Independent review into treatment and care provided by South London and Maudsley Mental Health Foundation Trust

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EXECUTIVE SUMMARY

INVESTIGATION INTO CARE AND TREATMENT PROVIDED BY SOUTH LONDON AND MAUDSLEY (SLAM) MENTAL HEALTH FOUNDATION TRUST

1. Introduction

1.1. This is the report of an investigation commissioned by NHS England into care and treatment provided by South London and Maudsley Mental Health Foundation Trust (SLAM) for `X', a 60yr old man who, on the morning of Friday 1st December 2017, fatally stabbed `G', another male resident at their seven-bedded supported accommodation in Southwark run by a Housing Association.

1.2. We would like to extend our condolences to the family of G who lost a brother and uncle, described by them as `vulnerable' and as `someone who wouldn't hurt a fly'. G's family remain concerned that someone who could commit such an act had been allowed to live relatively independently and they were concerned that X had been able to access knives.

1.3. X had been restricted to living at his address where he had been for almost 10 years under Section 41[1] of the Mental Health Act (MHA). The perpetrator, X, and the victim G had both been under the care of Southwark High Support Team; this is a community mental health team (CMHT) providing intensive support, monitoring, rehabilitation and advice for people, aged 18-65, who have severe and ongoing mental health problems and learning disabilities, and a history of offending.

1.4. We would like to thank the families (X's sister, G's sister and her daughters) who spoke with us over the course of the investigation, and the staff who participated in the investigation process. The team is also grateful to the Trust for providing open access to policy documents, case notes, an initial investigation report, and

[1] Section 41 is a `conditional,' potentially indefinite Order applied to ensure supervision after a Section 37 (a `hospital order') has been discharged

other material relevant to the care that was provided for X in the period leading up to 1st December 2017. This helped us to understand what changes have been made since the time of the incident and how services are provided now.

2. Methodology

2.1. More detail about how the investigation was commissioned, its Terms of Reference, the investigation team, and the methodology we used can be found in the main report attached. In summary, our approach combined a review of written material; interviews with staff who were involved in providing support for X, and with those responsible for the delivery and governance of current mental health services.

2.2. Our team also reviewed the initial investigation report prepared by the Trust immediately after the incident that led to the death of G. This concluded that G's death could not have been predicted. However, several contextual factors were highlighted in this report that may have had a bearing upon care quality and the management of risk overall. Importantly, the report is critical of X's risk assessments which, against a background of changes in the methods used by the Trust to assess risk methodology had been completed but were of an insufficiently good quality. The investigation report therefore made recommendations in three areas and these provided an additional focus for our team's inquiries about care.

- 2.2.1. Southwark Social Services and SLaM to agree a memorandum of understanding for the allocation and management within mental health teams of social supervision.
- 2.2.2. Specific training to be provided for all staff who are Social Supervisors.
- 2.2.3. Risk assessments and support and recovery plans to be reviewed within the CPA process for Southwark High Support Team. The team to ensure that they are making risk management plans for all patients and review the quality of support and recovery plans and risk management plans.

3. Background

3.1. A chronology of the care and treatment provided for X may be found in the main report. The first reports of X being unwell date back to 1987 when he was remanded to prison for drug offences; he was reported as being grandiose. He assaulted a fellow prisoner in a police cell and, in February 1988, he was convicted of GBH and unlawful wounding. He was detained under Section 37 of the MHA and admitted to Psychiatric Hospital. A report refers to him having been diagnosed with personality disorder, rather than a psychosis at this time. Whilst he was in hospital, X was convicted of two further charges of Grievous Bodily Harm and sentenced to 15 months imprisonment suspended (May 1988). He was discharged from hospital in August 1988.

3.2. In 1989, X was remanded to HMP Brixton or assault of two police officers who had been searching for drugs in his flat. In prison, he was seen by two psychiatrists, one of whom thought X was suffering from schizophrenia. X was convicted in 1990 and sentenced to 33 months imprisonment. During his time in HMP Parkhurst, X was diagnosed with schizophrenia and arrangements were made to transfer him to hospital for treatment. However, he was released on 14 July 1991 and went to live with his sister.

3.3. Over the next three weeks, X became abusive, threatening and was acting strangely. On 7 August 1991 X was admitted to Guy's Hospital after being charged of assault upon a caretaker whom he deludedly believed was a child molester. X was subsequently convicted of unlawful wounding and was placed on Section 37(41) of the MHA and was transferred to Kneesworth House Hospital where he received treatment for schizophrenia. X gradually responded to medication and on 25 January 1994 he was transferred to a non-secure pre-discharge unit, then in 1994 to a self-catering bungalow in the grounds of the hospital. He was subsequently transferred to the Bracton Unit and then discharged to the community in 1996.

3.4. It is not entirely clear if and how X's mental health and forensic history were related, but Police records show that he had an extensive forensic history including

twenty-five offences between 1968 and 1990 including GBH, unlawful wounding, substance misuse, assault and theft. It is also known that, in the past, X used cannabis and cocaine.

3.5. By 2005 X was living in a one-bed flat in Southwark but he was apparently unable to maintain his flat or his financial affairs effectively; evidence suggested that his flat was being used by drug pushers and that X was being exploited. The record also reports that X had a gambling problem. X was therefore given structured support to manage his financial affairs (a Local Authority `Appointeeship'[2]) and, with help from his sister, he moved into supported housing provided by a Housing Association.

3.6. Housing Association staff were able to confirm that X and G were known to one another from a previous housing project and that they were friends. G moved in June 2017 and his room was at the top of the house on the same floor as X. G had been diagnosed with schizophrenia and was described as vulnerable, though he had been stable for many years. He had no history of aggression or violence. None of the staff who knew X and G reported evidence of any hostility between them.

3.7. From 2008 to the date of the incident, X received care from the Southwark High Support Team and, over the years that followed, X's mental ill health was apparently treated effectively and there was no evidence of significantly disturbed or disruptive behaviour. Until 2010, X was also routinely screened for substance misuse but, after a long spell of negative results, routine testing was stopped and the restrictions upon X's living arrangements and supervision were gradually reduced. At the time of the incident, the team was considering recommending that X could move to a lower level of supported accommodation and, if this proved effective, that he might apply to the MHA Tribunal for a discharge from his Restriction Order.

[2] An appointee is responsible for managing a person's benefits; for helping to pay bills and manage money for someone who is vulnerable and/or has limited personal or financial resources.

3.8. Throughout 2017, X was given a depot (intramuscular) anti-psychotic medication and his last dose had been administered in the middle of November 2017. X had also been seen the day before the incident by his Social Supervisor (the professional reporting quarterly to the Ministry of Justice about MHA-restricted patients) and he had been seen for reviews of his care plan by the Southwark High Support Team Consultant Psychiatrist and by Housing placement staff.

3.9. However, in August 2017, X was screened again for cocaine after some drug paraphernalia had been found in G's room – something that G (who was also screened) described as a souvenir from the past. X's blood test result was positive although G's was not. The implications were discussed in a meeting between X, the Consultant Psychiatrist, and the Care Coordinator and X was offered a referral to drug support services. However, X said that the episode was `a one off' and he did not wish to be referred. Another screen was due to be done prior to the next CPA review which fell due in early December 2017 but, as X's mental state appeared to be stable, no further action was taken.

4. The incident

4.1. Police and ambulance services were called to the Housing placement in the early hours of Friday 1st December 2017 by residents who were woken by a disturbance; they found the victim G with stab wounds. G was sadly pronounced dead at the scene. CCTV footage subsequently showed X to have followed G into his room with a knife and it showed a struggle which ended three floors below in the garden of the property. CCTV footage also showed X to have subsequently cleaned the knife and returned it to the kitchen drawer. In Court, X said that he was trying to prevent G from self-harming.

4.2. Preliminary information was gathered about the incident by the Police after X was deemed to have capacity[3]. Housing staff were appreciative of the support provided by the High Support Team who arrived within 30 minutes. In the days that followed,

[3] The Mental Capacity Act 2005 sets out requirements for people to be assessed for their capacity in relation to important decisions about social care, the law, their finances, their treatment, etc. The term is used to describe a person who is capable of understanding, retaining, making a judgement about, and communicating their views.

support and counselling were provided for staff and residents. The other residents at the housing project were also re-housed in order to minimise the impact for them, all but one subsequently chose to return. The incident came as a complete shock to all the staff. No-one was able to identify at the time, or since, a likely reason for it.

4.3. Unfortunately, as staff understood that they were not supposed to give information about the case whilst it was being investigated, they believed falsely that X's sister could not be told anything when she telephoned. This was, in part, because X had given Police the name of his son (not his sister) as `nearest relative'. X's sister therefore only found out about the incident when she read a newspaper almost a week later and this was understandably very upsetting for her. The Trust subsequently wrote to her to apologise, and X's consultant contacted the prison in-reach team psychiatrist to ensure that relevant information about her involvement was shared.

4.4. Preliminary information was gathered about the incident by the Police and, when X was deemed at the Police station by a mental health custody nurse to have capacity[4], he allegedly told Police that he was trying to prevent G from self-harming. He gave Police contact details for his son as `nearest relative' and he was detained at Thameside prison. X's Consultant Psychiatrist offered to complete an assessment of X's mental health on the day of the incident. However, as the Police reportedly indicated that there were no reasons to be concerned about X's mental health, this was declined. X was found guilty of murder at Blackfriars Crown Court and sentenced to prison with a 20-year minimum tariff.

5. Findings

5.1. Our findings are set out in relation to the points listed in our Terms of Reference (see Appendix 1 of the main report). Our team was asked to comment upon the

[4] The Mental Capacity Act 2005 sets out requirements for people to be assessed for their capacity in relation to important decisions about social care, the law, their finances, their treatment, etc. The term is used to describe a person who is capable of understanding, retaining, making a judgement about, and communicating their views.

reorganisation of mental health services that has taken place since the time of the tragic incident that led to the death of G. This was completed in June 2018. Each borough now has four teams: High Support Team, Supported Living Team, Start Team (for the homeless), and a Personality Disorder Team whose work is organized around care pathways. Extra financial investment has resulted in a significant increase in staffing and training for staff to deliver psychological interventions and trauma-informed care is also being strengthened.

5.2. Care of `forensic' patients (those with mental ill health and a criminal record who are detained under a MHA restriction order) is now almost completely carried by a `centralised' forensic team as opposed to community teams. We believe that this will help to assure that concerns relating to safety and risk presented by patients who have mental ill health and criminality are addressed by those with the most appropriate training.

5.3. Each Directorate now has a small governance team to ensure that reporting and communication are effective and reports to the Board using a single set of `ward to board' assurance measures. The Director of Nursing carries responsibility for interpreting national guidance on the management of incidents, and there is a clear structure for managing, codifying and reporting them. Our team believes that the new system is working well. However, our team would like to recommend that progress be further augmented by nominating a Non-Executive Director with specific responsibility at Board level to support dissemination of learning from incidents.

Monitoring by the Clinical Commissioning Group

5.4. The Southwark Clinical Commissioning Group (CCG) carries responsibility to plan, monitor and commission (pay for) mental health and other NHS services in the area. The CCG also maintains oversight of the quality of services and therefore sees reports of investigations into serious incidents.

5.5. The initial investigation that was commissioned by the Trust into the care and treatment provided for X and G prior to the death of the latter concluded that the

incident, which was wholly unexpected by all those associated with both men, could not have been predicted. Having examined the case notes and spoken to staff and to the families of X and G, our team does not disagree. However, we also agree that there were some gaps in care quality relating to risk assessment and management, and the training provided by staff for social supervision (the role taken by a member of the team in relation to monitoring and reporting to the Home Office for patients who are restricted under the Mental Health Act).

5.6. The initial investigation report outlined concerns in relation to the way in which changes in the way that Trust staff assess and record risk using the electronic clinical records system. However, like the authors of the initial investigation report, we do not believe that a greater level of recorded historical detail could have prevented G's death. X had seen his Care Coordinator the day before the incident; staff knew him well, and despite his history, X had been mentally stable and shown no signs of aggression in over fifteen years. Indeed, staff were working towards retrieving his residency papers so that X could get a job, and consideration was being given to a move to a lower level of support as well as to rescinding his restriction order.

5.7. Our team was able to verify that significant improvements in the assessment and management of risk have been made since the time of the incident; for example, `SNAP' audits of risk assessments and care plans are now undertaken; these databased audits, assessed by Modern Matrons, are followed up with team leaders who can then ensure that any necessary improvements are addressed through individual supervision sessions with staff. Furthermore, members of clinical staff have had further training in the assessment of risk and risk management. We are also able to confirm that training for staff taking a role as `Social Supervisor' has been strengthened.

5.8. One area remained as a source of potential concern to our team and this relates to X's positive screen for cocaine which was undertaken in August 2017. Whilst the consultant and the Care Coordinator acted on this immediately and offered to refer X to the substance misuse service, and whilst we are not aware of any evidence to suggest that substance misuse played a part in the incident that led

to G's death, our team believes it might have been wise to re-instate screening for X at an earlier stage**.**

5.9. We would also urge the Clinical Commissioning Group and the Trust to be assured that there is an effective care pathway for patients with comorbid mental ill health and substance misuse problems, especially if such patients decline to refer themselves to the local service (CGL or `Change, Grow, Live'). Those to whom we spoke reported that this service is a good one. However, as willingness to attend (self-referral) is a requirement for access it, our team was not wholly confident that people with severe mental illness who commonly evidence flat affect and low levels of motivation will always get the help they need.

6. Conclusions and Recommendations

6.1. Overall, we believe that the initial investigation report represents a broadly accurate account of the care provided for X before he stabbed G in the early hours of Friday morning 1st December 2017 and we agree with the conclusions drawn in that report. We believe that the recommendations made in the report to strengthen services were also appropriate, and we can confirm that steps have now been taken in the context of a significant level of service reorganisation to improve the quality of care, improve risk assessment and management, and embed learning.

6.2. Inevitably, the focus for families who are bereaved in such, thankfully rare cases, will be upon the facts in X's history. It is natural for them to ask how someone with a criminal record such as X had could be allowed access to knives; to live unsupervised for even part of the day in accommodation with other vulnerable residents like G who, by all accounts, was vulnerable, harmless and had no history of violence.

6.3. It is true that X had a long history of criminality, substance misuse and of assault using a weapon. However, in over twenty years there had been no evidence of violent behavior, nor of a relapse of his mental ill health. Over this time, X had been seen to be stable and, although he was relatively quiet, he engaged well with staff; he was receiving treatment, and he was in contact with his family. Apart from

the positive drug screen in August 2017 which prompted staff to be more watchful, and to plan another screen for December 2017, no-one had reason to suspect that X presented a risk to himself or to others.

6.4. We may never know why the incident occurred. Nor have we had the opportunity to speak with X directly because he has not responded to our communications. However, it would not have been appropriate in law or according to other standards to fail to respond to what appeared to be an improvement in his presentation, or to help X work towards resettlement, rehabilitation and a greater level of independence. We do not believe that he should have been managed under a higher level of restriction and we believe that his treatment and care were appropriate. We were particularly impressed with the quality of care and support provided by the Housing Association.

6.5. Whilst there were shortcomings evident at the time of the incident in the assessment and records of risk assessment and the management of risk which were not causally related to the incident, our team could see that these have been addressed. However, we would like to recommend three areas that, in our view, need to be strengthened further:

6.6. **Recommendation 1** Our team recommends that a Non-Executive Director be nominated to carry specific responsibility at Trust Board level to support dissemination of learning from incidents.

6.7. **Recommendation 2** Our team recommends that a care pathway be developed by the Trust for submission to the CCG to elaborate treatment and onward referral for patients with complex mental ill health and comorbid substance misuse. The purpose would be to ensure that it is clear to all Trust staff how and to whom to refer people who fail to reach the threshold for access to CGL (or `Change, Grow, Live'), the independent drugs and alcohol service for adults over 18 who live in the Borough.

6.8. **Recommendation 3** We recommend that the Trust provide training for staff working with patients with complex needs and co-morbid substance misuse

problems. This should be designed to ensure that those staff can themselves provide support to such patients, and/or to ensure that they know how, and to whom, to refer.

INDEPENDENT INVESTIGATION INTO CARE AND TREATMENT PROVIDED FOR X BY SOUTH LONDON AND MAUDSELY (SLAM) MENTAL HEALTH FOUNDATION TRUST.

7. Introduction

7.1. This is the report of an investigation commissioned by NHS England under contract: OJEU 2016/S 147-266712; Department of Health guidance relating to Article 2 of the European Convention on Human Rights, and guidance published by NHS England[5] for investigating serious incidents in mental health services.

7.2. It concerns care provided by South London and Maudsley (SLAM) Mental Health Foundation Trust for `X', a 60yr old man who, on the morning of Friday 1st December 2017, fatally stabbed `G', another male resident at their Housing Association accommodation in Southwark. X was restricted to living at this address where he had been for almost 10 years under Section 37(41)[6] of the Mental Health Act (MHA).

7.3. We would like to thank G's family for speaking to us and we would like to extend our condolences to them for the loss of a brother and uncle, who was described to us by them as `vulnerable' and as `someone who wouldn't hurt a fly'. G's family remain concerned that someone who could commit such an act had been allowed to live relatively independently, close to vulnerable others, and they were concerned that X had been able to access knives from the kitchen.

7.4. We would also like to thank X's sister for speaking with us. She supported X since he was diagnosed with severe mental ill health, over twenty years previously, and she knew him well. X's sister was equally shocked about what happened; she believes her brother to have been very unwell when the incident occurred, and she considers that he is still unwell now.

[5] NHS England Patient Safety Domain (2015) `Revised Serious Incident Framework: Supporting learning to prevent recurrence.' www.england.nhs.uk/patientsafety/

[6] Section 41 is a `conditional,' potentially indefinite Order applied to ensure supervision after a Section 37 (a `hospital order') has been discharged

7.5. We would like to thank the staff who participated in the investigation process and the Trust for providing open access to policy documents, case notes and other material relevant to the care that was provided for X in the period leading up to December 2017 when the incident occurred. This helped us to understand the changes that have been made in the service, and how treatment and care are provided now.

8. Methodology

8.1. Appendix 1 contains a copy of our Terms of Reference (TOR). Our team did not consider it necessary to review G's clinical records.

8.2. Appendix 2 contains details about the investigation team (our team) that was appointed by NHS England. The team included individuals with a wide range of relevant skills including general and forensic Psychiatry, Nursing, Clinical Psychology, policy development, investigations and staff training.

8.3. Arrangements were made at an early stage to speak with X's sister who had maintained a good level of contact with X since he first became unwell. We also spoke with G's sister and her two daughters, all of whom remain very concerned about the circumstances of the death of their relative, and about the basis for believing that X was safe enough to be allowed to live in the housing project with other, potentially more vulnerable people like G. No meeting was held with X, who did not respond to correspondence relating to the investigation.

8.4. Arrangements were made to conduct personal interviews with staff from the Trust (see Appendix 3). Adapted Salmon Principles[7] were used for this non-judicial investigation meaning that all those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. Interviewees were offered the opportunity to be accompanied if they wished. Written accounts of the interviews were then verified for accuracy by each participant before being `signed off.' All witnesses were assured that their

[7] The Salmon Principles are six requirements set out under the Tribunals and Inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations. This investigation was not judicial, and solicitors were not involved in the investigation process.

testimony would be confidential[8] in that no personally identifying information would be included.

8.5. Direct access to the electronic clinical case notes recorded for X was provided by SLAM; the team was able to review current policies relating to, for example, care planning and risk assessment, and we were able to discuss progress with the Action Plan prepared by the Trust after the initial investigation.

8.6. Our team focused on the mental health care provided for X from the point when he first had contact with mental health services in 1987 to the time of the incident in 2017 in order to obtain a picture of the development of his mental health. However, we focused mainly upon the quality of care provided immediately prior to the incident; the circumstance of the incident itself, and the events that took place afterwards. Our aim is to help X, X's family, the family of the victim, G, and the Trust staff to learn whether there were omissions of care and identify any steps necessary to reduce risk and strengthen and improve mental health services.

9. Background

9.1. A detailed chronology of care provided for X over the course of his contact with the Trust is provided in Appendix 4. A narrative summary of the facts of the case, information about X's personal and psychiatric history, the incident, its antecedents and consequences, are provided below.

9.2 X was born overseas and his family moved to the UK when he was about 6yrs old; his father subsequently moved back and has now died. X came from a large family but was closest to his sister who is three years younger; their parents separated when X was 13yrs old. The notes do not record that there was any family history of mental ill health. X attended local state schools and it is reported in the notes that he described having disciplinary problems as a teenager. According to the notes, he did not obtain any qualifications and left school at the age of 15.

[8] A Court may subpoena witness statements in certain circumstances.

9.3 The first reports of X being unwell date back to 1987 when he was remanded to prison for drug offences; he was reported as being grandiose. He assaulted a fellow prisoner in a police cell and in February 1988 he was convicted of GBH and unlawful wounding. He was detained under Section 37 of the MHA and admitted to Psychiatric Hospital. A report refers to him having been diagnosed with personality disorder, rather than a psychosis at this time. Whilst he was in hospital, X was convicted of two further charges of Grievous Bodily Harm and sentenced to 15 months imprisonment suspended (May 1988). He was discharged from hospital in August 1988.

9.4 In 1989, X was remanded to HMP Brixton for the assault of two police officers who had been searching for drugs in his flat. In prison, he was seen by two psychiatrists, one of whom thought X was suffering from schizophrenia. X was convicted in 1990 and sentenced to 33 months imprisonment. During his time in HMP Parkhurst, X was diagnosed with schizophrenia and arrangements were made to transfer him to hospital for treatment. However, he was released on 14 July 1991 and went to live with his sister.

9.5 Over the next three weeks, X became abusive, threatening and was acting strangely. On 7 August 1991 X was admitted to Guy's Hospital for treatment of his mental ill health after he was arrested for assault upon a caretaker whom he deludedly believed was a child molester. X was subsequently convicted of unlawful wounding and was placed on Section 37(41) of the MHA. He was transferred to Kneesworth House Hospital where he received treatment for schizophrenia. X gradually responded to medication and in 1994 he was transferred to a non-secure pre-discharge unit. He then moved to a self-catering bungalow in the grounds of Kneesworth House Hospital and then to the Bracton Unit. He was discharged to Housing Association accommodation in 1996.

9.6 It is not entirely clear if and how X's mental health, substance misuse, and forensic history were related, but Police records show that he had an extensive forensic history including twenty-five offences between 1968 and 1990 including GBH, unlawful wounding, substance misuse, assault and theft. It is known that, in the past, X used cannabis and cocaine (which research shows may be associated with relapses in mental ill health and/or violent behaviour).

9.7 By 2005 X was living in a one-bed flat in Southwark but he was apparently unable to maintain his flat or his financial affairs effectively; evidence suggested that his flat was being used by drug dealers and that X was being exploited. The record also reports that X had a gambling problem. X was therefore given structured support to manage his financial affairs (a Local Authority `Appointeeship') and, with help from his sister, he moved into supported housing.

9.8 The Housing Association which owned the property where X lived operates across Greater London[9] and in Southwark. The average length of stay in is 2-3 years but several residents stay longer, depending upon their needs. Housing Association staff told our team that their training is effective, a view endorsed by the mental health staff we saw. Furthermore, the relationship between the Housing Project and the High Support Team is a strong one, and Housing Association staff spoke warmly of the good working relationship that they have with the Trust.

9.9 The perpetrator, X, and the victim G were both under the care of Southwark High Support Team (SHST), a community mental health team (CMHT) providing intensive support, monitoring, rehabilitation and advice for people, aged 18-65, who have severe and ongoing mental health problems and/or learning disabilities, and a history of offending. The house where they lived has seven local authority-funded rooms for men aged 18 and over. The property is staffed seven days per week between 9.00 am and 5.00 pm. Two or three staff are on

[9] The Housing project provides support for people with learning disabilities, autism and mental health problems as well as their families.

duty at any one time; they are trained in lone working; have emergency alarms and on-call arrangements are in place seven days per week. X had been a resident for almost ten years and was therefore very well known to the staff team. We could not establish exactly why X had remained in this accommodation for so long, although at least latterly delays were due to his needing help to obtain identity papers.

9.10 X received care from the Southward High Support Team between 2008 and the date of the incident and, over these years, X's mental ill health was apparently treated effectively. For over twenty years, there had been no evidence of significantly disturbed, disruptive or violent behaviour. Until 2010, X was also routinely screened for substance misuse but, after a long spell of negative results, routine testing was stopped and the restrictions upon X's living arrangements and supervision were gradually reduced. At the time of the incident, the team was considering recommending that X could move to a lower level of supported accommodation and, if this proved effective, that he might apply to the MHA Tribunal for a discharge from his Restriction Order.

9.11 Throughout 2017, X had been given a depot (intramuscular) anti-psychotic medication (Paliperidone) and his last dose had been administered in the middle of November 2017. The Consultant Psychiatrist saw X every six months and occasionally more often if he was there to visit someone else. A nurse administered X's medication monthly, and his Social Supervisor (the professional identified as having responsibility to report quarterly to the Ministry of Justice about MHA-restricted patients) saw him weekly. X was seen every day by the staff and had been seen the day before the incident by his Social Supervisor. No-one had concerns about him.

9.12 During 2017, X's Social Supervisor/Care Coordinator had been helping him to apply for his identity papers as X had expressed a wish to get a job; apply for his restriction order to be lifted; re-acquire his driver's license and move to more independent accommodation.

9.13 About five months before the incident in December 2017, X's son began to visit him, taking him to the gym, the sauna, his GP and to the shops. Staff at the housing project thought X might have felt `a bit caught' between his son and his sister, who had also supported X over the many years since his initial diagnosis. X seemed pleased to have contact with his son and it was his son's name rather than his sister's that, after his arrest, X gave to the Police as his next of kin.

9.14 During the summer of 2017 X had had some physical investigations. For example, he had an elective ultrasound procedure to assess his cardiovascular risk. Following an abnormal ECG, he was prescribed some blood thinners. A decision was taken to carry on prescribing his anti-psychotic medication as it represented only a low level of cardiovascular risk, appeared to be helpful in maintaining X's stable mental state, and did not appear to especially concern him.

9.15 G had moved into the Housing project in June 2017 from another property with 24hr staffing. He lived on the same floor as X at the top of the house. According to staff in the Housing project, X and G were known to one another from a previous housing project and they were friends. G had a history of intermittent cannabis use and he had previously used cocaine. G had also been diagnosed with schizophrenia although he had been stable for many years and was described by his family as `vulnerable'. G had no history of aggression or violence. None of the staff who knew X and G reported evidence of any hostility between them.

9.16 G had regular contact with his sister and her family, whom he visited at their home. Described as a gentle man by family as well as by staff, self-neglect and historical financial abuse from others were staff's main concerns. G was well engaged with the CMHT and with support staff. He was stabilised on Clozapine, an anti-psychotic medication.

9.17 In August 2017 X was screened randomly for cocaine after some drug paraphernalia (a pipe or `bong') had been found in G's room – something that G described as a souvenir from the past. X's blood test result was positive although

G’s was not. As X has not provided any further information since his conviction, we cannot elaborate this finding.

9.18 The implications of the positive drug screen were discussed in a meeting between X, his Consultant Psychiatrist and the Care Coordinator. X was offered a referral to drug support services. However, X said that the episode was `a one off’ and he did not wish to be referred. As X’s mental state appeared to be stable, no further action was taken. Another screen was due to be done prior to the next CPA review which fell due in early December 2017.

10. The Incident

10.1. Police and ambulance services were called to the Housing project just after 2.30 am on the morning of Friday 1st December 2017 by residents woken by a disturbance; they found the victim G with stab wounds. G was pronounced dead at the scene. CCTV footage subsequently showed X to have followed G into his room with a knife and it showed a struggle which ended three floors below in the garden. CCTV footage also showed X to have subsequently cleaned the knife and returned it to the kitchen drawer. Staff from the Housing project reported to our team that the incident had come as a complete shock to them. The Southwark High Support team told us that they felt the same way. No-one was able to identify at the time, or since, a likely reason for it and some staff continue to be disturbed by the events of that day.

10.2. Preliminary information was gathered about the incident by the Police and, when X was deemed at the Police station by a mental health custody nurse to have capacity[10], he allegedly told Police that he was trying to prevent G from self-harming. He gave Police contact details for his son as `nearest relative’ and he was detained at Thameside prison. X’s Consultant Psychiatrist offered to complete an assessment of X’s mental health on the day of the incident. However, as the

[10] The Mental Capacity Act 2005 sets out requirements for people to be assessed for their capacity in relation to important decisions about social care, the law, their finances, their treatment, etc. The term is used to describe a person who is capable of understanding, retaining, making a judgement about, and communicating their views.

Police reportedly indicated that there were no reasons to be concerned about X's mental health, this was declined.

10.3. Misunderstandings about who could provide information to external parties then led to X's sister failing to be told anything about her brother when she telephoned the Housing project to ask how he was. This error occurred partly because X had given Police the name of his son (not his sister) as `nearest relative' and partly because staff misunderstood what the Police expected them to do. X's sister therefore only found out about the incident when she read a newspaper almost a week later; this was understandably desperately upsetting for her. The Trust wrote to apologise to her, and X's consultant contacted the prison in-reach team psychiatrist to ensure that relevant information about her involvement was shared.

10.4. Housing staff were appreciative of the support provided by the High Support Team who arrived within 30 minutes of the incident and, in the days that followed, support and counselling were provided for staff and residents. Other residents at the housing project were re-housed in order to minimise the impact for them, although all but one has since chosen to return.

10.5. According to Detective leading the investigation, X gave several confused and conflicting accounts for how G received his injuries. For example, when interviewed, he suggested that G stabbed himself whilst trying to take his own life, an allegation that was undermined by the CCTV footage. X was subsequently found guilty of murder at Blackfriars Crown Court on 12th September 2018 and on 26th September 2018 he was sentenced to prison with a 20-year minimum tariff. He has now been moved to prison and his sister visits him when she can; she believes that X is still unwell and she reported to us that he has not discussed the incident with her.

11. Findings

11.1. In the following sections, our findings and conclusions are set out in relation to the points listed in our Terms of Reference (see Appendix 1).

Changes made following the Trust's internal investigation action plan (TOR 1. Bullet point 1)

11.2. Our team reviewed the Trust's detailed internal investigation report which concluded that the incident which resulted in the tragic death of G could not have been predicted. However, it also highlighted several factors that may have had a bearing upon care quality and the management of risk overall. Importantly, the report was critical of the risk assessments completed for X which, against a background of changes in the methods used by the Trust to assess risk methodology were of an insufficiently good quality. Although there was no evidence that X's level of risk had been miss-assessed, historical information about his forensic history had not been pulled forward into the new electronic forms adopted by the Trust in 2017.

11.3. The authors of the report of the internal investigation therefore made three recommendations and these areas provided an additional focus for our team's inquiries about care. The recommendations were as follows:

11.3.1 Southwark Social Services and SLAM to agree a memorandum of understanding for the allocation and management within mental health teams of social supervision.

11.3.2 Specific training to be provided for all staff who are Social Supervisors.

11.3.3 Risk assessments and support and recovery plans to be reviewed within the CPA process for Southwark High Support Team. The team to ensure that they are making risk management plans for all patients and review the quality of support and recovery plans and risk management plans.

Changes in commissioning (TOR 1. Bullet point two)

11.2 During 2018, after the incident which resulted in the death of G, services at the Trust were reorganised geographically around Boroughs rather than `clinical academic groups' (or CAGs). There are four boroughs: Southwark, Lewisham, Croydon and Lambeth (GAGs were focused on specific conditions or age

groups rather than localities).The purpose of the change was to improve service quality, reduce service gaps at points of age transition; working arrangements and communications with a wide range of local partners (e.g., Local Authorities, Sustainability and Transformation Partnerships (STPs), schools, housing, police, etc.). This restructuring was completed in June 2018 and a single set of new governance reporting systems using performance and quality reports was implemented in November 2018.

11.3 A commissioner in each borough now works with the Trust to deliver services in their locality. Each borough has its own complex care pathway with four teams: High Support Team, Supported Living Team, Start Team (for the homeless), and a Personality Disorder Team. More specialised cross-borough services are commissioned by Lewisham.

11.4 It is clearly too early to identify the impact of this change, although staff speak positively about it. Staff told our team that the new arrangements have helped to make services more responsive to local needs in Southwark; that communications with partner agencies will improve as a result, and that it will take time for changes to bed in. On a less positive note, staff still believe that the 2016 disaggregation of Southwark social services from NHS teams still represents a challenge to liaison. They say that this is particularly challenging in relation to patients' housing needs, especially in the context of shortages of affordable accommodation in London

11.5 Other plans are also being developed within the Trust that are designed to have an impact upon the overall quality of services; they include an increase of seventeen whole time equivalent staff including nurse associates, peer support workers, occupational therapy, psychology and medical staffing. This has been possible owing to extra financial investment by the Southwark Clinical Commissioning Group as well as some internal restructuring. The new arrangements will be associated with some changes in the staff skill mix, and training for staff to deliver psychological interventions and trauma-informed care will be strengthened.

11.6 Each Directorate now has a small governance team to ensure that reporting and communication are effective. Each Directorate reports to the Board using a single set of `ward to board' assurance measures. The Director of Nursing carries responsibility for interpreting national guidance on the management of incidents, and there is a clear structure for managing, codifying and reporting them, all of which are reviewed by the Governance team in their monthly Serious Incident Review Group (SIRG) meetings. Incident reports are first discussed at the Trust Board and then with the CCG. To support communication and learning, Southwark has their own serious incident `Learning Lessons' e-bulletin.

To work closely with all relevant stakeholders such as Police, Probation and specialised commissioning, Local authority etc in quality assuring the wider system to mitigate future risks Clinical Commissioning Group (CCG) monitoring (TOR 1. Bullet point 3)

11.7 Our team contacted the NHS prison in-reach team to establish whether any further information had emerged about X's mental state since the time of his arrest, and we spoke with the Detective Sergeant who was involved with the case. However, neither the commissioner of the investigation nor the investigation team identified any additional stakeholders prior to or during the investigation.

Gaps identified within the Trust internal report (TOR 2. Bullet point 1)

(a) The impact of organisational change on social supervision

11.8 Prior to the incident in which G lost his life, a review in 2016 by Southwark Council Mental Health Social Care had led to disaggregation of mental health social care services from NHS clinical teams. Social workers who formerly carried responsibility for providing social supervision ceased to be employed in teams, and responsibility for social supervision shifted to clinical team members.

11.9 A Social Supervisor is the professional responsible for providing quarterly reports to the Ministry of Justice for a mental health service user discharged

from hospital who is ‘restricted’ under the terms of Section 37/41 of the Mental Health Act. The role is statutory and, as such, can be distinguished from the role of Care Coordinator. Whilst the Social Supervisor has power to seek permission from the Ministry of Justice to recall the service user from the community if the risk of self-harm is significant or the person is at risk to the public, it is not a `policing’ role. A Social Supervisor will normally maintain a supportive relationship with the patient and liaise closely with the clinical team providing care.

11.10 A Care Coordinator is a member of the mental health team. He/she may help to assess a patient; co-ordinate and deliver care; draw up a Care Plan; help the patient to understand what to do in a crisis and provide support in the community. It is possible for a professional to hold both a role as a Care Coordinator and a Social Supervisor and the two roles would not normally be in conflict.

11.11 In X’s case, the role of Social Supervisor was taken by his Care Coordinator. The Care Coordinator had not received special training to be a Social Supervisor and, at the time, he had to learn what was required from colleagues and guidance published by the Home Office. The authors of the initial investigation did not believe this to have been salient in relation to the management of X’s risk or the death of G, but they thought that the Social Supervisor system should be strengthened, and they made two recommendations:

Initial Investigation Recommendation 1. Southwark Social Services and SLaM to agree a memorandum of understanding for the allocation and management within mental health teams of social supervision.
Initial Investigation Recommendation 2. Specific training to be provided for all staff who are social supervisors.

11.12 When the initial investigation report was completed into the care provided for X prior to the death of G, an Action Plan was developed, although it was delayed. Our team can confirm that a Memorandum of Understanding with the

Local Authority has been drafted and is currently awaiting Local Authority sign-off. It is therefore not possible to assess its impact. However, training for Social Supervisors has been developed covering roles, responsibilities and Home Office guidance. At the time when our team interviewed the staff, it had not quite been fully rolled-out, but we understand that this has now been implemented. Once again, the impact of this could not be assessed in full, but we gained an impression on the basis of their feedback to us that staff are now much more aware of their responsibilities.

Gaps identified within the Trust internal report (TOR 2.1 Bullet points 2 and 3)
(b) The migration of old to new Risk Assessment methodology
(c) The lack of documented detail

11.13 The report of the initial investigation was critical of the way in which a new Trust Risk Assessment Tool had been adopted in January 2017 for the electronic clinical records (known as the Electronic Patient Journey System or ePJS). The report argued that, whilst these shortcomings were not salient in relation to prediction or prevention of the incident that resulted in the death of G, there was an adverse impact on the quality of the risk assessments that were undertaken afterwards (including the risk assessments for X). 'Old' or historical information was not always transferred to the new system. There was only limited information on the Risk assessment form about X's forensic history (his criminal record) although this was available elsewhere in the archived paper notes. His risk, and support and recovery plans lacked detail and did not appear to have been completed with the involvement of the whole team. This was also true for G's risk assessment. The authors therefore made a third recommendation:

Initial Investigation Recommendation 3 `Risk assessments and support and recovery plans to be reviewed within the CPA process for Southwark High Support Team. The team to ensure that they are making risk management plans for all patients and review the quality of support and recovery plans and risk management plans.

11.14 When our team checked the records for X and discussed the risk assessment process with the Care Coordinator, we were able to verify that the criticisms of the risk assessments for X were valid. The last full risk assessment for X had been completed on 23rd September 2016 and whilst this contained information about his forensic history, and more detail about his medical history, much of this information had not been `pulled forward' into the assessment that was completed in June 2017. The latter lacked a clear formulation or any detail about the potential triggers for relapse. Having said this, it did not appear that anything new had been missed, and it did not appear that there was any evidence from any source that X's mental health was deteriorating or that he had relapsed.

11.15 Whilst X had not had a formal HCR-20 (questionnaire-based guidance for the assessment and management of violence risk which is now part of standard risk assessment) he had shown no signs of violent behavior for many years. There had been one brief altercation with another resident who was moved to a higher level of support, but this was not thought to be significant. Although quite reticent, X interacted appropriately with staff; he did not get into arguments; he went to the gym, and he was compliant with his anti-psychotic medication. Staff were working towards retrieving his residency papers so that he could get a job, and consideration was being given to moving him to a lower level of support and to rescinding his restriction order. X had also seen his Care Coordinator the day before the incident.

11.16 We could see that significant improvements in the assessment and management of risk have been made since the time of the incident; for example, audits of risk assessments and care plans are now undertaken. These databased audits, assessed by Modern Matrons, are followed up with team leaders who can then ensure that any necessary improvements are addressed through individual supervision sessions with staff. Our team thought it good practice that the SI team checks routinely whether historical information is now included within the new risk assessment tool.

11.17 Members of clinical teams who were interviewed have all had training in the assessment of risk and risk management, and the structured assessment of risk (HCR-20) has been added to the routine assessment of risk for all patients which is undertaken by the team working together. We believe that this will make the risk assessments stronger. We were also able to see that some team members who needed extra support are now receiving it.

11.18 Importantly, responsibility for the care of `forensic' patients (those with mental ill health and a criminal record who are detained under a MHA restriction order) has now almost completely moved as part of the re-structuring from community teams to a `centralised' forensic team. This should help to assure that concerns relating to safety and risk presented by patients who have mental ill health and criminality are addressed by those with the most appropriate training and skill.

11.19 Our team is content to conclude that the risk assessment tool effectively migrates the old and new risk assessments. However, one area remains a source of potential concern in relation to the management of risk and it relates to drug use. In August 2017 X's blood sample proved positive for cocaine. The consultant and the Care Coordinator acted on this immediately: they discussed the result with X; they offered to refer him on, and another drug screen was planned for December. Whilst we are not aware of any evidence to suggest that substance misuse played a part in the incident that led to G's death, our team believes it might have been wise to re-instate screening for X at an earlier stage; it was his test that proved positive rather than G's and he had a history of drug use (albeit from many years before).

11.20 For patients like X with complex mental ill health who do misuse illegal drugs, the Trust and the CCG need to be satisfied that staff are aware of the pathway to care, and that care is sufficient. Substance misuse services in Southwark are commissioned by the local authority and provided by CGL (or `Change, Grow, Live'). This is a free and confidential drug and alcohol service for adults over 18 who live in the Borough. However, as willingness to attend (self-referral) is a requirement for access to the service, our team was not wholly confident that

people with severe mental illness who commonly evidence flat affect and low levels of motivation will always get the help they need.

11.21 Our team would therefore like to recommend that a care pathway be developed for such patients. Related to this, we recommend that training should be provided for the staff working with patients with complex needs and co-morbid conditions to ensure that they know how and to whom to refer.

Whether learning has been embedded and whether the impact upon safety has been assured (TOR 2.2 Bullet point 1)

11.22 Our team spoke with members of the senior team in Southwark to understand how reports of serious incidents are received; how recommendations are managed and whether learning from serious incident (SI) reports is embedded. The locality governance team is establishing new processes across the Directorate which appear sound. For example, monthly action planning meetings now allow implementation of specific learning to be monitored and there is a `learning lessons' bulletin. In addition, two Modern Matrons were appointed in the summer of 2018 to join the community service to focus on improved clinical quality. Staff suggest that they are helping to make a difference. However, organisational change is always challenging and the translation of policy or decisions at Board level into action at the clinical level inevitably takes time.

11.23 Our team was not completely confident that learning is embedded fully, and we therefore recommend that a Non-Executive Director with specific responsibility at Board level be appointed to support dissemination of learning from incidents.

CCG monitoring of the action plan (TOR 2.2 Bullet point 2)

11.24 The Southwark Clinical Commissioning Group (CCG) carries responsibility to plan, monitor and commission (pay for) mental health and other NHS services in the area. The CCG also maintains oversight of the quality of services and therefore sees reports of investigations into serious incidents. We were able to

obtain information to help us understand how the CCG works with the Trust to mitigate risk, and how the CCG monitors progress with recommendations arising from investigations (outlined in the Action Plan). We spoke with the Service Director (adult services and addictions), the General Manager for Complex care, the Deputy Director for forensics and offender health and the governance lead for Southwark. We also spoke with the Head of Quality for the Clinical Commissioning Group in Southwark.

11.25 Since 2018, Serious Incident (SI) reports have been monitored and tracked by each of the local CCGs. Attention to address common or overarching themes is overseen by Lewisham CCG, the lead for this task. About two years ago, commissioners pushed to establish a pan-organisational SI Review Group (SIRG) which, with support from the Director of Nursing, operates to improve the timeliness and overall quality of SI reports; to identify learning which may need to be embedded as a result, and the engagement with families who are affected when serious incidents occur. The SIRG meets monthly and overarching or common themes are considered as part of each meeting agenda. Commissioners are therefore very actively engaged in monitoring the Trust and they endeavor to support action to improve the focus on learning, feedback to staff and improvements in service quality.

12. Conclusions and Recommendations

12.1. Our team has drawn several conclusions on the basis of a careful examination of the facts, scrutiny of the written records, and interviews with witnesses. Overall, we believe that the initial investigation report represents a broadly accurate account of the facts of the care provided prior to the death of G when he was stabbed by X in the early hours of Friday morning 1st December 2017 and we agree with the conclusions drawn in that report.

12.2. We believe that the recommendations made in the report to strengthen services were also appropriate. We are content to confirm that steps have now been taken in the context of a significant level of service reorganisation to improve service quality, improve risk assessment and management, and embed learning.

12.3. Inevitably, the focus for families who are bereaved in such, thankfully rare cases, will be upon the facts in X's history. It is natural for them to ask how someone with a criminal record such as X had could be allowed access to knives; to live unsupervised for even part of the day in accommodation with other vulnerable residents like G who, by all accounts, was vulnerable, harmless and had no history of violence.

12.4. It is true that X had a long history of criminality, substance misuse and of assault using a weapon. However, in over twenty years there had been no evidence of violent behavior, nor of a relapse of his mental ill health. Over this time, X had been clinically stable and, although he was relatively quiet, he engaged well with staff; he cared for himself effectively; and he was in contact with his family. He was being considered for a move to less supported accommodation; he was hoping to find a job; regain his driver's license and acquire proof of his `right to remain'. He was being treated with an intramuscular anti-psychotic after being diagnosed with schizophrenia and, apart from the positive drug screen in August 2017 which prompted staff to be more watchful and to plan another screen for December 2017, no-one had reason to suspect that X presented a risk to himself or to others.

12.5. We may never know why the incident occurred. The distress and sense of outrage that was expressed to us by G's family who believed that X should not have had unsupervised access to a knife is also, to some degree, understandable. However, our team believes that it would not have been appropriate in law, nor would it have been good clinical practice, to restrict X further, or to fail to help him work towards resettlement, rehabilitation and a greater level of independence given that he had been well for so long.

12.6. Our team was impressed with the quality of care provided by the Southwark High Support team, notwithstanding the shortcomings in the records of risk assessment and management that were initially evident, and we were very impressed with the Housing project. Our team also notes the significant reorganisation in services at SLAM which appear to be bedding in well although it is not possible yet to evaluate the impact. Our recommendations are designed to further strengthen services at the Trust:

Recommendation 1 Our team recommends that a Non-Executive Director be nominated to carry specific responsibility at Trust Board level to support dissemination of learning from incidents.

Recommendation 2 Our team recommends that a care pathway be developed by the Trust for submission to the CCG to elaborate treatment and onward referral for patients with complex mental ill health and comorbid substance misuse. The purpose would be to ensure that it is clear to all Trust staff how and to whom to refer people who fail to reach the threshold for access to CGL (or `Change, Grow, Live'), the independent drugs and alcohol service for adults over 18 who live in the Borough.

Recommendation 3 We recommend that the Trust provide training for staff working with patients with complex needs and co-morbid substance misuse problems. This should be designed to ensure that those staff can themselves provide support to such patients, and/or to ensure that they know how, and to whom, to refer.

APPENDIX 1

Terms of Reference

Independent Review of the Trust's internal investigation in regard to the care and treatment of X provided by South London and Maudsley

1. Purpose of the Review

To independently review:

- Changes made to care and practice following the Trust's internal investigation action plan.
- To independently review changes in commissioning processes.
- To work closely with all relevant stakeholders such as Police, Probation and specialised commissioning, Local authority etc in quality assuring the wider system to mitigate future risks.

The outcome of this review will be managed through governance structures in the commissioner and the provider's formal Board sub-committees and with Police and Probation services. The Commissioner will provide assurance to NHS England of completion of any actions/outcomes from the completed report.

2. Specific Terms of Reference

2.1 To independently review the gaps identified within the Trust internal report

a. To understand the impact of the arrangements and organisational change of Southwark social care from SLaM on social supervision.

b. To confirm that the Trust Risk Assessment Tool, effectively migrates the old and new risk assessments

c. To ascertain what actions the Trust are doing to ensure a systemic approach to the lack of documented detail in relation to risk assessments and recovery plans.

d. If identified during the investigation the need to review G's clinical records; this will be done in agreement with G's family.

2.2 Assurances

b. The processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services.
c. Comment on the CCG monitoring of the action plan.
d. To consider making further recommendations locally, regionally and nationally for improvement as appropriate.
e. Within 12 months of publication conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and feedback the outcome of the assessment to NHS England London.

3. **Timescale**

The review process starts when the investigator receives the Trust documents and the review should be completed within 6 months thereafter.

4. **Initial steps and stages**

NHS England will:

- Ensure that the X and G families are informed about the review process and understand how they can be involved including influencing the terms of reference.
- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

5. Outputs

5.1 A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations given specific consideration to the implementation locally, regionally and nationally, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

5.2 At the end of the review, to share the report with the Trust, and other services involved within the scope of the review and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.

5.3 A final presentation of the review to NHS England, Clinical Commissioning Group, Police, Probation service, local authority, independent organisations and provider Board and to staff involved in the incident as required.

5.4 We will require monthly updates and where required, these to be shared with families, CCGs and all relevant stakeholders.

5.5 The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate.

APPENDIX 2

Investigation team

Anne Richardson, BSc, MPhil, FBPsS, Director of ARC, is a clinical psychologist by training. She specialised in clinical work with adults with severe mental ill health and long-term needs. She is an experienced teacher/trainer and communicator, having worked as joint Course Director of the DClinPsy at UCL before moving to take a post at the Department of Health. Subsequently, as Head of mental health policy at the DH, she was instrumental in the development and delivery of the National Service Framework for Mental Health and, with Sir Jonathan Michael, she led development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008).

Hugh Griffiths, MBBS FRCPsych, is a former Consultant Psychiatrist in the North-East of England where he carried responsibility for inpatient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, and liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as National Clinical Director for Mental Health (England) at the Department of Health, he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework. He retired from this post in March 2013 and now works as a non-Exec in a mental health trust in the north of England.

Dr Ahmad Khouja, MRCPsych, MBChB, BA(Hons), DPhil (Oxon) is a practicing Consultant Psychiatrist with over 15 years working in forensic psychiatry. Now, as Executive Medical Director at Tees, Esk and Wear Valleys NHS Foundation Trust he carries clinical and operational responsibility for a range of services including medium and low secure, prison offender health and forensic community services. He is a member of the NHS England Clinical Reference Group for Secure Services and is a registered Court Expert for the Court of Protection in matters of assessments of capacity.

Adrian Childs RMN, RGN, DipN (Lond), MSc, Dip Exec Coaching, trained as a general and mental health nurse. He was director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust; he holds a diploma in leadership, mentoring and executive coaching. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. His previous experience includes serving as deputy chief executive and director of nursing at Devon Partnership NHS Trust and Newcastle, Northumberland and North Tyneside Mental Health Trust. In 2014 Adrian was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester.

APPENDIX 3

Consultees and witnesses (individual names have been removed)

Members of G's family

X's sister

Consultant Psychiatrist

Forensic Psychiatrist

Care Coordinator

Head of High Support team in Southwark

Team leader

Placement coordinator

Adult Service Director (Southwark)

General Manager for Complex Care

Deputy Director forensics and offender health

Staff at the Housing Project

Detective Sergeant, Met Police

Southwark CCG

APPENDIX 4

Chronology of care provided for X by South London and Maudsley Mental Health Foundation Trust

DATE	EVENT
1960	X arrived in the UK aged 6.
1968	Police records show X (age 22) was found guilty of unlawfully wounding a cellmate with a knife and he was sentenced to prison for GBH. X had been using cannabis and cocaine.
1988	X was admitted under the Mental Health Act (MHA) on a restriction order (S.37/41) following an assault on a caretaker with a chair. X was described as floridly psychotic and paranoid and grandiose with little insight. His diagnosis was given as schizophrenia.
1990	X was discharged.
1992	X reoffended and was again detained on Section 37/41 of the MHA
1996	X was conditionally discharged form his Section of the MHA.
2007	X was recalled to hospital briefly when Police thought his flat was being used by drug dealers. He was given structured support to manage his financial affairs as he was deemed vulnerable and unable to cope. X was then discharged to supported accommodation staffed by a Housing Association and funded by the Local Authority. Whilst at this address, X met and became friends with G, the victim.
2008	X moved to the address where the incident occurred. At this time, he was still restricted to living at the address (under S.37/41 of MHA) and his `Social Supervisor' provided routine reports to the Home Office concerning his mental state.
10.5.17	X had an appointment to attend cardiology department for investigations.
May 2017	G the victim moved into the same address as X. Their rooms were on the same corridor at the top of the house.
07.06.17	Seen by Care Coordinator and discussion took place of X's residency papers. X also due to be seen at the Acute General Hospital for an assessment of chest pain.
12.06.17	Seen by Dr. for a review.
14.06.17	X given his Depot Paliperidone 150mg. No side effects or problems reported.
21.06.17	Care Coordinator visited X at home. X reported feeling well. Discussed problem of getting British Passport. Also discussed cardiology report. No concerns.
05.07.17	Care Coordinator visited X at home. He said he was feeling well..
13.07.17	A report to indicate that X's drug chart had been lost and request passed on to write up a new one as his Depot is due tomorrow.
14.06.17	Depot given
26.08.17	Care Coordinator visited X at home and his son was present. Mr X's son said he would like to act as X's carer and find a flat together,

	which X said he would like. Staff at the home requested a `substance screen' for X.
29.08.17	Clinical Team Meeting – a discussion of X's case. X and his son were both involved. X's son expressed some concerns about X's physical health because he'd lost about 10kg in weight. X's son was offered a carer's assessment. The substance screen was discussed and agreed. X's mental health was described as stable.
Ist week of Sept 2017	X's drug screen result came in as positive for cocaine.
	The Dr discussed the positive drug screen with X and offered him a referral to the substance misuse service, which X declined. He said that the cocaine use `was a one-off'. Staff therefore agreed to `keep a watching brief'.
06.09.17	The Care Coordinator accompanied X on a visit to his GP, together with X's sister and his son. The visit was for completion of physical checks after health concerns relating to X's weight loss were raised. The GP reported that blood tests had been negative and an ECG normal.
15.09.17	X was given his Depot. There was nothing abnormal to report.
27.09.17	The Care Coordinator met with X to discuss the drug screen – X's position was as above. The Care Coordinator was also involved in trying to help X retrieve his drivers license.
07.11.17	X was given a formal diagnosis of Coronary Artery Disease and a discussion took place regarding the wisdom of maintaining his treatment with Paliperidone given that this drug has been linked with some cardiac symptoms although the risk is low. This was discussed with X and, given his stability on Paliperidone, it was agreed not to discontinue it.
17.11.17	X seen at home by the Care Coordinator. There was no change in his presentation which appeared still to be stable.
01.12.17	Date of the incident.