg at night, midazolam liquid 7.5 mg twice a day and promethazine 50 mg twice a day. His lithium dose was increased to 1200 mg at night after the results of blood tests showed it was at 0.47 mg/L, which is not at a therapeutic level.[24]

4.41 He appealed to the MHRT on 15 July 2010. A professionals meeting was held on Crystal PICU on 13 August 2010 to discuss his ongoing and future care. Depot medication had been discussed with him, and he was not keen; he continued to maintain that he could manage his illness by himself. It was noted that his mother appeared to minimise his symptoms when she attended a ward round. The notes in June and July 2010 record efforts to include Mr J's mother in ward rounds.

4.42 The following plan was agreed:

- Switch from oral risperidone to risperidone depot;
- Continue with a mood stabiliser, currently lithium;
- Care coordinator to make contact with the university;
- Care coordinator to contact Mr J's mother to establish her understanding of his illness and her likely cooperation with any monitoring of Mr J, including whether she is happy to have her live with him on discharge;
- Close monitoring in the community given his established pattern of lying about his medication compliance. To consider supported accommodation if his mother is not willing to cooperate with monitoring;
- Regular testing and monitoring of lithium level, and suggestion that these should be done without warning, as there is concern he may stop lithium but resume just before the blood test is due;

[24] *The therapeutic range for lithium has been established as 0.4 – 1.2 mmol/L (0.4 to 1.0 mmol/L in most patients).* http://labtestsonline.org.uk/understanding/analytes/lithium/tab/test/

- A CTO[25] should be made, and conditions suggested were: residence at a designated address, compliance with depot, compliance with lithium, submission to blood tests for lithium.

4.43 A CTO was made on 19 October 2010, which was due to expire on 18 April 2011. The care plan agreed was:

- [Mr J] to comply with his care and treatment plan.
- [Mr J] to attend appointments with his care coordinator and reviews by medical staff or other mental health professionals (including psychology).
- [Mr J] to agree to random blood tests in order to monitor levels of hi medication.
- [Mr J] to allow access to his accommodation, if requested by mental health professionals.

4.44 After a period of leave from the ward, Mr J was discharged on 19 October 2001. A seven day follow up visit was carried out on 25 October, when Mr J was seen by CPN1 and Dr E. Mr J reported struggling with the diagnosis of bipolar disorder, but was accepting lithium carbonate. He was willing to re-engage with Dr E, and an appointment was made for 4 November 2010.

4.45 A second opinion appointed doctor (SOAD)[26] saw Mr J on 10 November 2010, although it is not clear why this was requested. CPN1 met the SOAD on 10 November with Mr J and he was said to display some insight regarding the need for ongoing treatment. The SOAD gave the opinion that he did not have any current psychotic symptoms and had gained some insight into his illness. The following medication was agreed by the SOAD on 17 November 2010:

- one antipsychotic drug excluding clozapine;
- one antimuscarinic drug; and
- one antimanic drug orally.

4.46 Mr J was seen by Dr E on 19 November, 23 November, 1 December, and 15 December 2010. There are no further entries made by CPN1 in 2010, which suggests he was not seen by the care coordinator for the appropriate CTO monitoring.

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[25] *Community Treatment Order: Section 17A: The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E..*
*http://www.legislation.gov.uk/ukpga/1983/20/section/17A*

[26] *The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. http://www.cqc.org.uk/guidance-providers/mental-health-services/second-opinion-appointed-doctors-soads.*

## 2011

4.47 CPN 1 made a ‘late entry’ in the notes on 14 January 2011, although it is not clear when he was actually seen, although the note refs to ‘Xmas ok, kept a low profile’ which suggests it was after Christmas 2010. The note records Mr J’s engagement with psychology, that he is not pursing Islam at present, recently obtaining a certificate to work as a security guard, appears ambivalent about returning to medical studies, and that that he was encourage to attend Newham football group. It is also noted that he was encouraged to attend for a blood test to obtain serum lithium levels.

4.48 Mr J was seen by Dr E on 12 January 2011; 2, and 17 February; 3,10 and 17 March; 7, 14, 21 and 28 April; 5, 12, 19 and 26 May; 2,10 and 23 June, 7,14,21 and 28 July; 4,18 and 25 August; 6,15,22 September; 13,20 October; 17 November; 8, and 15 December.

4.49 Mr J did not attend a CPA review planned for 8 February 2011, and it appears this was rearranged for 15 February. There is a note made by the psychiatrist stating this occurred, but there are no details recorded of what was discussed. RC. CPA reviews were noted on 15 Feb 2011, 2 August 2011, 23 August 2011, and 24 January 2012.

4.50 The next entry by CPN1 is a phone call to Mr J on the 29 March 2011 regarding the possibility of lifting his CTO at a medical review on 4 April, which was due to expire on 18 April 2011.

4.51 The CTO was rescinded however on 4 April 2011 after a ‘period of stability’.

4.52 The psychiatrist sent an outpatients’ letter to the GP on 8 April 2011, stating that Mr J was maintained on lithium and risperidone, suggested a possible differential diagnosis of schizo-affective disorder, but the confirmed diagnosis was bipolar affective disorder. It was requested that GP do a lithium blood test and Mr J had been asked to attend GP for health check.

4.53 A medical review was arranged for 5 October 2011 after staff at the football group noticed him behaving strangely, his care coordinator noted him staring, and his mother expressed concern. No signs of relapse were elicited by Dr D, but Mr J made virtually no eye contact. He had been prescribed lithium carbonate 1200 mg and risperidone 3 mg daily. His risperidone was increased to 4 mg, and he was to be seen regularly by the care coordinator and reviewed medically again in November 2011.

4.54 At the medical review on 21 November 2011 he appeared entirely well, and the risperidone was reduced to 3 mg per day. It was suggested that a slow change to aripiprazole be considered over the next few months.

4.55 He was seen by CPN1 on 1 December 2011 after a session with Dr E, and reported no problems with the reduced dose of risperidone.

## 2012 Last admission

4.56 In February 2012 Mr J was referred by Dr E, the team clinical psychologist, to a bipolar disorder group, which focussed on understanding his diagnosis and enhancing social skills.

4.57 Mr J was seen by Dr E on 2 Feb, 9 Feb, 1 March, 14 March, 22 March, four of these contacts were entered late, several days after the contact.

4.58 On 21 March 2012 Mr J was brought to Newham University Hospital A&E by ambulance, which his brother had called following a disturbance at home. Mr J was seen briefly by an A&E doctor, but left before he could have a mental health assessment. His care coordinator was informed by the mental health liaison nurse, and urgent follow up was advised.

4.59 Dr E saw him on 22 March and made no reference to this event, which was recorded in RiO. He was noted to be '*sitting upright and wearing very dark sunglasses*'. There was discussion about Mr J's tendency to 'retreat' from the external world rather than try to test out some of his thoughts in reality. The psychologist's clinical entry for the contact on 22 March 2012 was made on 27 March 2012, after Mr J had been detained under the MHA.

4.60 The CMHT received several phone calls from Mr J's brother on 26 March 2012, expressing concern about his mental state; he had been agitated, not sleeping and breaking things at home, and threw his bed out of the window. His brother said he did not think he had been taking his medication. The family had called the police and an ambulance, although Mr J had reportedly left the house. CMHT staff maintained contact with his mother and brother during the day, and made the police aware, and he was regarded as missing by the end of the day.

4.61 Mr J was detained by the police on Sec 136 MHA and then on Sec 3 MHA on 27 March 2012 on Emerald Ward. His father as nearest relative reported that Mr J had done a lot of damage to the house, and was reported to be happy for his son to be placed on Sec 3 and detained for treatment.

4.62 Mr J was very agitated on admission, pacing and taking his clothes off. It was planned to restart risperidone 2 mg daily, with intramuscular midazolam and haloperidol[27] for agitation; to be nursed on 15-minute observations, have a urine drug screen. Mr J later said he had stopped taking his medication three weeks earlier. A home visit was carried out by his CMHT care coordinator to meet family and observe the damage caused to the house. The door frames were damaged, the inner front door was missing, the bed was missing from Mr J's room, stair carpet and cupboard doors and mirrors upstairs were missing. His mother appeared to downplay the damage caused, and is quoted as saying "*he is my son, what can I do, maybe these things needed changing, god will provide".*

[27] *Haloperidol is a neuroleptic medicine used treat illnesses such as schizophrenia. http://www.mhra.gov.uk/home/groups/spcpil/documents/spcpil/con1490937445565.pdf*

4.63 Mr J was physically unwell (vomiting) initially on Emerald Ward, after a period in seclusion, and medical checks were carried out and it was felt he may be oversedated. He was placed on one to one observation on 28 March 2012, and appeared drowsy and disorientated. ECG and blood tests were carried out and were found to be normal, and he was encouraged to eat and drink. By 29 March he was behaving bizarrely by touching people, was restless and agitated, and absconded from the ward when staff were in handover. He was circulated to police as missing, and turned up at home. His family escorted him back to the ward. A referral to Crystal Ward ICU was made, although he was later taken out for a walk in the hospital grounds with staff for fresh air.

4.64 Mr J was more settled behaviourally by 30 March but expressing grandiose delusions, touching nurses' heads to 'grant wishes', saying what was written would come true, and stating he had powers but would not use them. Mr J absconded again on 30 March, leaving the ward without staff permission.

4.65 Police were again alerted and his family said he had been home but had gone again. Police returned him to the ward on 31 March 2012 and he was transferred to Crystal Ward PICU. He presented no management problems initially but was observed lying on the ground laughing and talking to himself, He began saying his name after asking for anything, and dressing in towels in the manner of a toga, with towels wrapped around his head. At Crystal ward round on 4 April 2012, Mr J said that his father practised voodoo, and he had found some charms belonging to his father, and had been removing these from the house, which had caused conflict with his father. He maintained that his father had a powerful hold over the family, and these charms brought a negative energy to the house and stop the family from progressing.

4.66 Mr J submitted a MHRT appeal against Section 3 MHA on 5 April 2012, which he cancelled via his solicitor on 12 April 2012.

4.67 At Crystal Ward round on 10 April 2012, it was noted that he had been observed spitting out his medication which caused an angry confrontation, the medication was then changed to liquid. Mr J was informed that blood tests would be carried out with a view to prescribing a mood stabiliser. His father apparently visited in the week without problems, however the following week Mr J again verbalised his belief that his father controls the family, and was unhappy that Mr J was trying to get rid of the voodoo charms, which prompted the family to call the police. At this time he began to talk of moving out of the family home and requested help with accessing supported accommodation.

4.68 On 11 April 2012 there is a reference to telling a nurse of finding 'talismans' of his father's that were used to practice voodoo, and maintained that the needed to move out of the family home. There does not appear to have been any discussion with his father about this.

4.69 He remained bizarre in presentation, dressing oddly, covering his face and body in oil and wearing dark glasses, but did not present a management problem and was able to use escorted walks in the grounds safely. He was transferred back to Emerald Ward on 18 April.

4.70 He was seen by the Emerald Ward consultant (Dr F) after transfer back from Crystal Ward, and was noted to have no insight, but taking medication because he is sectioned; believes this is all due to family conflicts and he explained he was clearing his room to 'cleanse it of voodoo and graveyard dust' that he claimed his father uses in practicing voodoo. He denied suicidal ideation, and said he was a "Hassasani" which was an inhabitant of the planet "Sirius", with a mission to save the world. The plan was to start depot medication and consider a CTO. He was placed on 1:1 observations due to his risk of absconding. It was requested that his solicitor and mother were invited to ward rounds, and it was planned to start him on mood stabilising medication.

4.71 On 19 April Dr E saw him on the ward, as there had been a psychology session previously planned. Dr E reflected that Mr J had not been open with him on the last occasion they met in March, had presented himself as okay without any apparent problems, and had not discussed the extent of his preoccupations. Mr J's response was that he had not wanted to talk about negative things, and went on to describe his preoccupations with voodoo. It was fed back to him that he appeared to be considering his recent relapse as a spiritual experience rather than as a result of his mental illness, and he was encouraged to discuss with his psychiatrist.

4.72 Sodium valproate was increased to 1300 mg on 24 April 2012, with a plan to review his observations, and request that the care coordinator explore supported accommodation. At this time he was still expressing that he was god and was sent to deal with the problems of the world.

4.73 He was seen at Emerald Ward round by Dr F, with his mother present. Home leave had been successful so far and he was co-operating with medication. Dr F's opinion was that he was still hypomanic, but very guarded about symptoms, although co-operating. Further overnight leave was agreed in May 2012 with his mother's agreement.

4.74 His sodium valproate blood levels were noted to be within the therapeutic range (63.9, with range from 50-100) when checked on 23 May 2012, suggesting that Mr J was taking the medication.

4.75 Mr J had access to psychological therapy on Emerald Ward, and saw a psychologist weekly in April 2012 whilst an inpatient. By May 2012 he told the psychologist that his father had now told him the items he found were in fact herbal medicines from Nigeria for his sister, and not voodoo charms. This was questioned, reflected against his previous conviction about voodoo, and Mr J maintained that he had forgiven his father for not telling him what the items really were. In May 2012 he maintained that he was unable to help people using his 'spiritual gifts' because the medication was

slowing him down. It was agreed that Dr E would be contacted when Mr J left the ward, so that psychology contact in the community could resume.

4.76 A CPA review was carried out on 29 May 2012, with his solicitor in attendance. The care coordinator noted that he had contacted his mother to ask how his leave had gone, and was told all had gone well with no risk behaviours. Mr J told the meeting that he had resolved issues with his father about voodoo items in the house, and he was better able to identify triggers to relapse.

4.77 Discharge under CTO was agreed to take place on 29 May 2012. He was to continue on risperidone depot 50 mg every two weeks, with a reducing dose of oral risperidone and of sodium valproate, to be reviewed in four weeks. The pharmacist went through his medication with him, explaining how to take them and how to manage any possible side effects; contact with Dr E was to be restarted.

4.78 The mandatory conditions of his CTO were explained to him by the social worker; these were

- To meet with his care coordinator, psychologist and RC as requested
- To remain compliant with prescribed medication, receiving his depot and oral medication regularly
- To accept random urinary drug testing

4.79 After a CPA review on 10 July 2012, the GP was requested to stop the oral risperidone, and his medication was risperidone injection 50 mg every two weeks, sodium valproate 1300 mg at night, and procyclidine 5 mg twice daily. Mr J had asked that his CTO be reconsidered, because he would like to be trusted with taking his medication. Dr G advised that he would approach this with caution given the previous history of non-compliance. The plan was to continue to see the clinical psychologist two weekly, maintain regular contact with the CPN1, with a medical review planned for November, one month before the CTO expired. His diagnosis was revised to ICD10: F31.7 (bipolar disorder in remission).[28] CPN1 entered this in the clinical record on 20 Nov 2012.

4.80 In August 2012 Newham Child and Family consultation service wrote a letter of concern following a GP referral for a younger family member. This was copied to Mr J's care co-ordinator and the care coordinator for the other family member.

4.81 After his discharge on the CTO Mr J was open to discussing obstacles to preventing future relapse with Dr E in August 2012; which were Mr J's unhelpful attitude that each of his relapses were spiritual journeys rather than accepting his mental illness, and difficulty in changing aspects of his life, such as the mortgage issues, his wish to find a job and have fulfilling

[28] *ICD-10 Diagnosis Code F31.7 Bipolar disorder, currently in remission. http://icdlist.com/icd-10/F31.7*

relationships. He also stated his manic phases gave him 'true happiness' but was open to discussing how to attain happiness without the complications that being manic brings. Warning signs of relapse were identified as:

- Becoming increasingly withdrawn, feeling that he could find happiness inside him without any need for reaching out to the external world (withdrawing into a fantasy world).

- Becoming increasingly vigilant about the existence of an enemy (e.g. father, mental health professionals, society).

4.82 How to identify and act on early warning signs was discussed. Over the next few weeks Mr J showed signs of drowsiness, and had applied to work at a leisure centre. Mr J saw Dr E in September and October 2012 and his reluctance to take medication was discussed.

4.83 His care coordinator saw him on 10 July 2012 at the CPA review with Dr F and made the corresponding RiO entry on 20 November 2012, he saw him on 11 July and made a RiO entry that day, saw him on 5 September 2012 and made the entry the same day. He saw him on 17 October 2012, entered on 1 November 2012; at this time the risperidone depot had been reduced to 37.5 mg because of his drowsiness. He had been given a blood test form to assess sodium valproate levels.

4.84 A CPA review meeting was held on 8 October 2012 (but entered on 5 December 2014) with CPN1 Dr F and Mr J. Mr J was volunteering with a charity and playing football twice a week. He was unable to access his martial arts classes because of the restrictions related to his tag (in the evenings) which would expire on 16 October. At this time he denied any thoughts of harm to himself or others, and said the valproate appeared to be keeping his mood stable. He later disclosed he had suicidal thoughts around this time, but did not disclose them. He denied using illicit drugs and stated he may have one or two cans of cider a month to relax. The CTO was discussed, as it was due to expire the following month. He was noted to be consenting to have it renewed due to past compliance issues, especially with the mood stabiliser which it was acknowledged by him as playing a major role in his last relapse. The risperidone injection was reduced to 37.5 mg very two weeks to reduce his drowsiness, sodium valproate was kept at 1300 mg, and procyclidine at 5 mg twice daily. The plan was for a medication review in two months, to be given a request to have valproate levels done by his GP, continue weekly psychotherapy, and respond to the occupational health query from the leisure centre.

4.85 He was seen by the approved mental health professional (AMHP)[29] on 29 October 2012, to ascertain his views on CTO renewal. Mr J was noted to express insight about the need for the CTO, and said it was a safeguard for

[29] *The role of approved mental health professional, or AMHP in the United Kingdom was created in the 2007 amendment of the Mental Health Act 1983 to replace the role of approved social worker, or ASW. http://webarchive.nationalarchives.gov.uk/20120503145456/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106654.pdf*

him to help him remain complaint, and is recorded as happy to have his CTO extended for a further period.

4.86 The next contact by CPN1 is 31 October 2012, which was entered on 14 November 2012. There is a note that he attended to have his sodium valproate levels assessed, and to obtain the results from the GP, but there is no record of the results.

4.87 Mr J disclosed negative thinking to Dr E on 1 November 2012, and said he had felt “extremely suicidal” approximately two weeks earlier, but resisted the urge because his family would be upset. He was encouraged to use the psychology sessions to express such feelings and work with professionals to support him. He was noted to agree to disclose suicidal ideas in future sessions or in between sessions, by phone.

4.88 He was placed on ‘amber’ by the MDT after discussion with Dr F and CPN1. CPN1 telephoned Mr J to discuss his wellbeing after this disclosure (note made on 7 November 2012). He reported feeling better, and said he had been inactive which lowered his mood; CPN1 noted that the team will need to discuss this further as he may have unmet needs. He was seen by CPN1 after his psychology session on 8 November and complained of feeling bored. On exploration of his suicidal thoughts he admitted maladaptive thoughts over the past one to two months and said he had a negative outlook on life and no motivation to change things. The natural progression of bipolar disorder was discussed. He brought details of a personal trainer course, and wanted to apply for self-directed funding, but the cost was over the threshold. CPN1 was in discussion with the funding authority.

4.89 On 12 November 2012 Mr J admitted to Dr E that he was feeling even less motivated, and to having even stronger suicidal ideas than were disclosed the previous week. Thinking styles were discussed and he was encouraged to focus on short term goals. He was more positive by the end of the session. He attended for his depot on 14 November and was noted to appear well. At the psychology session on 16 November 2012 he was much more positive and able to discuss the cyclical nature of bipolar disorder and its effect on him.

4.90 On 29 November 2012 further work was done on relapse signs with Dr E, and he was encouraged to keep a diary to identify activating events (triggers), his corresponding thoughts and beliefs and his emotional reaction to them. This note was entered in RiO on 28 February 2013.

4.91 A CPA review was held on 17 December 2012 (but entered in RiO as an event by administration staff on 12 April 2013, and the staff grade doctor’s entry is dated 5 December 2014. (after his death) At this meeting it was noted he had no evidence of psychosis, was euthymic and appeared insightful, and it was agreed that he should continue on the same medication, attend psychology session, access community activities and see his GP for health checks. It was planned for Dr F to review him in the New Year.

4.92 In a therapy session with Dr E in December 2012 Mr J started to consider making plans to move out of the family home, and thought he would need a full-time job first. He was encouraged to consider supported accommodation with the assistance of benefits initially.

## 2013

4.93 Mr J was seen on 16 January 2013 by a CMHT nurse for his depot, and on 25 January CPN1 administered the depot. It was noted that he appeared somewhat restless and possibly experiencing akathisia[30]. He accepted procyclidine to help with this and 'gave assurances about other medication'. His physical observations were taken.

4.94 On 31 January Mr J saw Dr E, and talked of feeling stressed because he was undergoing a course to qualify as a personal trainer which his mother had paid for. The theme of this session was Mr J's need to be certain of success, but finding it difficult to cope with the demands of the course. Discussions on this topic continued in sessions with Dr E in February, reflecting back to him that he tended to want guaranteed success and being intolerant of the process and hard work involved. Mr J talked of feeling hopeless and not getting the success he wanted, and was encouraged to focus on reality rather than retreating into fantasy.

4.95 In March 2013 he attended the first session of the bipolar group, and was reported to appear as though he was caught up in his internal world. He did however share that his moods seem to appear out of the blue and that manic phases were very problematic

4.96 CPN1 recorded a meeting with him (the first in 2013) on 25 March. Mr J talked of being sacked as a volunteer at the charity shop, because of background checks showing his conviction for fraud and criminal damage. He was worried about future employment but was concentrating on his goal to be employed as a fitness trainer. He was also however applying to do security guard training, and there were other financial worries related to keeping up payments on the mortgage arrears. His father was said to be gradually moving back into the family home.

4.97 The bipolar group session on 25 March 2013 focussed on depression and low mood, and Mr J spoke of feeling hopeless when low in mood, and feeling unmotivated but tries to set himself short term goals and attending gym sessions.

4.98 In April 2013 he told Dr E that he did not get a job he had applied for and was trying to remain neutral rather than be either happy or low in mood. His tendency to aim for quick and grand success, then withdraw when he thinks progress is slow was reflected back to him.

4.99 The bipolar group in April 2013 focussed on the benefits of monitoring moods, and Mr J said he would rather do this himself and felt that others

[30] *Akathisia is a condition that is characterised by motor restlessness which may range from anxiety to an inability to lie or sit quietly, or to sleep. http://www.gpnotebook.co.uk/simplepage.cfm?ID=973471744*

were sometimes too intrusive. The group the following week concentrated on the signs and symptoms of mania, and Mr J participated well, saying he can recognise the signs but does not always want intervention because he is enjoying the feeling of being high. He said he hoped he would be able to self-monitor in the future, and recognised that mania is sometimes a defence against feeling depressed for him.

4.100 The bipolar group also covered the cognitive behavioural model illustrating the links between thoughts and behaviour, and a session by a psychiatrist on medication for bipolar disorder.

4.101 During April and May sessions with Dr E focussed on his disappointment at failing to gain employment, and subsequent decision to apply to university to study physiotherapy. His pattern of trying something then moving on quickly when that was not successful was discussed, and he was encouraged to focus on applying for jobs that were more casual for instance supermarkets, where he may have a better chance of success.

4.102 A CPA review took place on 13 May 2013, (but entered on 2 August 2013) with Dr F, CPN1 and the GP in attendance along with Mr J. the CTO was due to expire on 15 May 2013.

4.103 A CTO review was recorded by the AMHP as taking place on 14 May 2013, (but entered on 5 December 2014, after his death). His mother's views had been ascertained (although his father was in fact the nearest relative) and she reported that he was doing very well and believed stopping the CTO would give him a chance to be independent and take responsibility for his mental health. He was noted to have gained weight, and stated he no longer believes his father had been involved in witchcraft, but accepted the substance in question was medication. The AMHP's recommendation was that 'consideration should be given to encourage him to take more responsibility for his mental health and continue with the depot without the CTO, which was due to expire on 25 May 2013.

4.104 Dr F discharged him from the CTO on 17 May 2013, and sent the Section 23 form to the MHA office. A phone call was made to Mr J, to confirm this.

4.105 The bipolar group ended in June 2013, and Mr J was encouraged to work on his personal plans for preventing and managing possible mood episodes. He was encouraged to share this with friends and family. Mr continued to see Dr E, and discussion was around occupying his time and applying for jobs. He was noted to be unrealistic in his plans, for instance planning to borrow a large sum of money to open his own gym and then attract customers. In July 2013 he had had been turned down for three fitness jobs and his university application was unsuccessful. He then applied to train as a security guard.

4.106 Mr J continued to attend the wellbeing clinic regularly for his depot medication of risperidone 37.5 mg, and told CMHT staff that he was feeling well, and had no psychotic or depressive symptoms.

4.107 In August 2013 the recurring theme of moving from one goal to another was discussed, as he was now undergoing security guard training. Dr E requested that they review the benefits and goals of therapy at their next session as it 'could not go on for ever'. Mr J was noted to say he thinks he benefits from the therapy, and it challenges him positively.

4.108 The bipolar group held a follow up session in August 2013, looking at prevention strategies. Mr J said he had been using thought diaries and activity planning to keep his mood stable.

4.109 CPN1 met Mr J on 18 September 2013 to administer depot medication, and talked about recent endings: the bipolar group, CTO, possibly ending weekly therapy with Dr E though no date was set. Mr J said he felt stable, and was taking oral medication with no side effects. He mentioned he may consider attending a long term bipolar group.

4.110 In September and October 2013 CPN1 administered his depot, and Mr J said he was stable, mostly attending football and trying to obtain a security licence. The need to keep active was discussed and possibly returning to market research which may help financially, and he was referred to the team employment specialist. He appeared to accept that Dr F's team believed he would still require a care coordinator for the foreseeable future, partly to avoid too many changes. Mr J said he intended to request a further reduction in his medication.

4.111 14 October 2013 (entered on Dec 5 2014 after his death) Dr F's junior doctor requested by letter that the GP reduce his risperidone depot to 25 mg, to keep sodium valproate at 1300 mg, procyclidine 5 mg twice daily and to do a plasma level, and 'forward the results to us'. A medical review was planned with Dr F for 3 months' time, and 'if he remains mentally stable the risperidone dose could be changed from intramuscular to oral'.

4.112 The reduced depot started on 7 November 2013, and CPN1 administered this on 7, 13 and 27 November, and 11 December; with Mr J reporting feeling stable in mood, although frustrated at not being successful in gaining a job.

4.113 Psychology sessions with Dr E again covered Mr J's frustration with not finding a job, and his tendency to relapse into inactivity and daydreaming about success. There were no further discussions (since this was raised by Dr E in August) about reviewing the benefits of therapy and the possibility of ending.

4.114 In December 2013 it was agreed that Mr J would work with Dr E on his lack of consistency in following through on his plans, and he agreed that lack of motivation and fear of failure were the most important factors.

## 2014

4.115 In March 2014 Mr J said he had started dating a girl he had met through a dating website, and was a bit worried about not getting too involved too quickly in order to protect himself if the relationship did not work out.

Possible ending of therapy was discussed and Mr J was reported to be curious to find out how he would cope without therapy. It was agreed to reduce the sessions to fortnightly from 6 March 2014.

4.116 On 21 March 2014 Mr J said he could cope well with the two-week gap and said maybe it was time to stop altogether. He was reminded that it was agreed to end therapy gradually and Dr E wondered at his decision to stop suddenly. Mr J said they had covered everything he had been struggling with and could not think of anything to say. It was suggested they keep to the plan of stopping gradually and review in a few weeks which he agreed. Mr J said his new girlfriend complained that he was very quiet and also wanted to see him more, and said he was being careful not to get too close as he 'would feel suffocated'. He also talked of previously pretending to take his medication, and now realising being manic is not a helpful way of being happy.

4.117 In February 2014 his psychiatrist changed to Dr D, and he was first seen in April 2014. At a pre CPA meeting with CPN1, possible follow up in outpatients with Dr D rather than through a care coordinator was discussed, as Mr J was still giving 'assurance' about adherence to oral treatment. A recent blood test for liver function had been received from his GP which required repeating. His two-month relationship with a young woman (Miss K) was discussed.

4.118 He was seen by Dr E a day later, and appeared sleepy as he said he had been on his computer until 3 am. The longstanding issue of his high hopes not being realised and then becoming inactive and hopeless was discussed. The potentially limiting effects of living with his family, not having structure and having his name on the mortgage was also discussed, as he would not be eligible for housing or other benefits.

4.119 A CPA review on 16 April 2014 (entered on 5 December 2014 after death) with Dr D and CPN1 noted his bipolar disorder was in remission, and he was currently prescribed risperidone depot 25 mg every two weeks, sodium valproate 1300 mg at night, and procyclidine 5 mg twice daily.

4.120 Dr D noted that he was seeing Dr E fortnightly, he was doing well, looking for jobs with no major mood swings. He denied any use of alcohol drugs, was not psychotic or suicidal and was 'fully compliant with meds' (medication). The plan was: to stop the depot and start risperidone tablets, 2 mg for three days, 4 mg thereafter. CPN1 was to monitor (although it does not state how often), with a progress review in three months to consider whether care-coordination was still needed.

4.121 CPN1 saw him on 8 May, after a psychology session with Dr E he was reported to give assurance of ongoing stability, said he was compliant with risperidone 4 mg at night without side effects, his mood was level and he was eating and sleeping well. He reported losing weight and having less akathisia since the depot had been stopped. He had applied to the jobcentre for a course in fork lift truck driving and was busy with his newly formed band.

4.122 Dr E saw him on 8 May 2014 (the clinical note was entered in November 2014 after his death) and he reported feeling low over the past few weeks, and was having some difficulties in his relationship. He said that he was emotionally too attached and dependent on his girlfriend to be happy and was trying to get some spiritual guidance (from the internet) to achieve inner peace. He said he had been asking his girlfriend to see her more but she had been reluctant which made Mr J insecure and anxious. Managing uncertainty and insecurity were discussed. There is no evidence that this was discussed with CPN1.

4.123 On 12 May 2014 his GP sent a fax which stated Mr J had not picked up his prescription for sodium valproate since November 2013.

4.124 Mr J had stated in his last CPA review that he was fully compliant, and his last valproate blood test showed he was compliant (0.91mg/L). It was therefore assumed he had been compliant until the blood test. He was seen on 19 May 2014 for an urgent review with CPN1 (entered in clinical notes on 5 Dec 2014 after his death) that Mr J said he was doing well, said he had been fully compliant with medication, and he was taking his friend's valproate tablets, and was not psychotic or suicidal. He was practising with his band and attending training for a job. He was still seeing Dr E. The plan was to continue on the current medication, arrange a blood test for liver function and valproate levels. CPN1 was to monitor (not stated how frequently) and the next review was to be arranged by CPN1 (interval not stated).

4.125 Mr J called Dr E on 21 May 2014 to say he would not be able to attend psychology sessions for five weeks because he had been accepted onto a five-week work programme. He agreed to let Dr E know when he was ready to resume therapy sessions.

4.126 CPN1 saw Mr J on 30 June 2014. He was casually attired but kept his sunglasses on throughout the meeting. The wearing of sunglasses during a therapy session had previously been indicator of illness, but this is not noted. He gave 'assurance of compliance' with medication, and the last prescription had been collected on 8 June. He said he attended the GP practice three weeks earlier to have blood tests for liver function, thyroid and valproate levels (CPN1 did not note any results of these blood tests). He said he had now completed his course (in fork lift truck driving) and would be not be able to attend psychology sessions fortnightly, and was now thinking of attending monthly before eventually ending. Otherwise he said his relationship with Miss K was continuing, and he was still playing in the band. CPN1 noted that they planned to obtain the most recent blood results, and Mr J was to follow up with Dr E. There are no note of results or further contact with CPN1 apart from a 16 July CPA meeting and late entry for 22 August 2014 (entered 5 December 2014).

4.127 The results of his 17 June 2014 blood tests were obtained retrospectively and entered on 28 November 2014 by Dr D. The results were sodium valproate 67.5 mg/L (trough levels of 50-100 mg/L are associated with therapeutic response in bipolar disorder; therapeutic efficacy at plasma

levels of less than 45 mg/L is doubtful)[31] and all other blood tests for kidney function, lipids, serum glucose, liver function, urea and electrolytes and haemoglobin were normal.

4.128 A CPA review on 16 July 2014 was attended by CPN1, Mr J and Dr D's junior doctor. The notes state that Mr J *'seems very well'* that he denied having any psychotic symptoms for two years now, and said his mood was normal. No psychopathology was elicited and he was thought to have insight into his illness. The oral risperidone was reduced to 3 mg daily, and a further medical review/CPA meeting was to be planned for three months.

4.129 Dr E saw Mr J in the team waiting room on 16 July 2014 when he was waiting for his medical review meeting, and he said he had just finished the work placement and would call to arrange to meet.

4.130 CPN1 entered this note retrospectively on 5 December 2014: on 8 August 2014 he went to Mr J's house (the family home) and was greeted by Mr J in presumably nightwear (spelt as '*nightmare*'). Mr J invited CPN1 upstairs to his bedroom which appeared to be a living room, with a drum kit and other items of furniture, including a bed. He reported he was still experiencing drowsiness and excessive sleep on risperidone 3 mg, and planned to request a further reduction. (We note however that in May 2014 Mr J had told CPN1 that he was not experiencing any side effects from risperidone 4 mg). He said his appetite was okay and his mood was balanced. Mr J gave '*assurance of regular adherence following a pill count'* after '*observing remainder more or less correct from date of issue'*. He discussed his plans to apply for a physiotherapy course after unsuccessful attempts to find a job using his forklift training. CPN1 noted that he made Mr J aware he would need to remain well to achieve his goals and pursue his wish to take responsibility for his recovery.

4.131 On 2 September 2014 Dr E notes that Mr J attended his last session today (entered on 6 November 2014 after his death). There is no explanation of how the decision for this to be the last session was made. It is recorded that Mr J said he was doing well, had finished his fork lift truck course but not managed to get a job yet due to lack of experience. He was again encouraged to contact the employment specialist. Mr J said his relationship with Miss K had become more distant however he did not seem troubled by this, and said it may be better to stop the relationship as it was not going in the direction he wanted. Mr J was noted to say he felt he had benefitted from therapy and had a better understanding of himself. He was very happy to be off the depot and said he planned to ask Dr D to reduce his medication further. He was reminded not to hurry this and that he had come a long way. Mr J was noted to be happy to take a break from therapy and continue to follow his life plans himself; his decision was validated and it was suggested he consider group therapy if he wished to consider therapy again in the future.

[31] *NICE 2016 Bipolar disorder: assessment and management.htttps://www.nice.org.uk/guidance/cg185*

4.132 A CPA review meeting on 15 October 2014 was attended by Dr D and Mr J only. Mr J said things were going well, despite not being able to get a job with forklifts, and was planning to return to pursuing a career in fitness. He said he was fully compliant with medication, including the full dose of sodium valproate. He was keen for his medication to be reduced, and after discussing the risk of relapse, it was agreed to reduce the risperidone to 2 mg a day. He said he does not smoke, drink or take drugs, and said he had a blood test a few months ago, '*including valproate levels'*. Crisis plans were discussed, and he said he felt prepared to take on responsibility for his wellbeing, including picking up on relapse signs. He denied any suicidal ideas, delusional thought content or mood fluctuations. He was said to be cognitively intact with good insight. Dr D summarised: '*my overall impression was that [Mr J] presented as being stable in his mental state, with no evidence of acute deterioration'*. The plan was for risperidone to be reduced to 2 mg daily, the GP to forward the latest valproate levels, discharge from care coordination, and book into outpatient clinic, to receive an appointment 'in due course'. On 21 October 2014 Mr J was sent an outpatient appointment with Dr D for 9 April 2015.

4.133 There are no further CMHT contacts, until the police called on 31 October 2014, stating that Mr J had been found collapsed with a class A drug, and a female known to him had been stabbed in the street, who later died of her injuries. Mr J also died on 31 October 2014, after admission to hospital.

4.134 The joint inquest at Walthamstow Coroner's Court in October 2015 found that Miss K died of unlawful killing and Mr J died by suicide.

# 5 Internal investigation and action plan

5.1 The internal investigation team comprised:

- Serious incident reviewer (honorary consultant psychiatrist).
- Consultant psychiatrist, Tower Hamlets Directorate.

5.2 The terms of reference require us to 'Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan'.

5.3 And to 'Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan'.

**Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.**

5.4 The internal report is a well-constructed and detailed report, which evidences the use of root cause analysis techniques. It contains a frank analysis of care and service delivery problems, and made one wide ranging recommendation to address these, which was accepted by the Trust. Because of the depth of analysis and subsequent identification of care and service delivery problems, we have reviewed this report first. We agree with the care and service delivery problems identified and have not repeated them.

5.5 We will provide our own further analysis of issues which we feel the internal report has not identified in Section 6 of this report, using the structure of the terms of reference for the independent investigation.

5.6 The Trust commissioned the investigation immediately, and it was completed on 9 February 2015, which was within the expected time frame of 60 days. It was given executive approval by the Trust Medical Director on 3 March 2015.

5.7 As is usual practice, a serious incident investigator was allocated, and a subject matter expert from another directorate (in this case a consultant psychiatrist) was appointed to assist. The lead investigator Dr L is employed by the Trust and is a retired consultant psychiatrist who has completed many local serious incident investigations. The scope of the review was from January 2014 up to and following the incident on 31 October 2014. However, Mr J's history of contact with the Trust from 2008 was also reviewed.

5.8 The terms of reference for the internal investigation were:

- To review the initial incident management and support to those involved.
- To establish the facts and any specific problems to be addressed.

- To review the care the patient was receiving at the time of the incident.
- The suitability of that care in view of the client's history and assessed health and social care needs in relation to policy and good practice guidance.
- The extent to which the care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
- To look for improvements rather than apportion blame.
- To establish how recurrence may be reduced or eliminated.
- To formulate SMART recommendations.
- To provide a report as a record of the investigation process and a means of sharing lessons from the incident.

5.9 Staff interviews were conducted with the Newham consultant psychiatrist Dr D, the associate specialist, team manager and care coordinator CPN1, and the Newham clinical director. A telephone interview was conducted with the GP, and contact with Mr J's family and Miss K's family was made. A letter was received from Mr J's sister, expressing the family's views. The Trust legal department and Metropolitan Police were also consulted.

5.10 A case note and electronic record review was described, and the use of a tabular time line, NPSA contributory factors framework and 'fishbone' diagram. These were not included in the final report; however, care and service delivery problems are described, and their contributory factors listed.

5.11 A feedback meeting was arranged for the team involved, to share the findings of the report, and individual support was provided to staff by the Trust. Feedback was provided verbally and in writing to the GP who took part.

## Care delivery problems

**Three care delivery problems (CDPs) were identified**:

5.12 CDP 1: the decision to discharge [Mr J] from CPA was inappropriately risky for the reasons given below, and the summary was that the *'naivety of the final set of care plans in 2014 did not seem to involve a true assessment of risk, which would have needed to involve collateral information from his family and girlfriend. This is in the context that the patient had had five compulsory admissions to psychiatric hospitals between 2008-2014 in three countries (Spain, France and England*)'.

1. The consultant psychiatrist joined the CMHT in February 2014 and had only met Mr J three times. CPN1 did not attend the final CPA meeting, and the psychologist, Dr E told the internal investigation team that he

never attended CPA meetings as he felt this would compromise his therapeutic role.

2. The step down from fortnightly psychotherapy, monthly care coordinator contact and three monthly medical reviews to being offered an outpatient appointment in six months was a very significant reduction in the level of support being offered to a vulnerable patient with a history of relapsing illness leading to compulsory admission followed by compulsory community treatment.

3. Mr J had switched to oral medication in April 2014 and had recently reduced the oral medication from 4 mg in April, to 3 mg in July, and to 2 mg in October 2014. He had a previous history of noncompliance, and although his valproate blood levels were adequate in June 2014, the results of this proxy for compliance were not available to Dr D at the time of discharge from CPA in October 2014.

4. Mr J would be losing contact with CPN1, who had been his care coordinator for five years, and had recently ceased psychological therapy, having worked with Dr E for five years. These were both significant losses.

5. No corroborative history was available from family members to assist discharge planning and risk management despite the fact that the patient had continued to live in the family home throughout.

5.13 The patient was not employed, had significant financial worries and was the named mortgagee of the family home of which the mortgage was known to be in arrears.

5.14 The contributory factors review did not identify any pressures to discharge the patient.

5.15 CDP 2: lack of contact between CMHT staff and the family members and girlfriend despite the fact that he lived in the family home and had posed risks to the family at times of previous relapse.

1. There was no documentation on file that any family member had been offered or undergone a carer's assessment or had refused one. A Carer's assessment is expected to be offered annually to appropriate family members.

2. No family members were invited to CPA reviews and there is no documentation on file that this was because the patient had refused their involvement.

3. At interview, the care co-ordinator acknowledged that he had no contact with family members for over a year and possibly longer.

4. None of the telephone numbers listed on file or on RiO for family members of the patient were current.

5. There is no documentation on file that the team considered offering a meeting to the girlfriend of the patient should he agree.

5.16 The contributory factors review did not ascertain any reason for the care coordinators lack of engagement with the family of the patient or his girlfriend.

5.17 CDP3: There was no evidence that the care co-ordinator had seen the patient at least monthly. On the progress note section of the electronic patient record, he did not record any entries of contact with the patient after 30 June 2014, there are retrospective entries however.

5.18 The care coordinator did not keep adequate records, there was a retrospective entry made in November 2014 regarding a contact in August 2014.

5.19 This was to be addressed in a separate process by the Trust, and we were informed that this was resolved through a formal process.

## Service delivery problems

**One service delivery problem (SDP) was identified**:

5.20 SDP1: the opinion of the review panel was that this case represents an example of the multi-disciplinary team, patient and carers not working together according to the accepted practice of CPA.

The following examples are given

1. The psychological therapy continued weekly from 2009 until March 2014 and ended relatively abruptly in September 2014. The patient had reduced to fortnightly sessions in March 2014, but then attended only 5 times including the last session in September. The ending seems to have been driven by the patient without the appropriate level of therapeutic input being discussed in the MDT.

2. Care planning requires clinical leadership and governance. The psychologist in the CMHT should be discussing all cases with the relevant clinical lead for the CMHT and Consultant for the patients. This will lead to an agreed care plan incorporating the Bio-Psych-Social model and governance of resource.

3. The panel were told that only services users on red and amber of the traffic light system were routinely discussed by the MDT and the patient was always designated as green over the time period of the review. It was unclear how MDT discussion was being recorded and transferred to the process notes of individual patients.

5.21 There were no contributory factors identified for this service delivery problem.

## Family contacts

5.22 As part of the internal investigation Mr J's sister was invited to give feedback about the family's contact with the Trust and she expressed concern about the lack of effective communication between Trust staff and the family. The examples she gave included:

1. Not feeling heard when she contacted staff in 2012 when she felt her brother was relapsing. She said she was told that admitting him would be a breach of his human rights. However later that year he was admitted as he thought aliens were coming to get him, he had destroyed most of the house and tried to escape being taken to hospital, by running naked down the street where he lived.

2. She said that the family had never been informed about how to seek services if they were concerned that the patient was relapsing.

3. Not being introduced to the health professionals looking after the patient or given information about bi-polar affective disorder.

4. Not being involved in care planning.

5. The sister believes that the patient was not taking his medication.

6. Not involving the family in thinking about the patient disengaging from services and the risks involved.

7. The family feel that the patient was not adequately supported in his attempts to find a job.

5.23 Feedback was offered to Mr J's family by letter and in person, to which they did not respond. However, the lead investigator met them at the inquest in October 2015 and shared the executive summary of the report with them, following up with a letter.

5.24 Contact was also made with the family of Miss K who lived abroad and whose first language was not English. Support was provided by the Metropolitan Police family liaison officer, who arranged for addresses to be shared, and a letter was sent to them in their native language explaining the investigation process.

5.25 The lead investigator also met Miss K's family at the inquest in October 2015, and shared a translated copy of the executive summary with them, with the support of the family liaison officer who arranged for a native speaker to be present to explain the report. This was also followed up by letter in their native language.

5.26 We found no evidence of any action taken after concerns were expressed by the family GP regarding the youngest child's health. It would be expected there would be risk assessments regarding access to children, and a safeguarding alert raised if there were concerns.

## Analysis and discussion

5.27 The internal report suggested that the root cause of this incident 'lies in the mental state of the patient in the immediately preceding time period prior to the incident. The patient had not been seen by staff from mental health services for 16 days prior to the incident so very little is known of his mental state more recently. It is clear that the patient was able to present as well at the time of the discharge CPA on 15.10.14'.

5.28 This was discussed with the lead investigator as part of this independent investigation, and it was clarified that a causal link between his discharge and the homicide/suicide could not be established, therefore this was thought to be a logical hypothesis. However, the NPSA guidance[32] identifies the root cause as the:

- 'earliest point at which action could have been taken to:
- strengthen the support system for appropriate care to be delivered;
- avert the cause of the incident or prevent its occurrence; and
- significantly reduce its impact or recurrence'.

5.29 Using this definition, we question the attribution of the root cause to the patients' mental state. A key point was the May 2014 contact regarding him not collecting prescriptions for sodium valproate; he was seen for urgent reassessment, and should have been placed on 'amber' at that time, and there should have been a change in his risk assessment and monitoring. We consider that this would have 'strengthened the support system for appropriate care to be delivered', and possibly highlighted his non-compliance.

5.30 It was noted that it could have been predicted that the patient might make a suicide attempt at the time of relapse, and he had done previously in 2009. The report does not however note that he had also disclosed suicidal ideation in October and November 2012, at a time when there were no other concerns about his mental state.

5.31 The internal report concludes that it was predictable that [Mr J] would be at risk of relapse should he become noncompliant with medication. The lack of engagement with his family and the high-risk discharge strategy could be seen as increasing the likelihood of relapse. Given his history of suicidal behaviour it was said to be predictable that he may become suicidal on relapse, but that it would not have been possible to predict that he would commit a homicide.

5.32 We agree with this formulation, as there was nothing in his history to suggest he may become homicidal. The internal report stated that the homicide was not therefore preventable, but has not applied any consideration to the preventability of the suicide. We do not consider that

[32] *NPSA 'Root Cause Analysis (RCA) toolkit'*

his suicide was preventable, because there was no evidence that he was becoming depressed, and there had been no suicidal ideas expressed for some time.

5.33 The report notes that CPN1 failed to make timely entries, and had no record of seeing Mr J after 30 June 2014. However, the report makes no comment on the lack of contemporaneous clinical records which are evident from the start date of the electronic clinical record (RiO) in February 2012. The summary of his previous care does not include reference to the absence of a continuous record of CMHT clinical contacts starting from initial referral to Newham SE CMHT in December 2008, until August 2009.

Within the electronic records there are late entries made by Dr E and CPN1. This has been explored by the Trust as a separate issue from the serious incident process.

5.34 The internal report made one recommendation, which summarised the concerns about safe systems of delivery of care in this team:

5.35 The processes and systems of governing a person's care within Newham CMHT South East should be reviewed to include the following:

- The role and duties of care coordinators
- Decision making around psychological input
- The use of the traffic light system in determining case discussion within the MDT
- MDT involvement with carers and family members of service users.

5.36 The policy states that the recommendations should be written in in a SMART Specific, Measurable, Achievable, Realistic, Timescaled) format. However, we question whether it is appropriate to write recommendations in this format and suggest that recommendations should be outcome focussed, which in turn would lead to an action plan written in a SMART format.

5.37 Immediate action taken was that the CMHT regularly discussed the issues of documentation and contact with carers and family members at its business meetings, and random spot checks of CPA documentation were being undertaken at supervision.

5.38 We were supplied with the most up to date action plan, which had been revised and updated on 18 August 2016. It was noted in an update on 3 March 2015 that the recommendations in this action plan were overtaken by the restructure of the community teams in Newham during 2015 and 2016. Before this reconfiguration each consultant had 200/300 patients on their outpatient caseload, with patients who had been on CPA for many years. In the revised structure patients are allocated to CPA only if they are complex, with an expectation of treatment for up to three years.

5.39 Relevant to this action plan was the recognition that short-term assessment work in the CMHTs made it difficult for teams to focus on the care coordination of longer term cases. The team as it was configured no longer exists, and in its place, there is the Newham South East Community Recovery Team (CRT), and a separate assessment team. A further reconfiguration followed in April 2016 after the Local Authority withdrew its staff.

5.40 A 'whole systems review' was conducted and resulted in a revised 'Newham Adult Community Recovery Teams Operational Policy' dated June 2016. This policy provides explicit guidance about the role of care coordinators, the structures for supervision in the team, and multidisciplinary team working.

The specific elements of the role and duties of care coordinators, decision making around psychological input and use of the traffic light system in determining case discussion within the MDT are addressed in this policy document.

5.41 The evidence provided by the Trust for these elements is reviewed below.

5.42 As part of the redesign, the role and responsibilities of care coordinators was 'thoroughly reviewed' and a document entitled 'the key essentials of the care coordinator' was written in August 2015, which has been incorporated into the Newham Adult Community Recovery Teams Operational Policy. This provides clear guidance for practitioners who are care coordinators and is explicit about their responsibilities, including the requirement for timely and accurate recording, family involvement and monthly supervision. The policy also covers multidisciplinary working, psychology input, and the use of the traffic light system.

5.43 The Trust's evidence for the implementation of this recommendation includes a model for 'traffic light' discussions based on the guidance in the policy; evidence from the team business meetings in November and December 2014 and January 2015, noting lessons learned from a serious incident: i.e. the requirement for every contact to be recorded, all carers to be recorded on RiO, monthly carer contacts should be in place, and all team discussions should be recorded on RiO.

It was further recommended that random spot checks of CPA documentation should be done. However this has been overtaken by the introduction of electronic systems for recording adherence to the CPA policy, which is part of the Trust's monthly performance monitoring, and there is a key performance indicator based on carers' contacts.

5.44 The new operational policy includes a section on supervision, which provides a structured approach to the discussion of caseload, expected contacts and documentation, and any performance issues. Performance against the standards for supervision of nurses, psychologist and doctors are reported on monthly by the operational team lead to the performance manager.

5.45 We visited the team base in Newham South CRT, and met with clinicians, the team manager and care coordinators. The structures for supervision of clinicians in the CRT are clear and provide a robust framework for monitoring both care planning and professional practice. Each supervision session for care coordinators reviews the caseload, visits, carer contacts, CPA plans and any other patient issues. We observed samples of supervision records and spoke to the clinical lead nurse, team manager and a number of care coordinators. Information on adherence to supervision standards is sent to the Trust information management systems and this is monitored monthly in operational meetings.

5.46 The Trust CPA policy was revised in April 2016 and identifies the processes that are embedded in the electronic record system. Since August 2015 the Trust has introduced a system for all new assessments to be carried out using the new assessment forms on RiO. Six monthly reviews are flagged in the system, and the focus is on the use of recovery focussed care plans rather than the previous 'professional focused' structure. A Trust wide project on CPA was rolled out across the Trust in April 2017, led by one of Borough Directors. There is a suite of information metrics produced by the system at team, service and Borough levels, such as care plan reviews in date, CPA reviews planned and completed, and these are reported on centrally. Monthly operational meetings with the services focus on the performance against key targets and address those that may not be met. Reports on performance of the new processes are monitored.

5.47 The Trust has a 'People Participation Strategy 2017 to 2020' which sets out the Trust's vision for participation, going beyond engagement. This is overseen by the 'People participation committee, reporting to the Executive Director of Nursing.

5.48 The provision of psychological services in the CRT is described in detail in an appendix to the operational policy, and states that psychological interventions are offered at 'step 4' of the treatment provision. Step 4 service users are defined as presenting with complex psychological difficulties, implied by a high level of severity, comorbidity and chronicity. Complexity is defined by: severity with a high level of distress and an associated significant reduction in functioning and; co-morbidity (i.e. presenting with more than one mental health difficulty) and; chronicity (i.e. difficulties present for a number of years and/or over a number of life stages, not necessarily consecutive life stages).

5.49 The treatment length is explicitly stated as one year, based on evidence base practice and practice based evidence. Exceptionally this could be continued for up to 16 months. The expectation is also that psychologists will have oversight of and facilitate case discussion groups to assist with care planning, and work as an integral part of the MDT.

5.50 This guidance was not in place in 2014, and this document addresses expectations relevant to the recommendation regarding psychological input and MDT working.

5.51 The ‘traffic light’ system is described in the operational policy as a mechanism to be used to identify complex or high-risk service users for discussion at MDT meetings. The internal reported noted that ‘*only services users on red and amber of the traffic light system were routinely discussed by the MDT and the patient was always designated as green over the time period of the review. It was unclear how MDT discussion was being recorded and transferred to the process notes of individual patients’*.

5.52 It was reported that Mr J had been rated ‘green’ over the time period of the review. There is no examination of his presentation against the traffic light criteria in the internal report however. It is arguable that he should have been rated as ‘amber’ after it was discovered that he had not collected any sodium valproate prescriptions between November 2013 and May 2014. ‘Non-compliance with care plan/ medication’ is one of the markers of the ‘amber’ category, and the interventions are: *medical review at least 4-6 weekly, care co-ordinator reviews at least once weekly, MDT Review, CPA/ Professionals meeting if required.* There is no evidence that his risk assessment was reviewed after this either.

5.53 The plans written after his medical review in May 2014 with Dr F were:

> ‘to continue on the current medication, arrange a blood test for liver function and valproate levels. [CPN1] was to monitor (not stated how frequently) and the next review was to be arranged by [CPN1]’ (interval not stated).

5.54 We believe this plan could have been strengthened by including specific intervals for meetings and reviews.

5.55 The new operational policy guidance does not direct that service users rated ‘green’ should be discussed at every meeting, but that the ‘*weekly MDT clinical meetings are structured on the Traffic Light System for effective management of risk’*. The criteria and clinical expectation for green, amber and red are clearly listed however, and it is explicitly stated that all MDT discussions should be entered in the service users file.

5.56 In practice the CRT staff described all patients being discussed, with sub team meetings being more structured. The notes of discussions are entered directly into patient’s clinical record. The consultant, ST 6 doctor, senor nurses and care coordinators all attend the weekly meeting. Each consultant has a geographical ‘patch’ and four care coordinators are allocated to this patch, making the team small and manageable. The daily ‘huddle’ which is attended by all available team members each morning also services as a forum where risk management and emerging issues can be discussed.

5.57 The Trust has thoroughly reviewed the role and responsibilities of Care Coordinators and expectations in relation to contact with family and carers are clear and there are clear standards for documentation of clinical contacts on the electronic patient record. These are regularly scrutinised

during supervision and where there are individual performance issues these are managed by supervisors with the individuals concerned.

5.58 Expectations of care co-ordinators to invite all relevant professionals to CPA meetings have been clarified with all Community Teams. This would include Psychology where involved with care co-ordinated cases. The on-going need for Psychology input according to the CPA policy would be agreed at care planning meetings. The other change is the discussion of every case in the MDT meeting that happens now, not just those rated red or amber, so that overall scrutiny of care coordinated cases is more robust.

5.59 A whole-systems review of governing a person' care within Newham has been completed which includes:

- Decision making around psychological input;
- Use of the new traffic light system (The traffic light system was fully implemented in April 2016. However, it is not considered that this case would have been flagged up by application of RAG ratings);
- MDT involvement with carers and families; and
- Introduction of random spot-checks of CPA documentation.

5.60 The Trust has robust measures for maintaining oversight of the investigation process, quality and outcomes. Action plans are monitored systematically, and evidence of implementation which is gathered by operational services is held centrally. A team of investigators works centrally, with experienced investigators available to carry out complex investigations.

5.61 There is a daily incident grading panel held with executive directors, and if an incident is escalated to STEIS, an investigation team is identified. If a more serious incident occurs such as homicide, the Associate Director of Assurance will arrange a panel with an experienced investigator and a subject matter expert from another service. All Duty of Candour notifications are managed by the Executive Medical Director.

5.62 Timelines are overseen centrally, and action plans are agreed in services and fed back to the Associate Director of Assurance. There is a twice weekly performance report on targets and timings. The Trust attends a monthly serious incident panel with NHS Newham CCG and reports incidents accordingly. The Trust attends the quarterly London quality monitoring meetings.

5.63 There is a structured coordinated approach to the oversight of action plans. Local action plans are monitored through local governance meetings, and learning conveyed through local business and team meetings. The action plans are overseen centrally, with a clear line to Board oversight.

5.64 This process is clearly documented and is overseen by the Trust Executive team, with regular updates received by the Board.

5.65 An annual report is developed for the Quality Assurance Committee, which reports to the Trust Board. A monthly serious incident group reviews trends and themes, and learning from incidents, there is a learning/feedback meeting arranged for anyone who was involved in the investigation, and a quarterly learning forum is held to discuss learning from incidents. Each service is expected to send one representative, who is then expected to feed back to their service. This meeting was also described in our visit to the Newham CRT.

5.66 Twice yearly there is a corporate learning event, focussing on themes, for example record keeping, advances in RiO, communication with families, complaints.

5.67 NHS Newham CCG hold monthly serious incident review meetings which are attended by the Trust, and incidents and reports are discussed. The CCG holds the Trust to account and maintains records of whether they have closed the incident.

5.68 In addition NHS Newham CCG holds a number of contractual meetings with the Trust, these look at a suite Key Performance Indicators, which includes CPA monitoring. There is a monthly quality focused meeting where there is a focused discussion on quality issues arising and an oversight of action plans for significant cases.

5.69 Final reports may include changes requested by the CCG, lessons learned and themes from Serious Incidents are now incorporated into the quality assurance visits the CCG carried out for mental health services.

# 6 Arising issues, comment and analysis

6.1 The internal report noted that there were failures in the systems and processes governing Mr J's care within Newham CMHT. We have identified further issues that relate to this theme.

6.2 We have structured our analysis under the headings of the specific terms of reference.

### Review and assess compliance with local policies, national guidance and relevant statutory obligations

6.3 The internal report has noted that the multi-disciplinary team were not working with the patient and carers according to the accepted practice of CPA, and has made a recommendation about this.

6.4 The Trust Health Records policy states that entries in outpatient and community services should be made within 24 hours of the event. Furthermore, the health record should be 'reliable, accurate and timely' to support:

'Continuity of care, multi-disciplinary working, defence in cases of litigation or complaints, evidence based clinical practice, administrative and managerial decision making, legal requirements including requests for access to records, clinical audit and effectiveness, statutory and contractual reporting requirements'.

6.5 There is no evidence that Mr J was provided with the expected follow up in the community following his discharge in December 2008. He had been detained on Section 3 MHA and should have been provided with aftercare under Section 117 MHA. The monitoring of the CTO in 2011 and the arrangements for review of the second CTO in 2013 in our view also fall short of best practice.

**Recommendation 1:**

The Trust must assure itself that

- Section 117 aftercare arrangements are carried out, and that
- there are structured arrangements in place to ensure that the administration and monitoring of CTOs is carried out to meet best practice guidelines.

6.6 The health records for Mr J for 2012 to 2014 contain some retrospective entries. This occurred in the professions of nursing and psychology.

6.7 We did not observe any concerns about record keeping when we visited the Newham South CRT in August 2017 and the Trust has robust processes for monitoring this, along with other CPA standards. There are monthly metrics in place for each community team, care coordinator

contacts are monitored, and a series of quality standards relating to CPA are audited. These are then reviewed by quality and compliance managers with each team leader, and any issues addressed.

6.8 However within the policy it is stated that 'Electronic records are subject to regular audit including record keeping standards and legitimate relationship access to records. This may include targeted audits'.

6.9 We believe the Trust should demonstrate the effectiveness of the systems in place that should identify and address any concerns about record keeping. In this case individual staff had accessed their notes from previous months in the preparation for their internal investigation interviews. The electronic system recorded this as being the date the notes were actually made, ie it overwrote the entry date.

6.10 There were some late entries, but the Trust was unable to demonstrate which of these were actually late entries and which were merely accessed later. The system should record both accurately, and there should be no doubt about whether an entry is late or not.

**Recommendation 2:**

The Trust should provide assurance that the Health Records policy is being implemented in community teams.

6.11 The NICE guidance for 'Bipolar disorder: assessment and management' (CG185)[33] was published in 2006, then updated in September 2014 and February 2016. There are quality statements about best practice in care and treatment, and we have commented on the relevant sections of these in relation to Mr J's care.

**Adults with bipolar disorder have their early warning symptoms and triggers of relapse, preferred response during relapse and personal recovery goals specified in their care plan (NICE).**

6.12 Early warning signs and relapse triggers had been discussed with Mr J by a range of professionals over his period of care. He had individual psychological work which elicited warning signs and triggers, with prevention plans developed. He attended a 'bipolar group' run by CMHT psychological services, and attended 11 of the 12 sessions finishing in July 2013. This focussed on understanding bipolar disorder and identifying triggers and prevention strategies. The group feedback to Mr J was that he was able to identify warning signs for mania, but when manic he was reluctant to accept feedback because being manic can be pleasant for him.

6.13 His early warning signs for mania were: voices and visions that others cannot see, bizarre thoughts, greater energy, talking more and being unusually cheerful and happy. His helpful strategies to manage mania were

[33] *Bipolar disorder: assessment and management' NICE 2016. https://www.nice.org.uk/guidance/cg185*

reducing activities, taking medication and thinking twice before making major decisions.

6.14 His early warning signs for depressions were: feeling worthless, thoughts of dying/suicide, worrying, low energy and low motivation. He had identified exercise, activities and positive self-talk as being important in managing his moods, especially when low in mood.

6.15 The feedback from the 'Illness Perception Questionnaire'[34] which was administered before and after the group showed that Mr J believed he had more control over his illness, that he was experiencing slightly less symptoms, and had greater hope that treatment can help. In contrast it was noted that he believed that bipolar disorder had a greater effect on his emotions than before the group.

6.16 His personal goals were regularly discussed in psychology sessions, and his strategies to work towards them were regularly revised and planned with him.

6.17 This element of the quality standard was we believe met with appropriative treatment.

**Carers of adults with bipolar disorder are involved in care planning, decision-making and information sharing about the person as agreed in the care plan.**

6.18 This element of the quality standard was not met appropriately. Mr J's carers and significant others were not involved in care planning.

**Adults with bipolar disorder are offered psychological interventions.**

6.19 See above section. Mr J was offered psychological interventions from 2009 to 2014. This included individual work when he was an inpatient in Emerald and Crystal wards while recovering from relapse, and the group interventions described above. Mr J was able to access psychological resources readily and appears to have had an intensive level of input, notwithstanding our comments from 6.38 to 6.65 below (re psychology).

**Adults with bipolar disorder have a physical health assessment at least annually.**

6.20 Mr J's GP was copied in to all CPA invitations, and provided with follow up letters and reports. The responsibility for physical health checks in mental healthcare was with Mr J's GP. Letters were sent to him annually reminding him of the need for physical health checks, and where needed reminders were sent. The results of these routine checks were sent to the CMHT.

6.21 What appears to have been less clear was the management and monitoring of valproate blood levels. Monitoring of valproate levels is not necessarily used as an indicator of compliance, and does not have the

[34] *The illness perceptions questionnaire measures an individual's beliefs and feelings about their illness.* https://link.springer.com/referenceworkentry/10.1007%2F978-1-4419-1005-9_461

same requirement for close physical health monitoring as lithium carbonate. Sodium valproate trough levels of 50-100 mg/L are associated with therapeutic response in bipolar disorder, however the 'BALANCE'[35] trial showed combination therapy with lithium plus valproate and lithium monotherapy are more likely to prevent relapse than is valproate monotherapy. The NICE quality standards in relation to lithium therapy are that there should be '*evidence of practice arrangements and written clinical protocols to ensure that adults with bipolar disorder who are prescribed lithium have their dosage adjusted if their plasma lithium levels are outside the optimum range'*. There was no agreed protocol regarding lithium testing between the CMHT and GP, but the level of importance of valproate monitoring in Mr J's care was unclear. The practice has its own protocol and the electronic record system flags up alerts when routine monitoring is due. However NICE guidance is to '*not routinely measure plasma valproate levels unless there is evidence of ineffectiveness, poor adherence or toxicity'*.

6.22 The most recent valproate level recorded by the GP was 18 June 2014 and was 67.5 mg/L, previously 27 November 2013 at 95.1 mg/L, and it is noted that this was faxed to the CMHT, and that this was unchanged since the previous blood test in February 2012. An internet search of guidance for the care and treatment of bipolar disorder showed that many CCGs and NHS Trusts have developed clinical guidelines for the care of bipolar disorder, with the input of primary care, pharmacy and mental health services.

6.23 The GP surgery invites patients with long term mental health issues to have annual physical health checks, and there is a system in place to flag for recall if they have not attended. There are CCG prescribing guidelines in place for lithium, but no local guidelines for other medications which may be prescribed for mood stabilisation in bipolar disorder such as sodium valproate. All letters that arrive at the surgery are reviewed by doctors and actioned, and a duty system allows for urgent issues or appointments to be addressed. There is no current system to flag up if a blood test was requested by mental health services, and the patient does not comply. With regard to the non-collection of prescriptions, there is as system in place which would flag up that a prescription has not been collected after four weeks, but it was acknowledged that a system to flag up and take action would be useful. This could be arranged as part of an individual's care planning, developed in conjunction with the mental health services.

**Adults with bipolar disorder who currently work, and those who wish to find or return to work, receive supported employment programmes.**

6.24 Work, training and occupation were regular themes in all of Mr J's contacts with CMHT professionals, and he was encouraged to use the input of the CMHT employment specialist. There was a high degree of attention given

[35] *Lithium plus valproate combination therapy versus monotherapy for relapse prevention in bipolar I disorder (BALANCE): a randomised open-label trial Lancet 2010; 375: 385–95*

to this in our opinion, and meetings were rearranged to facilitate him attending courses and placements.

6.25 The Trust now has an established programme to ensure NICE compliance, which includes gap analysis for relevant new guidance and action trackers to close gaps. Additionally, action is taken to mitigate any clinical issues, such as those found in investigations with clinical alerts from the chief medical officer.

6.26 A Trust flow chart details the process and key guidance are followed by a project board, as required.

6.27 The NICE bipolar disorder guidance was published in 2014 before the current process was established and being a retrospective key guidance (such as psychosis, depression, personality disorder etc.) is in a rolling programme for gap analysis by Divisional Management Teams. A central project board will be convened to discuss the findings and ensure mitigations, if needed.

**Recommendation 3:**

The Trust and NHS Newham CCG should develop guidelines for the integrated care and treatment of bipolar disorder across primary health and secondary mental health services, which includes guidance for GP's action with regards to uncollected prescriptions in patients under secondary mental health care.

**Recommendation 4:**

The Trust should ensure that NICE guidance 'Bipolar disorder: assessment and management' is implemented and monitored.

## Risk assessments/management plan and care planning regarding risk to others

6.28 The risks identified in CPA review documents in August 2011 were:

- Risk to others - history of non-compliance together with his lack of insight has resulted in aggression/violent behaviour leading to arrests. Fire setting and to 'excessive risk taking'.
- Self-harm: August 2009 overdose of GBL, when he was found unconscious in the garden by family.
- Vulnerability - non-compliance possibly since first contact with mental health services in July 2008, except during periods of hospital admissions, and have contributed to ongoing relapse.

- Risk related to children - eight-year-old sister had to be evacuated when [Mr J] 'had set a fire in the home to prove a point'.

6.29 After discussion in the team meeting, Mr J was noted to be graded to 'amber' using the 'traffic light' structure on 6 October 2011 after concerns were raised by his mother and staff from the football group. An urgent medical review was arranged, and his medication was adjusted. There were no further entries regarding his 'amber' status, although the Trust guidance states that in amber status the service user should have: '*medical review at least 4-6 weekly, care coordinator reviews at least once weekly, MDT review, CPA/Professionals meeting if required. Exit from amber status should only occur after MDT review and formulated care plan'*. It is evident that this guidance was not followed.

6.30 Risk to self and others appears to have been regarded as present when Mr J was manic, and that this could be through impulsive and reckless behaviour.

6.31 There are a number of concerning instances of risk behaviour, that appear to have been treated as occurring only under the influence of relapse, which may be true, but which do not feature in his risk assessment.

- June 2008; driving towards oncoming traffic.
- August 2009; suicide attempt when not apparently manic or depressed.
- June 2010; caused two car accidents by grabbing the steering wheel and causing a crash.
- June 2010; following a woman in London, approached her and took something out of her bag; later saying he was having 'mind sex with her.
- October 2010; disclosed serious suicidal thoughts when not manic or depressed.

6.32 We believe a more longitudinal assessment of Mr J's risks, both when mentally well and unwell would have assisted, as his presentation was complex, with the ability to mask relapse symptoms. The risk assessments and management plans for 2014 were not available to us, and we could find no entries by the care coordinator that referred to an updated risk assessment or care or management plan.

6.33 There are Health of the Nation Outcome Scale Payment by Results (PbR)[36] worksheets that have scores entered for 3 July 2010, 19 October 2010, 15 February 2011, 2 March 2012, 29 May 2012, 8 October 2012 and 14 April 2014. There are no corresponding entries in clinical records that record any

[36] *https://improvement.nhs.uk/uploads/documents/Annex_C_-_Mental_Health_Clustering_bookletl.pdf Mental Health Clustering Tool (MHCT) Resource. The MHCT has been developed in partnership between the Department of Health, the Royal College of Psychiatrists Centre for Advanced Learning and Conferences and the Care Pathways and Packages Project (CPPP) as a means of allocating clients to Care Clusters which in turn supports care planning and enables Mental Health Payment by Results (MH PbR).*

discussion about these scores. Mr J was allocated to care cluster 11 '*ongoing recurrent psychosis (low symptoms)*'. This patient group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.[37]

6.34 There are undated and incomplete forms for 'Beck Depression Inventory', 'Beck Anxiety Inventory', 'Clinical Outcomes Routine Evaluation outcome measure', with no corresponding notes to record outcomes and subsequent care plans.

6.35 The Trust 'Clinical Risk Assessment and Management Policy' which is available on the internet was due for review in 2014. It is however the policy in place at the time of Mr J's death. The policy expectation is that risk assessments will be completed as part of CPA documentation.

6.36 The monitoring of the policy is: 'Completion of the Risk Assessment section of the CPA documentation set as part of the CPA process is audited annually using the Trust's electronic CPA and Risk Assessment Audit Tool. An annual report is prepared for the Clinical Effectiveness Sub Committee'. We have not seen the most recent report, but this case suggests that the mechanisms to ensure the policy was applied were not robust enough to detect the lack of application of the policy in this case.

6.37 However the new electronic clinical record system (eCPA) includes an 'in line' care plan and risk assessment, and the new risk assessment document is entitled 'my safety plan', which must be completed in partnership with the service user. The audit process for the new 'eCPA' was in development at the time of this investigation, and the intention is to have a quarterly audit programme with an overarching assurance system.

**Recommendation 5:**

The Trust should provide assurance that the clinical risk assessment policy is applied consistently in community teams, and ensure there are systems in place to monitor its application.

## Impact of cessation of psychological therapy in September 2014

6.38 In this section we have summarised Mr J's psychology contacts to provide some context, and discussed the cessation of contact in 2014. Individual psychological work started in 2009. Mr J was initially offered a four-week assessment by the Newham SE CMHT clinical psychologist Dr E, which he refused, but six months later agreed. Dr E initially saw him weekly, then fortnightly from March 2014 until September 2014.

[37] *Cluster 11, Ongoing Recurrent Psychosis (Low Symptoms)*
*http://www.mednetconsult.co.uk/imhsec/index.php/clusters/psychosis/cluster-11*

6.39 Contact with Dr E was maintained in the community between his hospital admissions and after he was discharged from hospital for the final time in 2012.

6.40 Mr J was seen for six weekly sessions by a psychologist on Crystal Ward while he was an inpatient in June 2010. A report from this psychologist sums up the themes that were covered. Mr J was particularly concerned with society's definition of how a person should behave when they are happy, and found society's attitude limiting, particularly when he was defined as being 'too happy'. He described his experience of 'bliss' as a heightened state in which his awareness of the world, particularly the spiritual world, is increased.

6.41 He said he found the teachings of the Christian church which his family attended frustrating, because he wanted to find his own definitions. During his teenage years he apparently developed an interest in his Nigerian origins, being from the Yoruba tribe, and he researched folk stories, art and creativity. His heritage was said to be important to him.

6.42 His experiences of 'bliss' which started in Spain in 2008 were discussed, and Mr J said he was frustrated that other people could not understand his 'blissful' experiences, and that he did not believe his hospital admissions were necessary. He was accepting of medication because that suppresses the bliss to some extent but he continued to feel spiritual. He expressed an interest in involving family members in psychological work in the future. A meeting took place with Dr E and Mr J to hand over. We have not found any similar summary reports by the CMHT psychologist for CPA meetings.

6.43 In February 2012 it is noted that Mr J said he had been studying his cultural background, and had found out that his ancestors believed in the concept of human sacrifice for the purpose of pleasing gods. According to Mr J, his mother told him that his maternal grandfather had tried to sacrifice some of his own children, including his mother, but she survived and is now trying to warn Mr J that his father is also part of such a cult and has the intention to sacrifice him. Dr E notes he tried to challenge Mr J on some of the discrepancies in his account, and consider how his difficult relationship with his father might be further damaged by such beliefs. By the following meeting, a week later, Mr J said he was less convinced that his father might harm him by spiritual means. We were informed by the Trust that his father was not living at the family home at the time, but this is not evident from the clinical records.

6.44 There is one reference to Mr J seeing a member of the Department of Spiritual, Religious and Cultural Care in April when he was referred as an inpatient on Crystal Ward in 2012, because he said he had converted to Islam and wanted some assistance. He was seen and assessed in April 2012 and the plan agreed was that he would be supplied with a prayer mat, Quran and beads. There was no further recorded contact with this department regarding spirituality, or any further discussion of his conversion to Islam.

6.45 There is no evidence of any discussion with Mr J's father or any other family member about these issues, and any exploration of the credibility or content of his beliefs/delusions about human sacrifice, or his father practising voodoo and using charms. We have referenced this in this psychology section because it appears to us to have been an excellent opportunity to explore this in a one to one situation, however the point is relevant across all his interactions with CMHT and inpatient care teams.

**Recommendation 6:**

The Trust should provide evidence that spiritual and cultural issues are effectively considered, assessed and incorporated into care plans.

6.46 During the time he was seen by Dr E, family dynamics remained a theme of the sessions, with Mr J discussing his difficult relationship with his father and his younger sister, and his feeling that his parents had control over him; and the pros and cons of withdrawing from them.

6.47 Other themes were Mr J's tendency to have ambitious aims for a new career or form of study, then change to something else when these did not happen quickly. His plans for work in personal fitness, security, physiotherapy and forklift driving were reviewed and barriers were discussed. Mr J's insight was a recurring theme, and work was done on his early warning signs and relapse prevention plans.

6.48 After his discharge on the CTO in 2013 Mr J was open to discussing obstacles to preventing future relapse with Dr E which were: Mr J's unhelpful attitude that each of his relapses were spiritual journeys rather than accepting his mental illness, and difficulty in changing aspects of his life, such as the mortgage issues, his wish to find a job and have fulfilling relationships.

6.49 Planning diaries were used with him to try to provide more structure in his day, and help him to focus on shorter term more realistic goals.

6.50 The model of psychological therapy used was reported to be 'integrative psychotherapy', with the use of CBT and motivational interviewing techniques.

6.51 The first reference to reviewing therapy and the possibility of ending was raised by Dr E in August 2013. Dr E requested that they review the benefits and goals of therapy at their next session as it '*could not go on for ever'*. Mr J was noted to say he thinks he benefits from the therapy, and it challenges him positively. There are no notes of review or further discussion of ending until March 2014.

6.52 On 6 March 2014 Dr E raised the question of thinking about ending therapy '*at some point*' and Mr J was curious to find out how he would cope without therapy. It was agreed to reduce sessions from weekly to fortnightly from 6

March 2014. This entry was made in RiO on 21 March 2014. It appears that CPN1 learned about the possibility of ending therapy directly from Mr J on 6 March 2014.

6.53 On 21 March 2014 Mr J said he could cope well with the two-week gap and said maybe it was time to stop altogether. He was reminded that it was agreed to end therapy gradually and Dr E wondered at his decision to stop suddenly. Mr J said they had covered everything he had been struggling with and could not think of anything to say. It was suggested they keep to the plan of stopping gradually and review in a few weeks, to which he agreed.

6.54 He was seen by Dr E on 3 April and 8 May and there is no explanation for this interval being monthly rather than the plan of fortnightly. Discussions on 8 May were around him feeling low in mood because of difficulties he reported in his relationship with his 'girlfriend' (Miss K), saying he felt he was too attached and dependent, and she was reluctant to see him more often. There was discussion about Mr J's insecurity in close relationships and need for certainty and control. The clinical record for this session was entered on 6 November 2014, after Mr J's death.

6.55 Mr J phoned Dr E on 21 May 2014 to say he had been accepted onto a training course and would not be able to attend for five weeks. He agreed to let Dr E know when he would be ready to resume sessions. This was two days after an urgent medical review by Dr D, who had been informed that Mr J had not collected his prescriptions since November 2013, but this was not mentioned by Dr E.

6.56 Dr E happened to see Mr J in the team waiting room on 16 July 2014 when he was waiting for his medical review meeting, and he said he had just finished the work placement and would call Dr E to arrange to meet.

6.57 The next and final meeting with Dr E was on 2 September 2014. It is not clear from the records why this was the last session, or how this was agreed with Mr J. Mr J said he was doing well, had recently finished his training in forklift driving and applying for jobs. He was advised again to contact the employment specialist. He mentioned that his relationship with Miss K was becoming more distant, however he did not seem troubled by this. He said he felt it might be better to stop the relationship as it was not going in the direction he wanted, and distracted him from his goal of getting a job. Mr J spoke of being very happy to be off the depot and hoping that Dr D would reduce his medication further. He was gently reminded not to hurry things. Mr J was reported to be happy to give therapy a break and '*continue to follow his life plans and find out how much he is capable of relying on himself*'. This note was entered on 6 November 2014, after Mr J's death.

6.58 The terms of reference required us to '*understand if the sudden cessation of his psychological therapy in September 2014 impacted upon his mental*

*health.*' To try to answer this we have referenced the NICE guidelines for psychological therapy in bipolar disorder (2014).[38]

6.59 Psychological interventions recommended specifically for adults with bipolar disorder include:

- a psychological intervention that has been developed specifically for bipolar disorder and has a published, evidence-based manual describing how it should be delivered; **or**

- a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couple's therapy) in line with recommendations in the NICE clinical guideline on depression.

6.60 We have not been provided with any evidence that the psychological therapy was structured or evidence based, or focussed on outcomes.

6.61 The NICE guidance also states that Healthcare professionals should:

- collaborate with adults with bipolar disorder to develop a care plan that specifies early warning symptoms and triggers of mania and depression relapse, preferred response during relapse and personal recovery goals.

6.62 The British Psychological Society 'Guidelines for Clinical Psychology Services' (2011)[39] state that evaluation is a critical and integral part of a clinical psychologist's work, and that the psychologist should work collaboratively within multi-professional teams.

6.63 It is clear that Mr J himself changed his approach to psychology sessions, possibly from the time that ending was mentioned in May 2014. He appears to have become much less engaged, and appears to have decided to end them, having one more session only that was described as his last. There is no evidence that this was discussed in any depth with him, or that a structured plan for ending was agreed and implemented with Mr J, after discussion within the CMHT. We would have expected an end of therapy report after such a long period of contact.

6.64 It is not possible for us to gauge the impact this had on Mr J, and we cannot speculate. However, we believe this approach did not conform to any accepted best practice guidance in managing the ending of what was a long term therapeutic relationship. Furthermore, we consider the lack of collaborative working and poor record keeping contributed to a fragmented approach to Mr J's care. We have raised this with the Trust and received assurance that this has been addressed through a separate process.

[38] *NICE: Bipolar disorder in adults. https://www.nice.org.uk/guidance/qs95/chapter/quality-statement-4-developmental-psychological-interventions*
[39] *Guidelines for Clinical Psychology Services BPS. http://www.bps.org.uk/system/files/Public%20files/DCP/cat-804.pdf*

6.65 The provision of psychological services to the Newham Recovery team has been changed radically, and was part of the action planning after the internal report. This is discussed in detail from 5.50 above.

6.66 Therefore, we have made no recommendation about the provision of psychological services in Newham CRT.

## Level of engagement with the family and any carers assessment in relation to [Mr J's] treatment and medication compliance, in particular any identified risk to family

6.67 Liaison with Mr J's family appears to have been of the expected standard during his inpatient stays, with his mother and father invited to ward rounds and review meetings in 2008, 2010 and 2012.

6.68 His mother was present at the discharge planning meeting in December 2008.

6.69 At a CPA review meeting in November 2009, in the section on 'carers', it is noted that there is no known carer, and therefore no need for a carers assessment. This should have been explored further, and the question of whether his mother was acting as carer should have been clarified.

6.70 As discussed in the section on psychology, there is no evidence that any enquiries were made of his father or mother about his preoccupation with voodoo or charms being used by his father. See recommendation 7 above.

6.71 The notes in June and July 2010 record efforts to include Mr J's mother in ward rounds, her attitude of treating him as an adult and expecting him to problem-solve. She was described as very religious, and did not really believe in mental illness.

6.72 There appears to be some discrepancy in the application of the MHA, his father was stated to be the Nearest Relative during his detention on Section 3 in 2012. In the review of his CTO in May 2013 his mother was consulted by the AMHP, with no reference to the previous detention.

6.73 It was noted in many CPA documents that Mr J lived in the family home with his mother, two adult siblings and an eight-year-old sibling. The Trust CPA policy is clear that risk assessment must include:

- 'consideration of risk to a child if the service user is responsible for or in contact with children'; and
- 'where risk concerns are identified consideration must be given as to whether procedures for protecting children, adults at risk and the public should be triggered'.

6.74 In August 2012 Mr J's younger sibling (then aged 12) was referred by the GP to the Trust's 'Newham child and family consultation service'. The letter

sent to the GP after the assessment outlines concerns about the effects of all three of the adult siblings' mental health on the child and suggests that the family is referred to the family therapy service.

6.75 This letter was copied to CPN1 (and to the other siblings' care coordinators) and is in Mr J's clinical records. There is no record of this having been received, or of any discussion within the team about potential risk to the child. Previous reckless behaviour by Mr J when manic had caused structural damage to the house, and including setting a fire when this child was eight years old.

6.76 Clearly this letter in August 2012 should have been followed by a team discussion and an assessment of risk, and this is a failure to implement this aspect of the CPA policy. It is also a potential safeguarding concern, and we can find no evidence that it was raised as a safeguarding alert.

6.77 CPN1 admitted to the internal investigation that he had no family contact for a year or more. There are notes of sporadic contact with Mr J's family during his period of care by the CMHT, but no engagement. The Trust CPA policy contains the mandatory expectation that carers will be contacted monthly.

6.78 Family contact was explored in the internal investigation, and is referred to at section 5.22 above. It is clear from Mr J's sister's feedback that the family did not feel that they were engaged with or consulted.

6.79 There was an awareness in the CMHT of previous risk behaviour towards his brother, an assault on his sister, and reckless behaviour which put his younger sibling at risk. None of these issues were incorporated into treatment plans, or were reported as safeguarding alerts

6.80 The family of Mr J did not engage with this independent investigation; hence we do not have their direct feedback, however there is ample evidence that they were not appropriately engaged by the CMHT.

6.81 In the current system there are mandatory questions in the electronic risk assessment related to whether the service user has any contact with children under the age of 18, this is then followed by further questions about who lives in the home and what are their ages and relationships to the service user.

6.82 Safeguarding issues are reviewed in a monthly meeting in each CRT, and the team leaders have ready access to safeguarding advice and input. A list of open referrals is kept and there is a local register for any safeguarding concerns regarding children.

6.83 Carer contacts are routinely monitored using the electronic systems, and specifically addressed in structured monthly supervision with care coordinators. There is a system for monitoring the frequency and quality of supervision for all care coordinators, and this includes contact with carers. Carer contact and risk assessment in relation to children is one of the Trust

audited key performance indicators. We have seen evidence of carer contacts made by care coordinators for Newham South CRT between September 0217 and March 2018. There were a total of 445 carer contacts across 12 care coordinators, and these monthly contacts ranged from three to 22 contacts.

**Review the current processes in place around discharge in particular any association with pressures to discharge from CPA and if any subsequent discharges from CPA resulted in similar incidents**

6.84 The Trust have conducted a review of serious incidents and have not found any links between recent suicides or homicides and CPA discharge. There were no pressures to discharge from CPA found. The Trust has substantially restructured their community services, and the caseloads for consultants has changed as part of this process. At the time of the Mr J incident, each CMHT provided assessment and treatment functions, and outpatient caseloads were close to 400 each.

6.85 The Trust developed a team to provide an assessment function, and the CRT provides a recovery function only, which meant that outpatient caseloads reduced to circa 200. The CRT is supported by a comprehensive recovery group programme which is provided by the Trust, and is open to all CRT patients. The feedback we were given by management and clinical and staff was that this model allows flexibility consultants in particular and ensures that some of their time is available to the team for structured meetings to review patients, team meetings, and informal consultation. One example was that the consultant psychiatrist in the Newham South CRT was able to attend local GP practice meetings to foster communication with the mental health team, and was readily available to GPs for advice about patients, which is good practice.

6.86 The revised Community Recovery Team Operational policy provides clear guidance for discharge planning. The liaison with ward for inpatients before discharge is clear, and the responsibilities of the care coordinator are clearly listed. There is guidance for all possible discharge or transfer scenarios including transfer to another Trust service, transfer to enhanced primary care services, external transfers and transfers for young people.

6.87 Since this incident the Trust has made changes to several processes which impact directly on the management of CPA and discharge planning:

6.88 The CRT has daily safety ‘huddles’ to discuss any pressing issues, where there are team members available to discuss any concerns.

6.89 The supervision of care coordinators and the progress of their patients is structured and reviews all planned discharges.

6.90 CPA processes are now monitored through the electronic notes, and flags all due CPA reviews and plans. The system monitors the requirements for and development of Section 117 plans or discharge plans. As part of the revision of the CPA process, the Trust has introduced recovery focused

care plans called DIALOG+[40], which are embedded in the documentation, but printable for the service user. The care coordinators we spoke to said that these plans are service user/recovery focused in such a way that they can only be developed in cooperation with the service user themselves.

6.91 The sub team meetings of the CRT are more structured, and include the consultant and the care coordinators for the consultant's patients, and other professionals. Care plans and upcoming changes are discussed and minutes are kept.

6.92 The CRT has two business meetings every month, one to focus on practice issues, and the other is a performance monitoring meeting, checking that Key performance indicators such as supervision and CPA review targets are being met.

6.93 The CRT consultants attend GP practices in their patch, keeping in touch with the enhanced psychiatric liaison clinics, making themselves available to GPs and attending GP practice meetings.

6.94 The CRT has psychosocial intervention practitioners and psychologists as part of the team, who attend team and CPA meetings, and can provide formulation based discussion where required.

**Understand the decision making around [Mr J's] discharge with particular attention as to why a more tailored step down from CPA was not in place to manage any potential relapse**

6.95 The internal report stated that the decision to discharge Mr J was a high-risk decision, and it was regarded as a significant care delivery problem, as described: '*It is the opinion of the panel that the decision to discharge the patient from CPA and follow him up with an out-patient appointment in six months' time was inappropriately risky'.* The reasons given for this opinion were:

- 'The consultant psychiatrist had only joined the CMHT in February 2014 and had only seen the patient three times at the point of discharge. The care co-ordinator did not attend the discharge CPA meeting and the psychologist never attended CPA meetings as he felt that attendance would compromise his therapeutic role.

- The step-down from care co-ordination with monthly meetings, three monthly medical reviews and, in the case of the patient, fortnightly psychotherapy sessions to an outpatient appointment offered in six months' time was a very significant reduction in the level of support being offered to a vulnerable patient with a history of relapsing illness leading to compulsory admission followed by community treatment order.

[40] *DIALOG+ is a therapeutic intervention that improves the communication between a health professional and a patient and, through that, outcomes of mental health care. It combines assessment, planning, intervention and evaluation in one procedure http://dialog.elft.nhs.uk/*

- The patient had only switched from depot to oral medication in April 2014 and had recently reduced his dose of oral anti-psychotic medication (risperidone) from 4 mg in April to 3 mg in July (and at the discharge CPA) to 2 mg daily. He had a previous history of non-compliance and, although he had been tested for valproate levels in June 2014, the results of this proxy for compliance were not available to the consultant at the time of the discharge CPA in October 2014.

- The patient had recently ended therapy sessions with the CMHT psychologist in September 2014 having worked with him for five years. This was a significant loss.

- The patient would also be losing his contact with his care co-ordinator again after five years and this was another highly significant loss.

- No corroborative history was available from family members to assist discharge planning and risk management despite the fact that the patient had continued to live in the family home throughout.

- The patient was not employed, had significant financial worries and was the named mortgagee of the family home of which the mortgage was known to be in arrears.

- In summary, the naivety of the final set of care plans in 2014 did not seem to involve a true assessment of risk, which would have needed to involve collateral information from his family and girlfriend'.

6.96 We have little to add to this, as we agree with this description of the issues. However, we were told by both Dr D and Dr E that Mr J wanting to reduce his medication was a constant theme, and this had been the case from Dr D's first meeting with him. Dr D said he did believe that Mr J was genuinely well when he saw him on 15 October 2014. Mr J had been discussed with CPN1 in the CMHT meeting, and had been flagged as someone who was doing well and may be discharged from CPA in the future. In our view Dr D should have planned to see him within three months to judge the cumulative effect of the reductions in medication to a low dose. But of course, it would not have meant he would have been seen before the homicide.

6.97 It is not clear whether CPN1 was invited to the final CPA meeting in October 2014, but family and Dr E were not invited. The Trust has taken action both formally and informally regarding the issues for individual and team learning in this case.

### Caseload management or supervision issues within the team pertaining to retrospective entries

6.98 The issue of retrospective entries was addressed by the Trust with regard to CPN1, in a separate process to the serious incident investigation.

6.99 The issue of other retrospective entries by other clinicians both before and after Mr J's death did not feature as an issue in the internal report.

6.100 The health record policy states that community/outpatient entries should be made '*within 24 hours of event'*. It is clear that this standard was not adhered to, and not picked up through supervision of quality monitoring. An agreed action from the Trust action plan after the internal report was that there should be a spot check of entries, however this has been overtaken by regular quality monitoring of clinical records through audit and caseload supervision.

6.101 The way in which community care in now provided in Newham SE is radically different. Each consultant psychiatrist in the CRT has a caseload of patients which includes CPA and outpatient (non CPA) care. The team has a recovery function, and is no longer expected to screen and assess referrals. Each area has a team dedicated to assessment and screening of new referrals. Each consultant psychiatrist works with two care coordinators, and is linked directly to GP practices, and attends GP practice meetings. There is ELFT primary care liaison nursing input to GP practices, and physical health checks are monitored and any concerns addressed.

6.102 There is clear guidance about monthly supervision for care coordinators and other professions. For care coordinators this is provided by lead clinical lead nurses, and the structure for supervision includes audit of case files, review of CPA targets, carer contacts and record keeping. We saw evidence that these are carried out and reported on, and these targets are included in Trust quality monitoring requirements.

**Understand if the 'whole systems review' following the internal trust report has had a quality improvement impact on the following areas within the team and across community services within the Trust:**

6.103 This summary provides an overarching review on the structure and effectiveness of organisational governance processes, both now and at the time of the incident (reflecting on substantial service changes since the date of incident in 2014). We had a telephone interview with the Director of Corporate Affairs, and in order to form our view we have predominantly reviewed the following documents:

- Well-led Governance Review/Grant Thornton, May 2016.
- CQC Feedback Report September 2016.
- Other documents requested from the Trust such as Assurance Structure Charts.
- The internal investigation report of March 2015 was taken as read.

**Background and context:**

6.104 It is clear that this is an organisation which has and continues to have a focus on governance, safety and effectiveness. It is one of the few Trusts to gain an 'Outstanding' Feedback Rating from the CQC (including in the Well-led sub domain); in addition to this ELFT has received a broadly favourable 'Well-led' External Assessment Review and is currently rated as '2' under the NHSI Single Oversight Framework.

6.105 Over the last few years ELFT has expanded its portfolio of services, including the delivery of community services in Newham and psychological therapies in Richmond and Children and Young People's speech and language therapy in Barnet. In April 2015 the Trust gained responsibility for mental health services in Bedfordshire and Luton. In April 2016 the Local Authority withdrew social work provision and took the opportunity to redesign community based teams into more 'recovery' based teams. The two community recovery teams do not have an assessment and brief treatment function. There were several key reasons for change but a key reason was that the short-term assessment work made it difficult for teams to focus on the care coordinated longer term cases. A key line of enquiry in relation to any reconfiguration is the extent to which this change was handled and whether there were any gaps in broader governance oversight and assurance.

**Key governance indicators (health check)**

6.106 There a number of key governance indicators, most of which are covered through the NHS Improvement 'Well-led Framework' (WLF) and CQC Safety and Well-led domains which we would expect to see working well in an organisation. These include:

6.107 **Risk Management Oversight:** The WLF Framework review in 2016 did not identify any material deficiencies in relation to risk management and confirmed that the Board Assurance Framework (BAF), Corporate, Directorate and local risk registers were seen to be working well. There was seen to be a good level of central support available for risk management through training and guidance and there was a good level of consistency in relation to risk management processes between the directorates. Some smaller concerns were noted about the clarity of risk ownership and target dates for risks to be managed down. We were not able to assess the quality of decision making following the escalation of risks but it is clear that there is an ongoing focus on risk management through the assurance structure.

The Trust has not historically been a high reporter of incidents when compared to national benchmarks although numbers have increased in the last two years.

6.108 **Service change and service improvement:** ELFT does appear to have enhanced processes for the identification of, implementation and also post-implementation analysis of Cost Improvement Programmes and service redesigns. The process of managing schemes is almost wholly owned by directorates with visible support from the Executive Team. There is a strong clinical focus associated with any service redesigns, for example,

the Business Case for the transfer of services from Luton and Bedfordshire was based upon the improvement of care services. This work was underpinned by both clinical and financial due diligence.

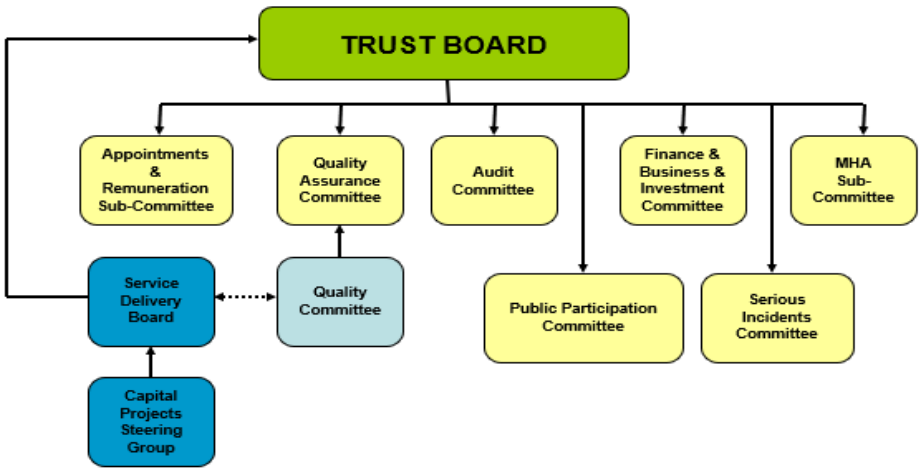
The Trust is a front runner in quality improvement (in partnership with the Institute for Healthcare Improvement) and has a dedicated strategy to ensure that at least 10% of all staff are trained in quality improvement practices. The Trust sees QI as key to delivering strategic aims and is in the process of scaling up improvement workstreams across all directorates. In the WLF Review, there was some commentary about the extent to which the Trust went back to check that service changes had embedded and actions sustained (in particular relation to incidents and complaints) although this was not seen to be an issue through the overall quality improvement programme.

6.109 **Culture and Leadership:** Again, the Trust can demonstrate significant good practice in this area. Notably, the Trust have been one of the four NHS Trusts nationally, to contribute to the development of the NHS Improvement /Kings' Fund Compassionate Culture[41] programmes. The Organisation Development Strategy has two spokes; one aimed at clinical and one at non-clinical leaders.

External Assurance through the WLF suggests that there is clear and visible leadership throughout the organisation. Board members were particularly seen to be aware of the detailed challenges 'on the ground' indicating that a) they receive good insights b) they have access to services to validate information and c) escalation routes operate effectively (through risk management and performance management processes etc.)

One of the most recognisable affirmations of organisational health is the National Staff Survey and ELFT were placed joint fourth in the Country (for like-for-like Trusts).

6.110 **The Assurance Structure:** The Trust has a fairly traditional Tier One and Two governance structure which is as follows:




[41] *The Kings Fund, work on NHS culture, compassionate and collective leadership and change management. https://www.kingsfund.org.uk/topics/organisational-culture*

6.111 Following the external Well-led review there were two notable items of commentary in relation to the governance structures and these include concerns relating to issues of timing and connectivity between Committees and the Board including:

The Trust Board sometimes received minutes which were on occasion out of step with the meeting cycle. In some cases, the Trust Board was reviewing minutes which were 2 months out of date. The timing of Committees was seen to introduce some disconnect. Items for assurance and escalation up to the Board from Committees (and sub-committees) were sometimes very brief and GT had indicated that full sets of minutes be shared.

6.112 **Data Quality:** The Trust has a Data Quality Framework which allocates degrees of confidence around data. There is also a central data warehouse and new services are migrated over to central systems and onto the main patient administration system (RiO) on a timely basis. Clinical leads have frequent liaison with the IT department and there is a clear focus on ensuring effective clinical information at the Trust. There was some commentary in the WLF Review around the frequency of validation checks for key indicators although no major issues have been identified through, for example, the Quality Account external audit.

6.113 **Safe Staffing:** Recruitment and retention of staff is an ongoing challenge for most Trusts and this is the case at ELFT. Figures for last year (to March 2016) indicate the trust vacancy rate was running at 7.2%. The turnover in the year up to January 2016 was 17%. There were also 12% of the staff who were on fixed term contracts or secondments.

Across the trust safe staffing levels are achieved most of the time, with levels of combined qualified and unqualified staff over 90%. Where the wards are unable to access qualified staff, they can book additional unqualified staff or the other way round. There are challenges around staff being able to access high-quality bank staff at last moment (as is the case nationally).
Pertinent challenges identified by the CQC in relation to Newham.
The Trust recognised that it had certain recruitment hotspots. These included staff in the Luton and Bedfordshire services, district nursing in Newham and recruiting care co-ordinators for community mental health services in London.

- In February 2016 there was a death in seclusion (Newham). Actions since then had included putting a sensor in the seclusion room to monitor patient breathing and this technology was being rolled out across all the seclusion rooms.

- In the acute mental health wards there were variations between numbers of detained patients who were absent without leave (AWOL) in the 3 months prior to the inspection. The numbers of patients who had escaped from the wards were one person in Tower Hamlets, two in City and Hackney, 11 in Newham, 14 in Luton and six in Bedfordshire. The number of patients who had gone AWOL during escorted leave

were five in Tower Hamlets, six in City and Hackney, two in Newham, 14 in Luton and one in Bedfordshire. The board were monitoring this and taking steps where needed.

- The trust was very aware of the need to support people receiving services for their mental health to have access to psychological therapies. There were lots of positive examples of this in the London services. For example, in the home treatment teams there were psychologists in both the Hackney and Newham teams. They provided assessments and initial treatment in mindfulness, cognitive behavioural therapy and distress tolerance.

- There were many examples of how the trust worked positively with external agencies. On the Newham community health inpatient wards external agencies joined the discharge meetings. This included staff who worked in the acute trust and also staff from the local authority and the local hospice.

- The arrangements for joint working with the local authorities varied across the trust. In Luton and Bedfordshire the trust directly employed social care staff. In City and Hackney a Section 75[42] agreement was in place. In Newham the local authority staff had been withdrawn from the trust services.

- For the patient led assessment of care experience the score for privacy' dignity and well-being was 90% which was similar to the England average result. In the community health services in Newham the trust used patient recorded experience measures and monitored trends over time. In March 2016 the percentage of patients giving positive responses was around 88% which matched the trust target, although this fluctuated on a month by month basis.

- We looked at the number of patients who did not attend (DNA) their appointments. The highest number of people were patients with the CMHTs. These were mainly for first appointments. The Newham assessment and brief treatment team had a DNA rate of 31% and Tower Hamlets Bow and Poplar had a DNA rate of 32%. Teams used a range of measures to reduce DNA rates. This included sending letters, making phone-calls, offering flexible appointments and also home visits. Patients who DNA were discussed by the multidisciplinary team to determine the level of risk. Work was ongoing to reduce the rates of patients who did not attend.

- There was a quality improvement project in the Community Health Newham directorate which aimed to reduce the number of formal complaints through an internal panel assessment of complaints received to determine the number that could be resolved informally in

[42] *Section 75 (National Health Service Act 2006) describes formal arrangements between NHS bodies and local authorities. National Health Service Act 2006.*

the first instance. Local managers would take responsibility for informal resolution.

6.114 It appears from the extent of good practice in relation to organisation wide governance, that the issues identified through this investigation were localised rather than systemic to the organisation.

# 7 Overall analysis and recommendations

7.1 The Trust's internal investigation acknowledged that there were a number of care delivery problems in Mr J's care, and an overarching service delivery problem of the multi-disciplinary team, patient and carers not working together according to the accepted practice of CPA.

7.2 Our investigation concurs with this as a summary, and we have added more detail in relation to the terms of reference.

7.3 We have reviewed the systems and processes that are now in place which govern people's care in the Newham CRT. We consider that it is clear that the Trust has learnt lessons and implemented changes that have greatly improved the oversight of the quality of care.

7.4 We have however made six recommendations for NHS services to address in order to further improve learning from this event. The recommendations are grouped in priority order as follows:

**Priority One**: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

**Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.

## Predictability and preventability

7.5 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[43] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[44]

7.6 We do not consider that there were any indications in Mr J's past or current presentation which would have led to a concern about his risk of committing a homicide. He did not present with any signs of relapse that might have or should have led to concerns about risk of violence to others or suicide. We conclude therefore that neither the homicide nor the suicide were predictable.

7.7 Prevention[45] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory

[43] *http://dictionary.reference.com/browse/predictability*
[44] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*
[45] *http://www.thefreedictionary.com/prevent*

counteraction"; therefore, for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring. As stated above, we do not consider that this incident was preventable, as there were no signs of relapse indicators or an increase in risk that may have raised concerns.

## Recommendations

**Priority One**:

**Recommendation 1:**

The Trust must assure itself that

- Section 117 aftercare arrangements are carried out, and that
- there are structured arrangements in place to ensure that the administration and monitoring of CTOs is carried out to meet best practice guidelines.

**Recommendation 3:**

The Trust and NHS Newham CCG should develop guidelines for the integrated care and treatment of bipolar disorder across primary health and secondary mental health services, which includes guidance for GP's action with regards to uncollected prescriptions in patients under secondary mental health care.

**Recommendation 5:**

The Trust should provide assurance that the clinical risk assessment policy is applied consistently in community teams, and ensure there are systems to in place to monitor its application.

**Priority Two:**

**Recommendation 2:**

The Trust should provide assurance that the Health Records policy is being implemented in community teams.

**Recommendation 4:**

The Trust should ensure that NICE guidance ‘Bipolar disorder: assessment and management’ is implemented and monitored.

**Recommendation 6:**

The Trust should provide evidence that spiritual and cultural issues are effectively considered, assessed and incorporated into care plans.

## Appendix A – Terms of reference

Core terms of reference

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from [Mr J's] first contact with services to the time of his offence.
- Review the appropriateness of the treatment of [codename] in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of [Mr J] harming himself or others.
- Examine the effectiveness of the [Mr J's] care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation

**Specific terms of reference**

1. To understand the decision making around [Mr J]'s discharge with particular attention as to why a more tailored step down from CPA was not in place to manage any potential relapse.
2. To review the current processes in place around discharge in particular any association with pressures to discharge from CPA and if any subsequent discharges from CPA resulted in similar incidents.
3. To understand if Mr J's previous risk to others was reflected in his current risk assessments/management plan and care planning.

4. To understand if the sudden cessation of his psychological therapy in September 2014 impacted upon his mental health.

5. To understand if the 'whole systems review' following the internal trust report has had a quality improvement impact on the following areas within the team and across community services within the Trust:

   - improved the role and duties of care coordinators
   - decision making around psychological input
   - the use of the traffic light system in determining case discussion within the MDT
   - MDT involvement with carers and family members of service users

6. To review the level of engagement with the family and any carer's assessment in relation to [Mr J]'s treatment and medication compliance, in particular any identified risk to family

7. To understand if there were any caseload management or supervision issues within the team specifically pertaining to retrospective entries following the index offence.

## Appendix B – Documents reviewed

East London NHS Foundation Trust documents

- Mr J's clinical records
- Health Records policy
- Care Programme Approach Policy v1.1
- Clinical Risk assessment and management policy
- Community Recovery Team Operational policy
- Supervision policy
- Transfer & Discharge protocol
- Incident Policy v8
- People participation strategy 2017 to 2020
- Carers strategy 2017
- Newham South CRT Carer contacts 2016-2017

Other documents

- Tollgate Medical Centre clinical records
- Well-led Governance Review / Grant Thornton, May 2016
- CQC Feedback Report September 2016
- Other documents requested from the Trust such as Assurance Structure Charts

## Appendix C – Professionals involved

| Pseudonym | Role and organisation |
|---|---|
| Dr E | Consultant clinical psychologist |
| Dr D | CMHT consultant from 2014 |
| Dr F | CMHT consultant until 2014 |
| CPN1 | Mr J's care coordinator, registered nurse |

## Appendix D – Glossary

| | |
|---|---|
| ELFT | East London NHS Foundation Trust |
| MHA | Mental Health Act |
| PICU | Psychiatric Intensive Care Unit |
| EIS | Early Intervention Service |
| CMHT | Community Mental Health Team |
| HTT | Home Treatment Team |
| CCG | Clinical Commissioning Group |
| GBL | Gamma hydroxybutyrate |
| CPA | Care Programme Approach |
| CTO | Community Treatment Order |
| CPN | Community Psychiatric Nurse |
| SOAD | Second opinion appointed doctor |
| ICD:10 | International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organization. |
| RiO | The electronic clinical records in use at ELFT |
| AMHP | Approved Mental Health Professional |
| SMART | Specific, Measurable, Achievable, Realistic, Timely |
| CDP | Care delivery problem |
| SDP | Service Delivery problem |
| CRT | Community Recovery Team |
| PbR | Payment by Results |
| DIALOG+ | DIALOG+ is a therapeutic intervention incorporating the DIALOG scale, in use at ELFT |
| WLF | Well led Framework |
| BAF | Board Assurance Framework |
| CQC | Care Quality Commission |
| DNA | Did not attend |

## Appendix E – Chronology

Chronology of the care and treatment of Mr J

**Crystal Ward: Psychiatric Intensive Care Ward**

**Emerald Ward: General Adult Ward**

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| Summary care from 2008 until 2014 | | | | |
| 03/10/2008 | 30/10/2008 | Initial Inpatient Admission | Mr J detained under S2 MHA and admitted to Crystal Ward following a referral by the SCMO Psychiatrist from the Police station. MR J had been arrested twice that day in two separate incidents. The first incident involved an attempt to by a Porsche using a fraudulent cheque, CS spray used on arrest. Mr J noted to be a bit manic but likeable and intelligent, he was released following a negative drug test. The second incident involved MR J trying to buy an expensive car from his neighbour for £600, when the neighbour refused, MR J threw a scooter through the car window. Mr J arrested and at the police station presented with a labile mood, MR J went from composed to very aggressive, taking clothes off and claimed he was God. | |
| 04/10/2008 | 30/10/2008 | Incidents during Admission | Mr J dropped his tea on the carpet and asked a female member of staff to pick it up aggressively. This was pre-empted by a visit by his mother, Mr J wanted to leave with her and various attempts to exit the ward. Mr J restrained and escorted to his room. The next day, Mr J kicked the ward door down attempting to leave. Restraint used when verbal de-escalation failed. | Mr J offered oral Lorazepam 2mg which he refused, intra-muscular injection given instead |
| 17/10/2008 | 30/10/2008 | Mental Health Review Tribunal | The Mental Health Act Tribunal Report recommends that Mr J remains in hospital for further assessment and treatment with the concern that MR J will not engage with mental health services, would deteriorate and become a risk to others and himself. | |
| 20/10/2008 | 30/10/2008 | Update to the GP | Mr J's appeal to the Mental Health Review Tribunal successful and Mr J is to be discharged from the Section. The Plan is to be offered short term support by the Home Treatment Team (HTT) and be followed up in the community by the Community Mental Health Team (CMHT) | Mr J to continue with Olanzapine 20mgs and Lorazepam 1mg |

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| 21/10/2008 | 30/10/2008 | Discharge from S2 MHA | Mr J discharged by the Mental Health Tribunal. Mr J refused the offer for ongoing support from the Home Treatment Team as he wants to live independently. Mr J agreed to comply with medication. Details of HTT given to him and the sister. Mr J agreed to engage with the Community Health Team. Decision to discharge by the Mental Health Tribunal made on the basis that treatment with HTT will be arranged for Mr J and CMHT available as an alternative. Mr J's assurance that he will continue with medication accepted. | |
| 28/10/2008 | 30/10/2008 | Inpatient Readmission | Mr J assessed and meets criteria for S3 MHA, paperwork completed. Mr J appears agitated and attempts to physically assault staff, oral medication offered refused. Mr J eventually agrees to take medication but remains threatening kicking the door and table and verbally abusive. His behaviour continues the next day, he blocks the exit door demanding to be let out. Remains hostile and aggressive with various attempts to leave | |
| 13/11/2008 | 30/10/2008 | Mental Health Review Tribunal | Letter of concern sent to the Mental Health Review Tribunal in relation to the decision to discharge Mr J from S2 MHA. Mr J had stopped medication and readmitted to the Ward one week after discharge. Police had been called to the home on 2 occasions due to aggressive and threatening behaviour | |
| 21/11/2008 | 30/10/2008 | Care Review/MDT Meeting | Mr J medication changed, Mr J to be transferred to the open ward. | Clopixol Acuphase stopped. Olanzapine 20mg restarted |
| 24/11/2008 | 30/10/2008 | Internal Ward Transfer | Mr J transferred to Emerald Ward from Crystal Ward. | |
| 24/11/2008 | 30/10/2008 | S17 MHA Leave of Absence | Mr J granted 3 hours escorted community leave. This is the first authorised leave granted. | |

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| 03/12/2008 | 30/10/2008 | Ward Round/CPA | Mr J had no problems with the 3 hours escorted leave, the plan is to increase next leave to 5 hours and discharge to Day Case. | Wean off Lorazepam, dose changed to 0.5mg |
| 09/12/2008 | 30/10/2008 | Ward Round/CPA | Mr J to be discharged from S3 MHA. Discharge CPA meeting planned for the next week with a family member in attendance. | Olanzapine reduced to 15mg |
| 16/12/2008 | 30/10/2008 | Care Review/MDT Meeting | Mr J's mother in attendance. Discharged to Day case, reason for the Early Intervention Service (EIS) referral refusal to be followed up, the alternative plan is a CMHT referral. | |
| 16/01/2009 | 30/10/2008 | EIS Referral | Letter from EIS in relation to the admission criteria, the service was not currently accepting cases with a diagnosis of bipolar affective disorder. Mr J not suitable for the service. | |
| 03/08/2009 | 30/10/2008 | Request for Assessment following Suicide Attempt | A letter to Home Treatment Team Manager requesting that an assessment is carried out on Mr J on discharge. Mr J had been admitted to the East Ham Ward and following an overdose of the illegal synthetic amphetamine GBL. Mr J bought this over the internet after he heard discussion of this agent and that someone had died from taking GBL with excess alcohol. | |
| 04/08/2009 | 30/10/2008 | Referral and Risk Assessment | Referral from HTT to CMHT. Mr J had been referred to HTT following a suicide attempt. Mr J had relapsed due to non-compliance to medication. | MR J had been discharged to HTT on Olanzapine 20mg. Commenced on Risperidone 2mg |
| 04/08/2009 | 04/08/2009 | HTT Visits | Appointment letter from the CMHT to Mr J in relation to a visit by the HTT on 12 August 2009. | |
| 05/08/2009 | 04/08/2009 | Clinical Care Review | The plan is for HTT daily visits. | Risperidone increase to 4mg from 7 August 2009 |

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| 26/08/2009 | 04/08/2009 | Discharge from HTT | GP Discharge Liaison Form indicates that Mr J was discharged without a Care Coordinator being assigned. | Mr J discharged on Risperidone 2mg for 56 days |
| 31/08/2009 | 04/08/2009 | Discharge Notification | The discharge assessment indicates that Mr J initially did not want to engage with HTT. Staff continued home visits and telephone contacts until he was willing to engage. The plan is for Mr J to be referred to HTT if there is a mental health crisis. Identified relapse indicators as aggressive/violent behaviour and risk to self when unwell | |
| 08/06/2010 | 21/09/2009 | Urgent Review Request | Letter requesting an urgent review. Mr J attended the centre for a mental health review with his mother. The centre had been informed a few days prior to the visit that Mr J had been admitted to a psychiatric hospital in France after he drove a car and caused an accident. Mr J admitted that he was non-compliant with medication. | |
| 24/06/2010 | 24/06/2010 | Arrest and Admission | Mr J arrested for suspected theft at West End. Also arrested on allegation of following women. MR J became violent at point of arrest and was sprayed with CS gas. MR J admitted to being non-compliant to medication. | |
| 25/06/2010 | 24/06/2010 | Inpatient Admission | GP Notification of Admission to Inpatient Mental Health form confirms that Mr J has been admitted to Emerald Ward under S3 MHA | |
| 25/06/2010 | 24/06/2010 | Internal Ward Transfer | Mr J transferred to Crystal Ward from seclusion, he had been agitated whilst at Emerald Ward and wanted to leave. | Lithium Carbonate 400mg commenced |
| 01/07/2010 | 24/06/2010 | Incidents during Admission | Mr J attempted to hit a student nurse over the head with the telephone whilst making a call. | |
| 08/07/2010 | 24/06/2010 | Incidents during Admission | Mr J making unrealistic demands on staff and becomes aggressive when these are not met, heard smashing objects in his room, was extremely threatening to staff. Mr J taken to seclusion, restraint by a number of staff. | Lithium Carbonate increased to 800mg |

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| 14/07/2010 | 21/09/2009 | Mental Health Review Tribunal | Notification of Mr J's appeal against S3 MHA. | |
| 13/08/2010 | 21/09/2009 | Professionals' Meeting | An email following a Professionals' Meeting at Crystal Ward. It was agreed that a Community Treatment Order (CTO) required because Mr J was not keen on depot medication, this is in line with his view that he does not need medication and plans to discontinue this in the future. | |
| 14/10/2010 | 21/09/2009 | CTO Referral | Mr J is assessed on 15 October 2010. The CTO is based on non-compliance with medication, significant risk to self and others and previous treatment plans unsuccessful. | |
| 19/10/2010 | 24/06/2010 | Discharge from S3 MHA | Mr J Discharged on CTO with a plan for psychology review and monitored by the Care Coordinator. Occupational Health review is also planned in relation to returning to medical school. Final Diagnosis Bipolar Affective Disorder and Schizoaffective Disorder. | MR J discharged on Lithium Carbonate 1.2g and Risperidone 2mg |
| 04/04/2011 | 21/09/2009 | Discharge from CTO | Mr J discharged from CTO to remain as an informal patient with CMHT. | |
| 08/12/2011 | 21/09/2009 | Psychologist Progress Reviews | Mr J mentioned that he was hostile against girls in school who rejected him. In the sessions MR J expressed difficulty in socialising. | |
| 12/01/2012 | 21/09/2009 | Psychologist Progress Reviews | Mr J expressed the desire to establish a romantic relationship. | |
| 21/03/2012 | 21/09/2009 | Emergency Admission | Fax to CMHT and the Care Coordinator informing them of Mr J's emergency admission at 18:00 on 20/03/2012 after he removed all his belongings out of the house. Mr J left without review by the Mental Health Liaison | |
| 23/03/2012 | 26/03/2012 | Inpatient Admission | Mr J brought in on a Section 136 MHA 1983 by Police. Mr J admitted non-compliance with medication for 3 weeks. Mr J admitted on Section 3 MHA 1983 Emerald Ward. | |

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| 29/03/2012 | 26/03/2012 | AWOL Incident | AWOL Incident report, Mr J absconded from the Ward when staff were in handover. | |
| 31/03/2012 | 26/03/2012 | Internal Ward Transfer | Mr J transferred from Emerald Ward to Crystal Ward. | |
| 05/04/2012 | 21/09/2009 | Mental Health Review Tribunal | Letter in relation to MR J's appeal to S3 MHA. | |
| 18/04/2012 | 26/03/2012 | Internal Ward Transfer | Mr J transferred from Crystal Ward to Emerald Ward. | |
| 24/04/2012 | 26/03/2012 | S17 MHA Leave of Absence | Letter from Solicitors in relation to Section 17 Leave. MR J currently on 15 minutes leave on hospital ground. Leave to his family home deemed premature. The letter from the solicitors is to have this reconsidered and the current S17 MHA leave increased. Requested to be invited to Mr J's ward round. | |
| 24/05/2012 | 26/03/2012 | S17 MHA Leave of Absence | Mr J on overnight leave to family home. | |
| 29/05/2012 | 26/03/2012 | Discharge from S3 MHA | Mr J discharged to family home on CTO with a 7 day follow up by the Care Coordinator. MR J to return to Ward on 31 May 2015 for depot. MR J recommencement of Psychologist input recommended. | Mr J discharged on Procyclidine 5mg, Sodium Valproate 1300mg, Risperidone 2mg, Risperdal Consta 50mg |
| 31/05/2012 | 22/02/2011 | Agreed Follow Up | Mr J attended Emerald Ward for his depot. | |
| 14/11/2012 | 21/09/2009 | CTO Referral | A medical report for the managers' hearing recommends continuation of CTO on the basis of Mr J's health, he has been reluctant to take medication due to lack of insight. Mr J's safety is also considered to ensure compliance and swiftly address relapses. The safety of others is | |

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| | | | also considered as Mr J has displayed aggressive behaviour towards his family during relapses. | |
| 13/05/2013 | 21/09/2009 | Discharge from CTO | Letter to the GP from CMHT, MR J discharged from CTO with a Plan to continue Psychologist visit and Bipolar Affective Disorder Group. Continued monitoring by Care Coordinator recommended. | |
| 09/01/2014 | 22/02/2011 | Psychologist Progress Reviews | Psychologist suspects Mr J to be on the verge of a relapse. | Mr J discharged on Risperdal Consta reduced to 25mg, Sodium Valproate 1300mg, Procyclidine 5mg |
| 21/03/2014 | 22/02/2011 | Psychologist Progress Reviews | During the therapy session Mr J expressed that his new girlfriend thinks he is quiet and wants to see him more but he is reluctant to get too close, discussed underlying sense of being afraid to show too much of himself and being rejected by people. MR J admitted to pretending to comply with his medication in order to hide and protect his manic state. | |
| 14/04/2014 | 21/09/2009 | Risk Score | Routine Observation and Examinations - HoNos-Pbr Score Sheet, MR J's agitation scored as moderate severe, whilst vulnerability scored as severe. | |
| 08/05/2014 | 22/02/2011 | Psychologist Progress Reviews | Mr J expressed that he felt low, had asked his girlfriend to see each other more but she refused. Mr J feels quite insecure and anxious. | |
| 12/05/2014 | 22/02/2011 | Agreed Follow Up | Fax received from GP, Mr J had not picked up prescription for Sodium Valproate from 8 November 2013 to 8 May 2014. | |
| 22/08/2014 | 22/02/2011 | Home Visit | Mr J requested a reduction to Risperidone, a pill count was done and this was more or less correct from the date of issue. | |
| 02/09/2014 | 22/02/2011 | Psychologist Progress Reviews | Mr J attended his last therapy session on 2 September 2014. Mr J mentioned that his relationship with his polish girlfriend was becoming distant but did not seem troubled by this. Mr J viewed the relationship as distractive from achieving his goals. | |

| Date | Source | Event | Information | Medication |
|---|---|---|---|---|
| 15/10/2014 | 22/02/2011 | CPA Meeting | Email following a CPA review meeting on 15 October 2O14 that confirm Mr J is compliant with all medication including Sodium Valproate. Mr J asked for his medication to be reduced. | Risperidone reduced to 2mg. |
| 31/10/2014 | 22/02/2011 | Arrest | Telephone call from Police, Mr J found with class A drugs and requiring treatment. | |
| 03/11/2014 | 22/02/2011 | Incident Notification | Call to the Police by the Care Coordinator when unable to contact MR J. Care Coordinator informed of incident at Ilford on the evening of 3 November 2014 where police found a female known to MR J in the street with multiple stab wounds who later died of her injuries. MR J found collapsed in nearby street who also died in hospital. Incident reported on Datix. | |
| 06/11/2014 | 22/02/2011 | Update to the GP | Notification to the GP of Mr J's death. | |