VERITA

IMPROVEMENT THROUGH INVESTIGATION

# Independent investigation into the care and treatment of Mr A and Mr B by South West London and St George's Mental Health NHS Trust

A report for NHS England (London region)

January 2022

Authors:
Chris Brougham
Nicola Salmon

© Verita 2022

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for regulated organisations.

This report has been written for NHS England London region and may not be used, published or reproduced in any way without their express written permission.

Verita
338 City Road
London EC1V 2PY

Telephone 020 7494 5670

E-mail enquiries@verita.net
Website www.verita.net

## Contents

# 1. Executive summary and recommendations

**Background**

1.1 Mr A was at the time of the incident a man in his late twenties with a diagnosis of unspecified psychosis and a history of cannabis use. He had been under the care of the South West London and St George's NHS Mental Health Trust ("the trust") Early Intervention Service (EIS) team since August 2014 after his first presentation to services in June 2014 and a period of support from the Home Treatment Team (HTT). He had never needed admission to hospital. Mr A had no history of violence or identified risk of causing harm to others. His overall risk profile was low, with occasional periods of medium risk of self-neglect.

1.2 Mr B, now deceased, was a man in his early twenties who was under the care of the EIS team since April 2015. He had been intermittently involved with mental health services, since 2007. He had diagnoses of unspecified non-organic psychosis and mental and behavioural disorder due to multiple substance use (cocaine and cannabis) at the time of the incident. He had an historical diagnosis of attention deficit hyperactivity disorder (ADHD) and learning/educational difficulties. He had never required hospitalisation but had been in a secure unit and Young Offenders Institute (YOI) as a teenager.

1.3 Mr A and Mr B both received care from EIS which provides intensive community support to people experiencing symptoms of a first episode in psychosis. Mr A and Mr B both resided at the same hostel. This is a low need supported accommodation hostel managed by a housing charity that provide a range of properties in London.

1.4 During the early hours of the morning in early 2017, the police were called to a disturbance at the hostel. Mr A went upstairs to complain about noise coming from Mr B's room. Mr A returned to his own room. Mr B then went and knocked on Mr A's door. Mr A opened the door holding a knife.

1.5 On arrival, officers established that there were three individuals involved, Mr A, Mr B and Miss H (Mr B's partner). Mr A told officers that Mr B and Miss H had been fighting and creating a disturbance. Mr A told officers that he had told Mr B and Miss H to stop at which point Mr B became abusive towards him. Officers witnessed Mr B holding Miss H tightly, refusing to let her go and suspected that Mr B had assaulted her. As a result, he was arrested. Miss H refused to engage with police and would not make or substantiate any allegations.

The police never questioned Mr A, despite being informed later that he had a knife when he approached Mr B.

1.6 Five days later Mr A stabbed and killed Mr B at the hostel. Mr A was convicted of manslaughter on the grounds of diminished responsibility. Mr A is a patient in an NHS medium secure unit.

1.7 The trust commissioned a level two serious incident investigation into Mr A and Mr B's care and treatment one month after the incident. A consultant psychiatrist and a consultant nurse from another trust carried out the investigation. The investigation panel conducted interviews with the staff involved in Mr A and B's care.

1.8 The internal investigation report was completed in August 2017. It made ten recommendations to improve services. These are included at appendix E.

1.9 In 2018, NHS England London commissioned Verita to carry out this level three independent review of the care and treatment of Mr A and Mr B under the NHS Serious Incident Framework.

1.10 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries. Chris Brougham and Nicola Salmon carried out the investigation. Dr Junais Puthiyarackal a general psychiatrist provided expert advice. Kieran Seale peer reviewed this report. Biographies of the team are included as appendix A.

**Overall conclusions – care and treatment**

*Mr A's care and treatment*

1.11 Our expert found the mental health care and treatment provided by EIS to Mr A was in line with standard practice. His care was overseen by a psychiatrist and mainly involved contact with care co-ordinator and other members of staff as well as outpatient reviews as and when required according to the discretion of the care co-ordinator.

1.12 From examining Mr A's clinical notes and CPA records, we found that housing and employment were key preoccupations for Mr A throughout his treatment under EIS.

Difficulties in either of these areas, combined with non-concordance with prescribed medication and use of cannabis triggered relapses. The presentation of Mr A's symptoms (withdrawn, quiet, distracted) could in some cases coincide with some of Mr A's character traits (reserved, quiet, introverted). This could have made it difficult to gauge the full extent of Mr A's mental state.

**1.13** Mr A had smoked cannabis for ten years and despite being informed by clinical staff of the detrimental effect it would have, he said that he felt it had little effect on his mental state. The EIS team were never really sure about the extent of use. When asked, Mr A denied using cannabis frequently, however he admitted taking it in January, April and July 2016. In early 2017, Mr A's room was searched, there was a strong smell of incense and it was suspected he had been using cannabis.

**1.14** The local community drug and alcohol service is self-directed and provides alcohol treatment and support services. The EIS team advised Mr A to address his cannabis use on several occasions, but he refused it. While urine drug testing is standard practice within addiction treatment, it is not used routinely within community mental health centres. Our expert has advised that it would have been good practice to routinely include urine drug screening (UDS) into Mr A's care plan. This would have helped the team to get a better idea of the extent of Mr A's substance misuse.

**1.15** Mr A did not have a history of self-harm or harm to others and did not have a forensic history. He had never acted aggressively or lost control with members of the clinical team at any time throughout his care and treatment. In the light of this, we consider the rationale of keeping Mr A in the amber zone before November 2016 to be reasonable as he had a history of low risk of harm to self and others. Occasionally he was at medium risk of self-neglect. However, his non-concordance with medication and use of cannabis meant that Mr A required more contact than the green zone allowed.

**1.16** We consider though that he should have been moved to the red zone when contact became difficult following his medical review in November 2016. The team should have been more assertive in putting plans in place to meet Mr A face-to-face to assess his mental state in the winter of 2016 / 2017.

**1.17** Mr A was not seen face-to-face by care coordinator 1 after his medical review on 24 November 2016. Clinical records show that there were four phone calls between Mr A and

care coordinator 1 between November 2016 and the incident during which Mr A seems to become increasingly frustrated by his housing situation.

**1.18** EIS had agreed to monitor Mr A more regularly following the medical review. Any signs that this was becoming difficult should therefore have been flagged for a more urgent review. Warning signs were not picked up as Mr A was still engaging with work, which was a slight change in his usual presentation.

**1.19** Up to November 2016 the EIS team regularly contacted his family for updates. However, this appears not to be the case in the winter of 2016/ 2017. This was a missed opportunity as Mr A's family may have been able to give useful insight into his mental state.

*Mr B's care and treatment*

**1.20** Mr B's care and treatment under EIS involved frequent support from a care coordinator, medical reviews when needed as well as liaising with multiagency professionals involved in his care including social services. This is a standard practice in keeping with the current recommendations.

**1.21** Mr B had significant problems with substance misuse. At times these probably contributed to his worsening of psychotic symptoms in addition to the non-concordance with his prescribed medication. At times he displayed disinhibited and aggressive behaviour while which could have made him vulnerable to others.

**1.22** Mr B lived at a semi-independent unit for young people since 2014. By mid-2016, Mr B was nearing the end of his tenancy placement at the semi-independent unit. EIS made a referral for supported accommodation to the local authority. The local authority act as a single point of access for all supported accommodation placements and commissions organisations, such as the housing charity to provide the service. The housing charity's policy is to interview referrals they receive from the local authority to see whether they are suitable for their accommodation.

**1.23** We have reviewed the form which was sent by the trust to the local authority. The form provides an overview of Mr B's needs, however there are parts of the referral form which were not completed. We also reviewed a referral form written by the leaving care

personal advisor assigned to Mr B while he was living at the semi-independent unit. This form was not fully completed either.

**1.24** We have reviewed the protocol between South West London & St George's NHS Mental Health Trust and the local borough council housing department. The protocol states that in addition to the application form, all referrals from the Mental Health Trust should be supported by documentation.

**1.25** Although the protocol makes it clear that no applications can be considered without a risk history, risk management plan and crisis and contingency plans, the referral form contained no information about Mr B's risk history or safeguarding issues.

*Management of Mr A and Mr B between the incidents*

**1.26** The evidence shows that EIS and the housing charity, took the first incident on the Monday seriously. Both agencies acknowledged the apparent tension between Mr A and Mr B, made efforts to try to understand the details of the incident and put plans in place to reduce risk.

**1.27** We are encouraged that EIS maintained the effective use of its zoning structures and supervision strategy throughout the week following the incident on the Monday. We found that care coordinators and key workers for Mr A and Mr B worked well to share information with plans for each service user. This helped to create a more coordinated approach. We note that plans to hasten a separation were largely focussed on moving Mr B as no interim plan seems to have been discussed with regards to Mr A. However, we acknowledge the significant difficulties staff faced in contacting Mr A and that Mr A had been non-compliant with scheduled attempts at arranging new accommodation to that date.

**1.28** It was good practice that Mr A's care coordinator made repeated attempt to try to contact Mr A, although, he did not respond.

**1.29** It was useful that two care coordinators were able to meet with Mr B as they were able to complete a full mental state and risk assessment and put a plan in place to reduce risk. We agree with care coordinator 3's assessment that the safety plan was imperfect as

this relied on Mr B's perception of his own risk and compliance in staying at his mother's house.

**1.30** Nevertheless, we find there were two significant missed opportunities in the week following the Monday incident.

**1.31** The first, was the inability to meet Mr A out of hours. The incident involving the knife on the Monday was out of character for Mr A. This should have raised significant concerns about his mental state. Despite numerous attempts to contact Mr A to arrange a face-to-face meeting after the Monday incident, none took place. We find this scheduling conflict was largely caused by the incompatibility of the operating hours of EIS and the housing charity with those of people working full time.

**1.32** The second, were the several opportunities to separate Mr A and Mr B after the incident on the Monday by finding alternative accommodation. Discussions took place within and between agencies, but no firm arrangements were made so both Mr A and B remained at the hostel which put them both at risk.

**1.33** We have been told by staff at EIS that they have since learned that emergency bed and breakfast accommodation could have been requested, however, staff were not aware of this at the time of the incident. This could have resulted in Mr A and Mr B being separated at an earlier time.

**1.34** We agree with the trust internal investigation report that it was predictable that there would have been a further altercation between Mr A and B after the near miss incident with the knife. We accept that staff recognised the existence of a risk of further incidents. We also agree that it was not possible to predict the severity or nature of the subsequent fatal incident.

**1.35** We also agree that the second incident may have been prevented had EIS and the housing charity mitigated the risks and developed plans to separate Mr A and B during the intervening week.

**1.36** A near miss should be reported as a serious incident where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.

**1.37** As stated in the trust internal investigation report, the incident on the Monday was never reported as a serious incident by the trust staff involved. It is likely that if this incident had been reported it would have prompted a review of the case by the operational manager and community matron. That would have flagged up the absence of face-to-face contacts with Mr A by trust staff.

**1.38** The housing charity did report the incident under their serious incident policy. They also informed the trust about the incident.

**1.39** There appears to have been a misinterpretation over the 'ownership' of the incident. Although the housing charity had reported the incident, this should not have precluded EIS from also reporting it as it met the criteria of a near miss.

**1.40** It is likely that if this incident had been reported it would have prompted a review of the case by the operational manager and community matron. That would have flagged up the absence of face-to-face contacts with Mr A by trust staff.

**Overall conclusions - services**

*Early Intervention Service in psychosis*

**1.41** The EIS team is made up of professionals in line with the joint NICE / NHS England guidance on implementing early intervention in psychosis.

**1.42** The 'Standards for Early Intervention in Psychosis Services' developed by the Royal College of Psychiatrists' state that full-time care coordinators should not have a caseload of more than 15 (reduced pro-rata for part-time staff). We noted that the Care Quality Commission (CQC) routine visit in October 2017 found that staff in some early intervention teams had caseload sizes in excess of the nationally recommended maximum number. The trust has taken some action to reduce caseloads, but we do not believe that they currently meet the national recommended standard.

**1.43** The overall aim of all early intervention services is to enable recovery through the provision of individually tailored, evidence-based interventions and support. One of the key

aims is to provide support to those service users who wish to obtain employment. We were told that about 30 per cent of service users from EIS were working. The Early Intervention services operational policy states that EIS operate core hours Monday to Friday 9am – 5pm, however the service is flexible in responding to those service users or carers in employment or education who may request to be seen outside of these hours.

**1.44** Although we were told there was a 'buddy system' in place for flexible working, we heard that staff going to visit service users out of hours was not the usual practice at the time. Although flexibility was expected there was no formal system in place to ensure such visits took place if necessary. Putting a formal system in place would be desirable as other policies (such as lone working) are needed to align with flexible working to reduce the risk to staff who work alone.

**1.45** There are other models of working, such as Flexible Assertive Community Treatment (FACT), where the clinical team share small caseloads and are available out of hours. An approach such as this might meet the needs of service users in EIS better.

**1.46** The trust's clinical risk policy sets out the process for carrying out risk assessments. The trust uses a zoning system to facilitate the delivery of targeted mental health interventions. This is an evidence-based approach to ensure that service users receive appropriate levels of support while they are using community mental health services.

**1.47** The caseload is zoned into red, amber and green zones. Service users might move between zones depending on their needs. The trust's internal investigation report flagged zoning up as an issue and recommended that EIS should review the use of the amber zone. We have since been advised that the zoning process has been improved since this incident. We accept the recommendations made by the internal investigation report in relation to zoning. We welcome the changes that EIS have made to the zoning process. We note however, that the issue of zoning service users within the EIS team requires continuous monitoring.

**1.48** The Care Programme Approach (CPA) is used to assess and plan mental health care to make sure that service users receive the necessary support. Enhanced CPA is for service users with complex needs or who require their care needs to be provided by a range of providers. All service users on the EIS caseload are on the enhanced CPA. At the time of the incident formal CPA reviews were carried out at least annually.

**1.49** The trust has a virtual risk team (VRT) which is a resource for clinical staff. At the time, this consisted of around 12 experienced practitioners who were available for staff to access when supporting a service user with complex needs. Mr A and Mr B may have benefited support from the team, but EIS did not refer them. The failure to refer Mr A and Mr B to the VRT was a missed opportunity as they could have provided a fresh view and advice on management.

*The housing charity and joint working with the trust*

**1.50** We reviewed the most recent support plans for Mr A and Mr B completed by the housing charity. Overall, we found the housing charity support plans to be of good quality and used as a key means of monitoring support given to residents. The collaborative approach to support planning between the housing charity and EIS care coordinators is in line with good practice.

**1.51** The housing charity aims to promote independent living skills, including cooking. Residents are expected to prepare and cook meals for themselves, using their own kitchen equipment, including knives. We have been advised that there is not a standalone protocol for management of weapons and knives at the hostel.

**1.52** The housing charity has a licence agreement with residents which sets out the terms under which they live in the property. The agreement sets out the rights and responsibilities of residents. The agreement makes it clear that if the resident does not keep to this agreement legal action could be taken. Each resident must sign this agreement before taking up residence.

**1.53** We are satisfied that although the housing charity does not have a specific protocol relating to weapons, it does have a formal agreement in place to make it clear that residents must not carry out unlawful or violent acts.

**1.54** The housing charity staff do not have a statutory role with regards to its residents. There is a joint operating procedure between EIS and the housing charity. The procedure makes it clear that there should be collaboration, the sharing of information and joint working.

**1.55** We found that staff at the housing charity hostel and EIS had formed effective daily working relationships, characterised by consistent open dialogue and that they communicated and coordinated well throughout Mr A's tenancy. We found evidence that members of both the EIS and hostel teams were in regular phone, email and face-to-face contact about issues around their shared service users and that staff from the housing charity attended multi-disciplinary and care planning meetings. On the whole, staff from EIS and the hostel worked well together, meeting the expectations of a joint operating procedure between EIS and the housing charity.

*Support to families and duty of candour*

**1.56** We examined whether the trust met the requirements of the statutory duty of candour regulation (2014). This duty makes it clear that healthcare providers must promote a culture that encourages candour, openness and honesty at all levels.

**1.57** We also refer to the NHS Serious Incident Framework. This outlines the need for the family to:

- be made aware, in person and in writing, as soon as possible of the process of the investigation to be held, the rationale for the investigation and the purpose of the investigation
- have the opportunity to express any concerns and questions
- have an opportunity to inform the terms of reference for investigations
- be provided with the terms of reference to ensure their questions are reflected and
- know how they will be able to contribute to the process of investigation, for example by giving evidence.

**1.58** The trust did have some contact with Mr A's family after the fatal incident. There is no record though to show that a duty of candour letter was sent out, an apology was made or that an opportunity was provided to Mr A's family to inform them of the terms of reference for the trust investigation. There is evidence however, that the trust sent Mr A's mother a copy of the trust internal investigation report.

**1.59** The trust was advised that contact with Mr B's family should be through the police family liaison. The trust provided the police with the contact details for the trust family liaison team to be passed to Mr B's family. It is not known what discussions were held in relation to contact with Miss H (who was also a victim of the incidents) and her family. We were told by Miss H's mother that they were not contacted by the trust after the incident. There was been no direct communication between the trust and Mr B's family until spring/summer 2020.

**1.60** Mr B's family and Miss H were not contacted to advise them that the trust was internally investigating the incident, nor were they invited to contribute to the investigation. The trust did not share the final report with Mr B's family or Miss H. Mr B's family solicitor has since requested and received a copy of the trust internal investigation via the coroner's office. Mr B's family have confirmed to us that nobody from the trust has contacted them since the incident.

**1.61** Miss H and her family received a copy of the trust report and an earlier draft of this independent investigation report from NHS England London regional mental health team in the spring of 2020. Miss H is now receiving support from the trust.

**1.62** The support provided to Mr B's family was of poor quality by all accounts and did not meet the expectations of the family. Miss H also did not receive any support or communication from the trust directly following the incident. We are pleased to hear that Miss H is now receiving support from the trust.

**1.63** Mr B's family and Miss H should have had the opportunity to express any concerns and questions about his care and treatment, and comment on the terms of reference for the trust investigation. They should have also been informed how they could contribute to the process of the investigation, for example by giving evidence.

**1.64** The trust could have written to Mr B's family directly or through the police family liaison to see if they needed any other support and signposted them accordingly.

**1.65** We are disappointed to find out that the trust has never apologised to Mr B's family and Miss H and her family despite the internal investigation finding that that fatal incident may have been prevented.

**1.66** The trust has breached the statutory duty of candour.

**1.67** The trust has told us that the circumstances around this incident were very challenging but acknowledge that they did not fulfil the requirements of statutory duty of candour int his case. They have also told us that they have since developed the family liaison role within the trust and have recently contributed to the development of national guidance.

**1.68** The housing charity do not have a statutory duty to offer support to families, but they do have a death and bereavement policy which sets out what to do in the event of a death.

**1.69** Following the fatal incident, the hostel became a crime scene. All residents were temporarily relocated. The police and the CID attended to carry out forensic examinations. Once they had finished their investigation, the property was handed back to the housing charity. There was a lot of blood at the scene, so specialist contractors were used to remove the blood and chemicals that the forensic team had used on walls and the doors. All the carpets were replaced but the old carpets were left in black bags outside the property. One of the bags was on its side and there was a corner which was stuck out that had a blood splatter on it. Mr B's sister told us they went to Mr B's room after the incident and they had seen Mr B's blood on the carpet outside the hostel.

**1.70** We understand that the incident was unprecedented, and the housing charity did their best to get all the carpets replaced so Mr B's relatives could visit his room and other tenants could return to their homes. No family should have to see items which contain the blood stains of their loved one following a violent incident. The housing charity staff should have ensured that it did not happen.

**Recommendations**

**R1** The trust should have a system in place to ensure that the care coordinators within the EIS hold caseloads within the current national recommended number (no more than 15) to promote effective support to service users.

**R2** The trust should ensure that the EIS uses a model of working to enable clinical staff to work outside office hours so that service users can be visited, assessed and monitored face to face if necessary.

**R3** The trust should carry out an audit to ensure that CPA reviews take place in line with trust policy.

**R4** EIS should carry out regular audits to ensure that service users are placed within the correct zone in line with the risks that they present and that they are reviewed, and targeted mental health interventions are delivered in line with the standards within the zoning system.

**R5** EIS should consider using urine or saliva testing as part of care planning where it is known that the service user regularly takes drugs.

**R6** EIS should ensure that they engage all sources of information including families when trying to visit service users that are hard to engage.

**R7** EIS and the housing charity should ensure that all staff are aware of all emergency accommodation options available to them.

**R8** EIS should ensure that all incidents that meet the criteria are reported and investigated so improvements can be put in place where necessary.

**R9** The trust should ensure that those affected by an incident are offered support in a timely manner.

**R10** The trust must ensure that they use the systems in place for complying with duty of candour and carry out regular audits to ensure they are meeting the requirements of the act.

## 2. Introduction

**2.1** Mr A was at the time of the incident man in his late twenties with a diagnosis of unspecified psychosis and a history of cannabis use. He had been under the care of the trust's Early Intervention Service (EIS) team since August 2014 after his first presentation to services in June 2014 and a period of support from the Home Treatment Team (HTT). He had never needed admission to hospital.

**2.2** Mr B, now deceased, was a man in his early twenties who was under the care of the EIS team since April 2015. He had been intermittently involved with mental health services, since 2007 when he was seen by Child and Adolescent Mental Health Services (CAMHS). He had diagnoses of unspecified non-organic psychosis and mental and behavioural disorder due to multiple substance use (cocaine and cannabis) at the time of the incident. He had an historical diagnosis of attention deficit hyperactivity disorder (ADHD) and learning/educational difficulties. He had never required hospitalisation but had been in a secure unit and Young Offenders Institute (YOI) as a teenager.

**2.3** Mr A and Mr B both received care from EIS which provides intensive community support to people experiencing symptoms of a first episode in psychosis. Mr A and Mr B also both lived at a hostel for single homeless people with mental health problems in London. The hostel is run by a housing charity that provides training, support and accommodation for homeless people.

**2.4** During the early hours of Monday morning in early 2017, the police were called to a disturbance at the hostel. Mr A went upstairs to complain about noise coming from Mr B's room. Mr A returned to his own room. Mr B then went and knocked on Mr A's door. Mr A opened the door holding a knife.

**2.5** Five days later, on the early hours of Saturday morning Mr A stabbed and killed Mr B at the hostel they both lived in. Mr A was convicted of manslaughter on the grounds of diminished responsibility. Mr A is a patient in an NHS medium secure unit.

**2.6** The trust commissioned a level two serious incident investigation into Mr A and Mr B's care and treatment in one month after the incident. A consultant psychiatrist and a consultant nurse from another trust carried out the investigation. The investigation panel conducted interviews with the staff involved in Mr A and B's care.

2.7 The trust told us that they were advised not to contact Mr B's family directly following the incident but offered the family the opportunity to contribute via the trust family liaison and police family liaison teams. Mr B's family did not contribute to the internal serious incident investigation.

2.8 Mr A's family contacted his care coordinator at the Early Intervention Service (EIS) on the day after the incident on the Sunday to obtain more details and information about the incident. EIS maintained contact with the family by telephone.

2.9 The internal investigation report was completed in August 2017. It made ten recommendations to improve services. These are included at appendix E.

2.10 In 2018, NHS England London commissioned Verita to carry out this level three independent review of the care and treatment of Mr A and Mr B under the NHS Serious Incident Framework.

2.11 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries. Chris Brougham and Nicola Salmon carried out the investigation supported by Laura Neil. Dr Junais Puthiyarackal a general psychiatrist provided expert advice. Kieran Seale peer reviewed this report. Biographies of the team are included as appendix A.

# 3. Terms of reference

**3.1** The following are the terms of reference for the investigation:

The investigation team will use the trust internal investigation as a starting point to examine the care and treatment of Mr A from August 2016 until the time of the offence. The investigation will focus on the areas that have not already been fully reviewed or analysed. These include the following:

**Mr A**

- To understand the outcome of Mr A's Mental Health Assessment following the Saturday incident.
- The risk assessment and risk management system in place and whether Mr A was zoned correctly, and risk managed appropriately. This will include:
    - the rationale for Mr A remaining in the amber zone for months prior to the offence;
    - the effectiveness of the escalation process/ communication during zoning meetings;
    - the clinical management of Mr A's cannabis use
    - the response and plan by EIS when Mr A was not seen individually after his medical review in November 2016;
    - the process for re-assessing Mr A's mental health following the Monday incident

*Joint care*

- Examine whether Mr A's care plan was developed jointly with housing and EIS;
- Review the communication between the trust and hostel staff when there were signs that Mr A's mental health was deteriorating.

**Mr B**

- Review the appropriateness of Mr B being accepted into the housing charity hostel.

**Mr A and Mr B**

- To obtain further information about their whereabouts/behaviours from housing staff/relatives/ visitors/other residents during in the days between the first incident on the Monday until the fatal incident on the Saturday.
- To review the process for re-assessing Mr A's mental health and their presentation and understanding of the incident on the Monday.
- To review the incident that took place on Monday.
- To review the Risk Assessment and Management plan for each patient following the first incident.
- To review the immediate decisions and actions taken following the first incident and the feasibility of the two patients being separated at an earlier opportunity.
- How agencies involved and supported Mr B's and Mr A's families following the incident in line with openness and the statutory duty of candour.

**Processes / protocols**

3.2 We will review the following:

- The rational for majority of patients being zoned as amber and how the patients are reviewed at present.
- The drug and alcohol policies/ procedures and clinical guidelines.
- The current protocol/process for management of weapons/knives at the accommodation where both patients were residing.
- The caseloads management and dynamics of EIS.
- The process/system in regard to EIS arranging appointments or planned meetings with service users who have a noted increase in risk and are unable to attend due to work commitments, in particular when their care coordinator is unable to see them at alternative times.

- The process of developing a joint care plan with housing and EIS.
- Staff understanding of reporting incidents and escalating concerns in the hostel.
- Staff understanding of reporting incidents and escalating concerns including referral to the trust Virtual Risk Team and referral to Home Treatment Team processes.
- The effectiveness of supervision processes in both the housing charity hostel and EIS team.
- To review commissioning arrangement of the supported housing project in London.
- To review the role of the local authority in decision making processes around referral and acceptance of potential tenants.

**3.3** Full terms of reference are included at appendix B.

## 4. A tribute to Mr B

**4.1** Mr B's family have written the following tribute in memory of Mr B.

*"It's so hard to have to put it into words who [Mr B] is/was as a person because we don't know how to refer to him as a past tense. He will never be forgotten and his memory lives on through us every day and no matter what words we use to describe [Mr B] I feel that they can't even begin to express and make others understand the type person he was.*

*Despite what [Mr B] looked like on paper around the time of his death he was bettering his life for himself and his daughter he was doing bits of landscape gardening here and there and was hoping to get a full-time job in it as it was something he enjoyed.*

*He always made sure he always looked well-presented and well-groomed with his hair always neatly done.*

*To us [Mr B] was one of a kind, he was loved by so many who knew the real him and didn't misunderstand him. He would walk into the room and light it up with a cheeky big smile always on his face, and his cheeky larger than life personality. He was always laughing and joking and used to joke about all the girls always fancying him!*

*No matter what challenges [Mr B] faced in life he was always selfless and there for the people he loved the most, to help and support them. His quirky little sayings and cheesy one-liners would somehow always put a smile on your face and help you get through whatever you were dealing with at the time! He would always say "don't worry girl keep your chin up". He would do anything to help you if he could.*

*He was a loving son, brother but most importantly he was the most doting father to his beautiful daughter - he would walk miles day or night just to see her or bring her whatever she needed because distance did not matter, she was his world and everything in it.*

*We couldn't have asked for a better son, brother or father. We were so proud of the man he became and the father he was. He may not have been perfect to anyone*

*else but to everyone who knew him he was irreplaceable and loved so very much. Our hearts are forever broken. He is so dearly missed every day and the void he has left in our hearts can never be filled. We lost our legend and the rock of our family."*

# 5. Approach and structure

**Approach to the independent investigation**

5.1 NHS England, London Region, commissioned the independent investigation under the NHS Serious Incident Framework. The investigation team consisted of Chris Brougham, a director/investigator and Nicola Salmon a consultant from Verita. Dr Junais Puthiyarackal a consultant psychiatrist in General Adult Psychiatry provided expert advice. From now on the investigation team will be referred to as 'we'. Our biographies are in appendix A.

5.2 We have been asked to review the care and treatment provided to the victim – Mr B in addition to the perpetrator. We have provided a factual account of Mr B's personal history and presentation. Any information written about Mr B is intended to provide a full picture of his needs so that we are able to make a considered view about his mental health care and the appropriateness of being accepted into the hostel.

5.3 We would like to reiterate that Mr B was the victim of a violent and tragic incident in which he very sadly lost his life at a young age.

5.4 We have met with Mr B's family and Miss H and her family during the course of this investigation and they have shared many warm and fond memories of Mr B as a person. No matter what Mr B's personal circumstances were, he did not deserve to die in such a horrific and violent manner. We acknowledge that the families involved continue to live with and struggle to come to terms with the upsetting and wide-ranging consequences of this tragic incident.

5.5 We reviewed documentary evidence (see appendix D). This included:

- National guidance
- Trust policies and procedures
- The housing charity policies and procedures
- Mr A and B's clinical records and
- The trust internal investigation report

5.6 We interviewed the following staff:

- Mr A and B's care coordinators (care coordinator 1 and 2 respectively)
- A consultant psychiatrist that cared for Mr A and Mr B
- An associate specialist psychiatrist
- Mr A and B's hostel key workers (hostel key worker 1 and 2)

5.7 Mr A gave us permission to review his medical records. We met with Mr A at the beginning of the investigation to explain the process and then interviewed him formally, so he could tell us about his care and treatment. We sent him a copy of our report to comment on.

5.8 We met with Mr A's mother at the beginning of the investigation to explain the process. We offered to interview her to hear her views about Mr A's care and treatment, but she declined. We understand her reasons for not wanting to be interviewed. We interviewed Mr A, so he could tell us about his care and treatment. We sent Mr A's mother a copy of our report to comment on.

5.9 We met with Mr B's mother and sister at the beginning of the investigation to explain the process. We also interviewed Mr B's mother, aunt and sister to hear their views about Mr B's care and treatment. We sent their solicitor a copy of our report, so Mr B's family could comment on the report.

5.10 We were initially unable to contact Miss H to participate in this investigation. During the publication process for this report in January 2020, NHS England received contact from Miss H and her mother via her victim support worker. Progress on the publication of the report was paused to allow Miss H an opportunity to make comments on its content. NHS England facilitated a meeting with Miss H and her mother to discuss the trust internal report and the most recent version of this independent investigation report. Following this meeting, we met with Miss H's mother on her behalf to answer her questions on aspects of this report.

5.11 We followed established good practice in conducting the work, for example by offering interviewees the opportunity to be accompanied and to comment on and make amendments to the transcripts of their interview.

5.12 We have not examined any safeguarding issues as we have been informed that a Safeguarding Adult Review will be commissioned separately.

5.13 We made findings, comments and recommendations based on our interviews and the information available to us to the best of our knowledge and belief.

**Structure of this report**

5.14 This independent investigation report includes a chronology outlining the care and treatment of Mr A and Mr B. Part one provides background information about the services that Mr A and B accessed plus an overview of their treatment, care, and the incidents occurring in early 2017. Part two contains our comment and analysis of the issues that are outlined in the terms of reference.

5.15 Our comments and opinions are in ***bold italics***.

# Part one: background and chronology

## 6. Background to services

### Early Intervention Service

**6.1** EIS works with adult service users who have experienced a first episode of psychosis and their carers. EIS provides intensive community support including biological, psychosocial and risk management. At the time of the incident, EIS worked largely with young people from the age of 17 to 35, however their remit has recently been extended to work with adults up to the age of 65. EIS work with service users for up to three years. The team works within core hours, 8am to 6pm Monday to Friday, although some flexibility is expected from staff as required.

### The housing charity

**6.2** The housing charity that provides support to homeless people in London across an array of projects. One of these projects, provides supported housing for single homeless people in a London borough who have mental health support needs or drug and alcohol problems. The project houses up to 39 residents across six houses, including the hostel that Mr A and Mr B lived in. Staff are non-clinical and work with residents to agree individual support plans to enable them to become more independent, develop new skills, access training and employment opportunities, and build the support networks to help them move forward with their lives. The housing charity do not have any statutory powers, but staff work in partnership with the statutory agencies involved with residents. Placements in the housing charity project are designed to last up to two years.

**6.3** The housing charity service is commissioned by the local borough council to provide housing related support. The council housing options team have priority referral rights to the housing charity project. Other agencies can refer individuals to the project via the housing options team in a 'single point of access' arrangement.

*The hostel*

**6.4** Mr A and Mr B lived in a hostel which is one of the houses in the housing charity project. It offers single person, supported accommodation for vulnerable men. The aim of the project is to support residents to gain and develop life skills required to maintain an independent tenancy. Staff in the project, facilitate and signpost residents to services. Each resident has their own bedroom but share kitchen and bathroom facilities. The hostel does not allow children or pets in the premises. Any visitors must sign in and overnight guests are restricted in that staff must be notified in advance and there are limits to the number of nights any guest can stay.

**6.5** The hostel is classified as low support accommodation. This means that residents did not have any major physical health needs that they would need supported in order to live independently. The hostel is staffed during office hours (Monday – Friday, 9am – 5pm). There is no staff cover at weekends. Outside of staffed hours, residents have access to an 'on-call' member of staff through a helpline. At the time of the incident there was no CCTV in the hostel.

**6.6** At the time of the incident residents were placed under assured shorthold tenancies, which are the terms most commonly used in private rented accommodation. This gives the housing charity residents the rights of a tenant and meant that the housing charity had to give warnings, notice and obtain a court order in order to evict a resident from the hostel. We have been told that the housing charity now use a more flexible licensing system to place residents within their projects.

**Staffing**

**6.7** Upon acceptance onto care packages, service users are assigned a primary contact to liaise with on a regular basis. This ensures continuity of care.

**6.8** We set out below, the individuals that Mr A and Mr B were assigned to by EIS and the housing charity.

| | **Mr A** | **Mr B** |
|---|---|---|
| **EIS Community Psychiatric Nurse (CPN)** | Care coordinator 1 | Care coordinator 2<br>Transitioning to care coordinator 4 |
| **EIS secondary CPN** | | Care coordinator 3 |
| **The housing charity key worker** | Key worker 1 | Key worker 2 |

# 7. Chronology of key events

7.1 In this chapter we provide an overview of Mr A and Mr B's care and treatment. We also give an overview of the key events in the week from the initial "near-miss" incident on Monday to the final incident later that week, on Saturday. We discuss the actions taken by agencies involved in greater depth at chapter 11.

**Mr A**

7.2 At the time of the incident. Mr A was a man in his late twenties with a diagnosis of unspecified psychosis and a history of cannabis use. He had been under the care of the EIS team since July 2014 after his first presentation to services in June of the same year. He received support from the Home Treatment Team (HTT). He had never required admission to hospital.

*Personal history*

7.3 Mr A grew up in South London. After leaving school he attended a college to study building craft operations for a year. In April 2015 he went to study information technology courses.

7.4 Mr A was working as a shop assistant at a stationary supplies shop prior to his contact with mental health services but obtained a job with at a telecommunications company in October 2016. Mr A's mother described him as being quiet and an introvert by nature.

*Overview of Mr A's care and treatment*

7.5 Mr A first presented to mental health services in the summer of 2014 when he was taken to A&E by his family. His clinical records show that he was under additional stress at work and due to recently losing a tenancy, his housing situation was uncertain. He had not slept for several days and had lost weight. He seemed distracted and at times mute. There was also evidence of psychosis. He was supported by the HTT, commenced on low dose

Olanzapine 5mg and referred to EIS. He was accepted by EIS in July 2014 and supported by them until the incident in 2017.

**7.6** Mr A had no history of violence or identified risk of causing harm to others. His overall risk profile was low, with occasional periods of medium risk of self-neglect.

**7.7** Mr A had diagnoses of unspecified non-organic psychosis and mental and behavioural disorder due to cannabis (harmful use) at the time of the incident.

**7.8** Mr A was initially complying with medication, although he had said that he was unhappy with it due to its sedative effects and weight gain. He also reported three episodes of pericarditis (inflammation of the pericardium, the sac that surrounds and protects the heart). He was referred to cardiology. By February 2015 he had stopped the medication but had appeared in stable mental state for ten months after this.

**7.9** Mr A attended a housing assessment with care coordinator 1 on 9 March 2015. He said he was taking medication and did not report any problems with his mental health. The option of a placement at the housing charity was discussed. He reported not having any problems with the accommodation being offered or sharing with others. He said he would be content to be there but would preserve his privacy. Mr A moved into the hostel on 13 May 2015. On 21 May 2015 Mr A was seen by a hostel key worker, a student nurse, and care coordinator 1. He appeared to be settling in well. No psychotic or affective symptoms were observed or reported.

**7.10** The Care Programme Approach (CPA) meeting took place as planned on 15 July 2015. Mr A was seen (with his mother) by the consultant psychiatrist and care coordinator 1. The review says that Mr A 's mental state had been stable since his first episode of psychosis in summer 2014. He told trust staff that although he had previously informed them that he was taking his medication, he had in fact stopped taking it in February 2015. There had not been any evidence of any relapse. The clinical team felt he had settled well into supported accommodation since May 2015 and was looking at employment and training opportunities. No concerns had been expressed by his key worker at the housing charity. There was some on-going cannabis and alcohol misuse although this had been difficult to quantify. However, the clinical team felt Mr A understood the increased risk of relapse associated with substance misuse. The clinical team considered any risks to be low to himself in terms of risk of suicide, self-neglect, and risk of harm to others.

**7.11** In November 2015 the clinical team were concerned about Mr A's mental state, so he was seen at the hostel by an associate specialist psychiatrist. He was not sleeping or eating, had vague suicidal ideas and seemed perplexed and pre-occupied. The clinical team noted that he had been under additional stress, following the death of another resident at the hostel and because he had started at college. He had been medication free for ten months but agreed to restart Olanzapine 5mg and had support again from HTT.

**7.12** In January 2016 Mr A's mother was unwell and was subsequently in hospital for several months. In April there was evidence of a decline in Mr A's mental state characterised by thought disorder, poor concentration and difficulty focussing during assessment. When seen by the doctor he disclosed that he had once again stopped the oral medication but again agreed to restart (Olanzapine 5mg). He was supported by HTT. He took the medication until November 2016.

**7.13** In between the three reported episodes of suspected psychosis (June 2014, November 2015, April 2016) staff at the hostel raised minor concerns about his behaviour or mental state on a number of occasions. Staff had suspicions of cannabis use throughout. Towards the end of 2015 several attempts were made to engage Mr A with psychological support. He was offered Cognitive Behavioural Therapy for psychosis (CBTp) and Family Intervention (FI) work but he never took this up. His family (mother and grand-mother) were involved in his care, attended reviews and were offered carers support.

*Comment*

***From examining Mr A's clinical notes and CPA records, we found that housing and employment were key preoccupations for Mr A throughout his treatment under EIS. Difficulties in either of these areas, combined with non-concordance with prescribed medication and use of cannabis triggered relapses.***

***The presentation of Mr A's symptoms (withdrawn, quiet, distracted) could in some cases coincide with some of Mr A's character traits (reserved, quiet, introverted). This could have made it difficult to gauge the full extent of Mr A's mental state.***

***It is also worth noting, that Mr A did not have a history suggesting a risk of violence or causing harm to others.***

**Mr B**

**7.14** Mr B, now deceased, was a man in his early twenties who was under the care of the EIS team since spring 2015. He had been intermittently cared for by mental health services, since 2007 when he was first seen by Child & Adolescent Mental Health Services (CAMHS).

**7.15** Mr B had diagnoses of unspecified non-organic psychosis and mental and behavioural disorder including paranoia. This was put down to harmful substance use (cocaine and cannabis). He had an historical diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and learning/educational difficulties. He had never required hospitalisation but had been in a secure unit and Young Offenders Institute (YOI) as a teenager.

*Overview of Mr B's care and treatment*

**7.16** Mr B was first seen by a CAMHS consultant in 2007 and diagnosed with ADHD and literacy problems. At school Mr B had a statement of Special Educational Needs. In 2009 he was referred back to CAMHS by his GP and was started on medication for ADHD. He was under a referral order with the Youth Offender Team for breaking a window.

**7.17** In Autumn 2011 he was charged with stealing a car (taking and driving away). In early 2012 he was admitted to a specialist unit for young people. Three months after release he stole a car and was detained for five months at a YOI which (a prison for male juveniles). He was released in late 2013. The trust internal investigation report states that documentation showed that Mr B had been subject to assaults whilst at the specialist unit and the YOI.

**7.18** In early 2014, Mr B was placed at a semi-independent housing unit.

**7.19** In spring 2015 Mr B's GP referred him, to the local community mental health team (CMHT). There was evidence of paranoid thoughts and auditory hallucinations. He was assessed and accepted by EIS, allocated care coordinator 2 as his community psychiatric

nurse and placed on the care programme approach. He reported a history of alcohol, cocaine and cannabis use. His girlfriend, Miss E was pregnant with their child which was due in autumn 2015.

**7.20** Mr B was taking medication until summer 2015 but stopped without consulting with EIS. This was discussed fully at the medical review with the consultant psychiatrist in around one month later when alternative medication options were given. However, Mr B was keen to remain medication free. Mr B had recent convictions for carrying a blade, resisting arrest and criminal damage. He received a 12-week suspended sentence, six months' probation, and a tag to stay at his accommodation between 9pm and 7am.

**7.21** Miss E had the baby in the late autumn 2015. Mr B was happy following the birth of his daughter, but he found this a stressful time. By the time he had his next medical review in early 2016, Mr B was back on medication. Clinicians noted, however, that Mr B did not take the medication. He was offered a depot injection (long acting medication) but declined.

**7.22** Mr B was offered cognitive behaviour therapy and family Intervention work and had been referred to the CIRCLE trial[1] to support him with his cannabis use.

**7.23** In spring 2016, Mr B split up with Miss E.

**7.24** Consultant psychiatrist 1 carried out a medical review in the summer of2016 at Mr B's mother's address. Care coordinator 2 was present. Mr B was seen briefly with his mother. He was not taking any psychotropic medication. The plan was to:

- Refer to the Home Treatment Team
- Restart Risperidone at 2mg
- Discuss deterioration in his mental state with children & family social services
- Refer to the Multi Agency Safeguarding Hub (MASH)

**7.25** Mr B was given an eviction notice from the semi-independent unit in early summer 2016 as part of his planned move onto supported accommodation. He was due to leave on one month later, but this was extended. He was referred to the housing charity in August

[1] CIRCLE is a randomised controlled trial testing a new treatment aimed at helping people who are currently early intervention service users to reduce or stop using cannabis.

but was initially rejected because the housing charity interviewer believed Mr B was under the influence of alcohol in the interview. We were told by care coordinator 2, that the member of the EIS team who accompanied Mr B did not believe this to be the case.

**7.26** In early autumn 2016 Mr B was involved in a safeguarding incident[1], so he was monitored more closely by EIS. Later in the same month he was arrested for a further incident. Mr B told care coordinator 2 that he had a new girlfriend Miss H, who was supportive.

**7.27** Care coordinator 2 helped Mr B to appeal the initial rejection by the housing charity. The appeal was successful, so Mr B moved into the hostel in late Autumn 2016. Staff at the hostel had concerns about his placement, because he broke house rules by drinking alcohol, having visitors and displaying inappropriate behaviour in communal areas.

**7.28** Five days before the first incident with Mr A, EIS held a CPA review for Mr B at the hostel. Consultant psychiatrist 1 attended with other members of the team. Mr B was encouraged to attend but stayed in his room. No immediate concerns were expressed in the meeting about his mental state and he was thought to be taking the Risperidone. The meeting noted that he had only attended two to three sessions of CBTp and then disengaged. The difficulties settling into the hostel, his new relationship, safeguarding concerns in relation to his daughter were all explored in the meeting.

*Comment*

***Mr B had significant problems with substance misuse along with a history of ADHD and literacy problems. At times these probably contributed to his worsening of psychotic symptoms in addition to the non-concordance with his prescribed medication. At times he displayed disinhibited and aggressive behaviour which could have made him vulnerable to others.***

***Despite Mr B's problems, he did not deserve to die in the circumstances that he did.***

[1] We do not discuss safeguarding issues in this report as there will be a separate independent safeguarding review.

**Events in the week following the first incident**

*Monday*

**7.29** In the early hours of Monday morning and Mr A went to Mr B's room to complain about noise coming from his room. Mr A then returned to his own room. Mr B subsequently knocked on Mr A's door. When Mr A opened the door, he was holding a knife.

**7.30** The police investigation report shows that residents in adjoining properties called the police reporting a disturbance. On arrival, officers established that there were three individuals involved: Mr A, Mr B and Miss H. Mr A told officers that Mr B and Miss H had been fighting and creating a disturbance. Mr A told officers that he had told Mr B and Miss H to stop at which point Mr B became abusive towards him. Officers witnessed Mr B holding Miss H tightly, refusing to let her go and suspected that Mr B had assaulted her. As a result, Mr B was arrested. Miss H refused to engage with police and did not make any allegations against Mr B.

**7.31** During that morning, a police officer phoned Miss H as part of the police investigation. She told the officer that the incident had occurred in a corridor inside the hostel and involved a male fitting Mr A's description who had a knife (later understood to be Mr A). She refused to provide any further details about the incident.

**7.32** In the late afternoon, two police officers interviewed Mr B. He denied committing any offences and explained that he had not done anything wrong. He said that he could not understand why he had been arrested. He did not make any allegations against Mr A and did not disclose any matters of concern in relation to him or his safety. Following the interview and a review of the evidence, Mr B was released from custody with no further action being taken against him.

**7.33** Staff at EIS and the housing charity became aware of the incident that day, but the details remained unclear. The fact that it was Mr B, rather than Mr A, who was arrested by police, complicated their understanding of the incident.

*Tuesday*

**7.34** The following day, staff at the hostel became more aware of the details of the incident and in particular that Mr A had held a knife when he opened the door to Mr B. Key worker 1 shared this information with care coordinator 1 and expressed concern that Mr A was mentally unwell. Care coordinator 1 spoke with the EIS team manager, and was advised to get more information and to try to see Mr A. It was agreed to meet with Mr A on the following day. However, hostel key worker 1 said he was unable to contact Mr A to confirm his attendance.

*Wednesday*

**7.35** Two days after the incident, Mr A and Mr B were placed on the red zone, for enhanced contact from the EIS team and discussed in the Wednesday red zoning meeting. Care coordinator 2 told the team about the incident. Care coordinator 1 arranged an urgent visit to the hostel to meet Mr A and to get more details.

**7.36** Care coordinator 1 went to the hostel during the morning and met with key worker 1 who had contacted the police to inform them about the incident. Care coordinator 1 and hostel key worker 1 went to Mr A's room but he was not there. They conducted a room search. They noted that the room was messy with the window left open and a strong smell of incense. It was suspected he had been using cannabis. Key worker 1 discussed his concerns about Mr A becoming fixated and preoccupied with his housing situation and wanting to move to independent accommodation, whilst not cooperating with the process.

**7.37** Hostel key worker 1 phoned Mr A to ask when he would be available to attend an urgent meeting to discuss the incident. He also told Mr A that a warning letter had been placed under his door regarding the incident. Mr A responded that he was okay and was busy with work. Mr A said that he had gone to Mr B to tell him to lower the noise. When Mr B came knocking at his door he needed to defend himself as he did not know Mr B's intentions. Care coordinator 1 asked Mr A if he was using drugs or alcohol, but he refused to discuss this. Mr A said that he wanted to get his own flat and that this needed to be sorted out as soon as possible. The plan for care coordinator 1 was to arrange a review meeting and a medical review.

**7.38** Mr B's care coordinators (care coordinator 2 and care coordinator 4) attempted to visit him. However, he was unavailable as he was appearing at Wimbledon Magistrates Court

in relation to a previous case. Instead, they tried to get more information about the incident from the hostel staff and the police. They agreed to try to find Mr B an alternative accommodation placement by liaising with social worker 1. Care coordinator 2 emailed social worker 1 to this effect.

**7.39** The plan for the housing charity hostel staff was to:

- Update the police with the facts about Mr A being in possession of the knife
- To give Mr B a second written warning
- To issue Mr A with a final written warning
- For care coordinator 1 and key worker 1 to meet with Mr A at the hostel to discuss the incident and carry out a risk assessment
- To try to expedite for Mr A or Mr B to be moved into a new accommodation.

*Thursday*

**7.40** At 2:30pm on the Thursday of that week, care coordinator 1 phoned Mr A but he did not respond. At 3:30pm care coordinator 1 phoned Mr A's father who told him he thought that Mr A had "*every right to defend himself*". He reported that Mr A was anxious about his housing situation and requested for him to be moved quickly.

**7.41** At 3:30pm Mr B called care coordinator 2 and told her of the incident. She acknowledged she knew Mr B had been taken into custody. Mr B said that he did not feel safe at the hostel. Care coordinator 2 asked him whether she could meet with him. They agreed she and care coordinator 4 would see him at 4:00 pm that day at Mr B's mother's house. Care coordinator 2 advised him to stay at his mother's address. Mr B confirmed that he would stay because his life had been threatened. He complained that staff were taking sides and he felt he had been blamed.

**7.42** Care coordinator 2 had a family emergency and was unable to see Mr B as planned. Care coordinator 2 informed Mr B that Mr B's secondary care coordinator (care coordinator 3) was on her way to see him instead.

**7.43** Care coordinator 4 and care coordinator 3 met Mr B as he was leaving his mother's house with Miss H. Mr B wanted the meeting to take place in a local café. However, this was closed so the meeting took place in the street.

**7.44** Mr B said that he was unhappy about the incident, that his life was threatened and that he felt that no one was taking him seriously. Mr B did not feel that the housing charity hostel staff were on his side. He was angry that Miss H was banned from the hostel and he had been accused of domestic violence, which both had denied. Care coordinator 3 assessed Mr B's mental state. She noted that Mr B was calm and made good eye contact. There were no signs of paranoid thoughts. Mr B did not report that strangers were 'out to get him' as he had done previously when unwell. His speech was normal in rate, tone and volume. There was no evidence of perceptive abnormalities. Care coordinator 3 found no positive signs of psychosis could be elicited. Mr B said that he was feeling mentally well despite feeling stressed. Care coordinator 3 thought that Mr B's anger was proportionate considering the recent incident. He appeared happy about his relationship with Miss H. There was no evidence of depressed mood.

**7.45** Mr B said that if he saw Mr A he would retaliate. Care coordinator 3 and care coordinator 4 talked through consequences of this approach. Mr B appeared able to understand the discussion and concluded that revenge was not a positive strategy and it would be better to walk away if he met Mr A again. They also encouraged him to talk with hostel key worker 2 for support. Mr B agreed that this was sensible advice and Miss H was also supportive. Mr B was encouraged to call the police and he said that he might do if he felt unsafe. Care coordinator 3 and care coordinator 4 discussed with Mr B whether it could be helpful for him to stay somewhere else that evening such as his mother's house and Mr B said he would think about it. The safety plan was for Mr B was to:

- Avoid further contact with Mr A if possible
- Call the police if he felt unsafe
- Consider staying somewhere else such as his mother's house.

**7.46** Mr B said that he wanted to move into a different accommodation. The secondary care coordinator and care coordinator 4 informed him that he had been re-referred to social services for alternative accommodation. Mr B was told that care coordinator 2 would be in touch on the following Tuesday to arrange to meet and that there was a meeting planned with social worker 1 to discuss his placement and the possibility of moving out. Miss H gave

care coordinator 4 her phone number as Mr B did not have a phone at the time. Both care coordinators concluded that Mr B was relatively stable in his mental state despite being distressed about the Monday incident. They felt he had no signs of psychosis and he had mental capacity to understand, decide and consent to the safety plan. It was agreed that the assessment would be discussed with the rest of the team at the red zoning meeting the following day.

**7.47** Care coordinator 3 updated hostel key worker 2 regarding Mr B's mental state and shared the advice they gave Mr B regarding the incident.

*Friday*

**7.48** Mr B's case was discussed in the red zoning meeting at 9:30am by the clinical team. It was agreed that the housing charity hostel was not a suitable accommodation for Mr B. A multi-professional meeting was arranged for the following Wednesday to discuss alternative accommodation. Mr A's case was also discussed. It was agreed that his care coordinator would review him and assess whether he needed a medical review.

**7.49** On Friday at 3:00 pm care coordinator 1 phoned Mr A but he did not respond and there was no opportunity to leave a message.

**7.50** Care coordinator 4 called Miss H but she had not seen Mr B that day because he was having contact with his daughter. She had spoken to Mr B briefly, but he had not mentioned any problems at the hostel. Care coordinator 4 called Miss E but she did not respond. Care coordinator 4's plan was to call Miss H again on Monday to inform Mr B about the meeting with social services housing on the following Wednesday.

*Comment*

***We understand that Mr A was working full time throughout the week of the incidents but stayed at the hostel every night.***

***Mr B stayed between the hostel and Miss H's home. He visited his mother's home on the Thursday.***

*Details known about the fatal Saturday incident*

**7.51** Around 3:00 am on Saturday morning Mr A stabbed Mr B at the hostel where they both lived. Police and paramedics arrived and tried to save Mr B, but he was later pronounced dead in hospital. A post-mortem examination concluded that he died as a result of stab wounds to the heart and neck. A post-mortem toxicology report confirmed that there were no drugs present in Mr B's system at the time of his death.

**7.52** Mr A was arrested at the scene on suspicion of murder and admitted to fatally wounding Mr B but said that he had acted in self-defence. During the Saturday morning, a mental health practitioner at Lewisham Custody Centre called to inform the trust that Mr A had been arrested for murder. The trust confirmed that Mr A was known to the trust and gave *"minimum need to know information"* to the mental health practitioner.

**7.53** While awaiting trial, Mr A was held at HMP Belmarsh. Mr A was transferred to an NHS medium secure unit in Spring 2017. Upon arrival he was held in seclusion and assessed by a psychiatrist who found Mr A to have evidence of perplexity, formal thought disorder, paranoia and persecutory ideation, as well as associated irritability and aggression. He was considered to pose a high risk of violence to others if challenged. Effective antipsychotic treatment was commenced to reduce the risk.

**7.54** He was found guilty of Mr B's manslaughter by diminished responsibility in August 2017. We have seen the judge's remarks during Mr A's sentencing on 4 August 2017. He summarised from the reports of two psychiatrists (Dr T and Dr S) that:

> *"The psychiatric assessments show how deep your [Mr A's] mental health problems are… [Dr T] makes clear and confirms his diagnosis of paranoid schizophrenia, which as he correctly observes is a mental disorder within the meaning of the Mental Health Act, and is of a nature and degree that makes it appropriate for you to be detained in hospital for medical treatment necessary for your own health, and the protection of others."*

## Part two: issues arising, comment and analysis

In part two of the report we provide our comment and analysis on the issues that are outlined in the terms of reference.

## 8. Early intervention service

**Skill mix**

**8.1** The terms of reference ask us to consider the skill mix in EIS. EIS provides intensive community support to people experiencing symptoms of a first episode in psychosis. This includes biological, psychosocial and risk management with individuals from the ages of 17 to 65 for a duration of up to three years.

**8.2** The joint guidance developed by the National Institute for Health and Care Excellence (NICE) and NHS England on Implementing Early Intervention in Psychosis advises that having the right workforce with the right skills is essential to ensuring that care can be delivered effectively. The guidance says that early intervention services in psychosis should be multidisciplinary and staff should have specialist knowledge and training in working with people with psychosis. The guidance says that the team should be made up of the following:

- Care coordinators
- A dedicated consultant psychiatrist
- Psychological therapist/clinical psychologist
- Education and employment specialists.

**8.3** The team manager at EIS told us that the team had relatively low staff turnover, with many staff working in the team for several years, creating a stable workforce. He told us that within team there is a:

> *"Consultant Psychiatrist, an Associate Specialist, often an SHO, … and at the moment we have a specialist registrar. There is a clinical psychologist, there's a CBTP Therapist. There are eight CPNs (Community Psychiatric Nurses), two social workers, two OTs [occupational therapists], an employment specialist and a team secretary, and we now have a Deputy Manager, which we didn't have at the time."*

8.4 At the time of the incident there was a consultant psychiatrist who worked four days a week Monday to Thursday and one associate specialist psychiatrist. The medical psychiatrists do not have caseloads but support the team with CPA reviews, new assessments, medication reviews, emergencies, mental health assessments, consultations, leadership, teaching and management commitments. At times there are core level medical trainees and higher medical trainees.

8.5 The team also had ten whole time equivalent care coordinators and 1.7 vacancies. One of these vacancies was covered by an agency community psychiatric nurse and another nurse who was seconded.

*Comment*

***The team is made up of professionals in line with the joint NICE / NHS England guidance on implementing early intervention in psychosis***.

**Caseloads within EIS**

8.6 The 'Standards for Early Intervention in Psychosis Services' developed by the Royal College of Psychiatrists' and the College Centre for Quality Improvement state that full-time care coordinators should not have a caseload of more than 15 (reduced pro-rata for part-time staff). We asked clinical staff about the current caseloads. We were told that there had been new housing developments within the borough which had increased the population and had resulted in more service users. The age range of its service users had also been widened to include all adults up to the age of 65. We were told that at one-point caseloads were nearer 30. We noted that the Care Quality Commission (CQC) routine visit in October 2017 found that staff in some early intervention teams had caseload sizes in excess of the nationally recommended maximum number. This creates pressure on the teams and potentially affected the quality of care that service users received. Care coordinator 3 also told us that a number of factors have led to an increase in workload:

> *"There are more referrals, but also, we did widen our catchment, and I think we're quite flexible as a team in terms of who we're taking, we do take people sometimes*

*who are diagnostically uncertain, because there isn't a separate at risk mental state team in this Trust, so we sometimes worry about where people will go if we don't provide them a service. I think there are a few variables at play".*

**8.7** Care coordinator 4 told us:

*"We did talk about … [caseloads] on our team away day last week, and we are working on referral criteria, and we're trying to take on this kind of diagnostic uncertainty group for an assessment period, rather than the whole EIS [Early Intervention Service] package".*

**8.8** We were told that the trust has made steps to decrease caseload sizes by employing an advanced clinical practitioner to facilitate discharges and expediate the transfer of service users to a community mental health trust or another early intervention service, if the service user has moved into a different catchment area.

**8.9** Care coordinator 4 also said:

*"It is not so easy to discharge patients because EIS, by definition, are supposed to work with people for two or three years. If someone is better, we don't discharge after a year, so we are supposed to work with them for a specific length of time".*

**8.10** Another CQC visit took place in October 2018. They wrote in their report that the trust should continue to act to reduce the caseloads of care coordinators in the early intervention teams, so that they can consistently provide effective support to service users experiencing a first episode of psychosis. CQC say that it is important to ensure that caseloads are not too high as higher caseloads can result in care coordinators being unable to engage with service users assertively.

*Comment*

***The trust has taken some action to reduce caseloads, but we do not believe that they currently meet the national recommended standard.***

*Recommendation*

**R1** The trust should have a system in place to ensure that the care coordinators within the EIS hold caseloads within the current national recommended number (no more than 15) to promote effective support to service users.

**EIS out of hours / flexible working**

**8.11** The overall aim of all early intervention services is to enable recovery through the provision of individually tailored, evidence-based interventions and support. One of the key aims is to provide support to those service users who wish to obtain employment. Evidence shows that employment is good for mental health and is central to recovery for people with mental health conditions. The EIS team manager told us that about 30 per cent of service users from EIS were working. The Early Intervention services operational policy states that EIS operate core hours Monday to Friday 9am – 5pm, however the service is flexible in responding to those service users or carers in employment or education who may request to be seen outside of these hours. The policy goes on the state that outside the 9am - 5pm core hours on weekdays, and at weekends, cover for urgent and emergency work will be provided by the Crisis and Home Treatment Team, duty doctors, senior managers and on-call Approved Mental Health Practitioners (AMHPs). In this way a responsive service is available to service users and carers 24 hours a day seven days a week. The team manager told us:

> *"Our aim is to assist people to reach their own recovery goals, which is often going to college or work, and to discharge them back to the care of the GP…"*
>
> *"…Our goal with the client is that they are working… the World Health Organisation values work as a good form of mental health… the expectation would be that we would see people out of hours… therefore, flexible working is engrained in the Service. We have some of our team meetings at 9.30 so that people can do early visits… we don't have meetings on a Thursday – Monday now, and a Thursday morning so that we can see people early in the morning, and also there's an expectation that we follow our lone-working policy for when we see people out of hours in the evening, and they identify a buddy, and they call them and say, 'I have finished my*

*shift and I am going home now.' If they don't there's obviously a protocol that we follow".*

**8.12** Although we were told there was a 'buddy system' in place for flexible working, we heard that staff going to visit service users out of hours was not the usual practice at the time. Although flexibility was expected there was no formal system in place to ensure such visits took place if necessary. We found no evidence that EIS staff attempted to engage with Mr A out of hours in the week following the Monday incident. This is an important omission. Given that one of the aims of the service is to get service users back to work, visiting them outside office hours to assess and monitor their progress is important. Putting a formal system in place would be desirable as other policies (such as lone working) are needed to align with flexible working to reduce the risk to staff who work alone.

*Comment*

***There are other models of working, such as Flexible Assertive Community Treatment (FACT), where the clinical team share small caseloads and are available out of hours. An approach such as this might meet the needs of service users in EIS better.***

*Recommendation*

**R2** The trust should ensure that the EIS uses a model of working to enable clinical staff to work outside office hours so that service users can be visited, assessed and monitored face to face if necessary.

**8.13** We discuss later in the report the issue that Mr A was not seen face-to-face by care coordinator 1 after November 2016.

# 9. Risk assessment and risk management

**Clinical risk assessment and risk management**

**9.1** In this chapter we examine whether Mr A's risk was properly assessed and zoned correctly in accordance with trust procedures.

**Risk assessment**

**9.2** The main principles of risk assessment are:

- Understanding psychiatry history and other life events
- Understanding the service user's current mental state
- Identifying and understanding risk factors and associated adverse outcomes, reflected in a risk formulation that states the overall judgement about risk
- Developing a risk management plan that is informed by the risk formulation
- Communicating the management plan to those who need to know.

**9.3** South West London & St George's Mental Health NHS Trust use the following risk domains:

- Behaviour causing concern or harm to others
- Capacity regarding specific areas of decision making
- Intent and/or plan to kill self (by any means)
- Repetitive acts of taking poisonous substances, biting, self-cutting, striking, burning, breaking bones
- Incapacity or loss of control as a result of misuse of alcohol or drugs (prescribed or illicit)
- Memory problems; disorientation in person, place, time or communication problems
- Incapacity arising from disability or physical illness
- The effect of hallucinations and delusions on mental state, behaviour and daily life
- The effect of depressed mood on mental state, behaviour and daily life

- Potential self-neglect or neglect by others
- Evidence of exploitation by others

**9.4** The trust's clinical risk policy sets out the process for carrying out risk assessments. It states that the assessment and management of risk requires structured clinical judgement (incorporating clinical expertise and evidence-based decision making) as well as effective engagement and collaboration with the service user and the people closest to them. The strengths of the service user must be recognised as part of this process, ensuring that everything possible is done to promote recovery in a way that gives proper regard to the things that matter the most to them.

**9.5** Positive risk taking is about weighing up the likelihood of different outcomes and recognising possible benefits/possible harm that may arise from a particular situation and course of action. Exploring positive risk taking is therefore an important part of the process and requires the service user, carers and staff to work in collaboration. Positive risk management recognises that some decisions carry risks and will balance the choices that matter the most to the service user with their safety and the safety of others.

**Zoning in EIS**

**9.6** The trust uses a zoning system to facilitate the delivery of targeted mental health interventions. This is an evidence-based approach to ensure that service users receive appropriate levels of support while they are using community mental health services.

**9.7** The caseload is zoned into red, amber and green zones. Service users might move between zones depending on their needs.

**9.8** The red zone is for service users who are currently at risk or in crisis or whose care requires a daily review. This may include service users who are experiencing relapse, have stopped medication, or who have disengaged from the team. It may also include service users who have a variety of complex social needs that are placing them under stress, with the accompanying risk of relapse of their psychosis. A service user in the red zone is likely to be a service user who:

- is new to the team

- requires home treatment team
- is relapsing or disengaging
- is in crisis.

**9.9** A service user within the red zone should be seen at least once every week by their care coordinator.

**9.10** The amber zone includes service users who continue to present with increased levels of need but do not present with major risk factors. A service user within the amber zone should be seen at least every two weeks by the care coordinator. If a service user misses three face-to-face meetings, they would move into the red zone.

**9.11** The green zone is for service users who are stable in their mental state. A service user in the green zone is reviewed at least every four weeks by the care coordinator.

**9.12** Multidisciplinary team (MDT) meetings are carried out once a week. At this meeting new referrals are discussed and service users in all zones that require MDT discussion are considered.

**9.13** At the time of the incident there were zoning meetings three times per week to discuss red zone service users. Those identified as being amber and green were discussed monthly in supervision. Services users in the red zone were expected to be seen at least weekly and those in the amber zone were to be seen at least every two weeks. Those on green were seen at least once per month. Direct contact could include telephone contact but should always include a review of the service user's mental state.

**The Care Programme Approach**

**9.14** The Care Programme Approach (CPA) is used to assess and plan mental health care to make sure that service users receive the necessary support. Enhanced CPA is for service users with complex needs or who require their care needs to be provided by a range of providers. All service users on the EIS caseload are on the enhanced CPA. At the time of the incident formal CPA reviews were carried out at least annually. These meetings were organised by care coordinators. The policy makes it clear that service users should receive a care plan to support their mental health, physical health, psychological and family

interventions, social inclusion accommodation and finances. The service user also has a collaborative crisis plan highlighting relapse indicator and a crisis plan.

**Mr A**

**9.15** In this section we examine whether Mr A was zoned correctly, and risk assessed, and risk managed appropriately. We also discuss Mr A's CPA records. We will examine the rationale for Mr A remaining in the amber zone for several months prior to the offence and the effectiveness of the escalation process/ communication during zoning meetings.

**9.16** Mr A was discussed at the multi-disciplinary team meeting on 29 July 2014 where it was agreed that he met the acceptance criteria to be treated by EIS. He was allocated a community psychiatric nurse who was also his care coordinator (1). On 30 July 2014, Mr A was discharged from HTT and taken on by EIS on 1 August 2014. Mr A was placed in the red zone initially as he was a new service user. No thoughts of deliberate self-harm or suicide were elicited from him. The clinical team thought that Mr A may have a drug induced psychosis or a first episode of psychosis. His risk of suicide was assessed as being low. Police records show that in 2005 when Mr A was a minor, he received a caution for possession of a bladed article however the trust did not know about this at the time. Mr A's risk of harm to others was assessed as being low (noting that the Trust did not know of the previous caution). His risk of self-neglect was assessed as being medium.

*Comment*

***Mr A was risk assessed and placed in the red zone at the start of his treatment under the EIS team. This was in line with the zoning policy as Mr A was a new service user following a first episode of psychosis and had just been discharged by the home treatment team.***

***Trust staff were not aware that Mr A had received a caution for the possession of a bladed article in 2005. A caution is given to anyone aged 10 or over for minor crimes. The person has to admit an offence and agree to be cautioned. Although the trust did not know about this caution, it probably would not have changed the care and***

***treatment provided to Mr A given it was a minor offence and took place nine years prior to his contact with mental health services.***

**9.17** On 13 August 2014 Mr A was changed from red to amber zone. This decision was made after discussion in the red zoning meeting and feedback from care coordinator 1 who had seen him on 11 August 2014 and advised that his mental state had improved. The care coordinator reported that his thoughts were clear, there was no evidence of thought disorder and he did not present with any psychotic symptoms. At this point Mr A was engaging with the team. He said he was not using cannabis and only drinking alcohol on a social basis. Mr A continued to take Olanzapine 5mg once a day and engage with his care coordinator.

**9.18** A CPA meeting took place on 16 September 2014. He was assessed as being a low risk of suicide, and harm to others.

*Comment*

***The decision to change Mr A from the red zone to amber was in line with the zoning policy as Mr A was assessed and appeared settled. He was taking his medication, was not psychotic and did not appear to have been at risk or present as a risk.***

**9.19** A CPA meeting took place on 15 July 2015. Records show that he did not have any concerns with the housing offered. There were some on-going cannabis and alcohol misuse although this had been difficult to quantify. However, it was felt Mr A understood the increased risk of relapse associated with substance misuse. The risks were considered to be low to himself in terms of risk of suicide, self-neglect, and risk of harm to others.

**9.20** On 4 November 2015, the associate specialist psychiatrist and secondary care coordinator 1 carried out an urgent review of Mr A because his family and hostel staff raised concerns that there had been a change in his behaviour. The associate specialist psychiatrist concluded that Mr A had had a relapse in mental state similar to his initial presentation to mental health services with poor sleep, poor eating, and thought disorder. Contributing factors included the recent death of a fellow resident in supported housing, stress of starting

a new college course and cannabis use. He was placed on the red zone due to the deterioration in mental state, namely three times per week team discussion.

*Comment*

***The decision to change Mr A from the amber zone back to the red zone was in line with the zoning policy. Mr A was risk assessed and reviewed by a psychiatrist who saw that his mental state had relapsed and so needed closer monitoring.***

**9.21** On 20 November 2015 Mr A was taken off the red zone because his mental state had improved. He was coherent with no psychotic or symptoms of low mood. He was engaging with his care coordinator 1 and EIS employment specialist. He had agreed to have an assessment for psychology. He agreed to continue taking medication. The community Home Treatment Team therefore discharged him.

*Comment*

***The decision to change Mr A from the red zone to amber was in line with the zoning policy as Mr A had been assessed and appeared settled. He was engaging with services and was taking prescribed medication.***

**9.22** On 11 April 2016 care coordinator 1 went to Mr A's grandmother's home and met with her and Mr A's mother. They told the care coordinator that Mr A had been acting very strangely, was guarded, his communication was poor, and he appeared to be distant sometimes. There had not been any reports of verbal or physical aggression. They were uncertain about his concordance with medication. The associate specialist psychiatrist carried out a medical review on 15 April at Mr A's grandmother's house. His father, aunt and his grandmother were in attendance. Mr A 's family reported that he seemed distracted and having problems with his concentration. They had not noticed any unusual behaviours, or any agitation or aggression. Mr A said he did not understand why people would have concerns about him. The clinical records show that the associate specialist psychiatrist's impression was that Mr A had signs indicative of a relapse.

**9.23** The associate specialist psychiatrist concluded that the triggers of the relapse appeared to have been non-compliance with medication and use of cannabis. Mr A agreed after a protracted conversation to restart medication. He was informed that he was a high risk of an admission to hospital if he did not restart medication. The associate specialist psychiatrist did not think a Mental Health Act assessment was needed at the time. The plan was for Mr A to restart Olanzapine 5mg once a day, to be monitored closely by care coordinator 1 and if it was thought that he was not compliant, for him to be referred to the crisis and home treatment team to supervise medication. He was placed in the red zone due to the deterioration in his mental state.

*Comment*

***The decision to change Mr A from amber back to the red zone was in line with the zoning policy as he appeared to have relapsed and so needed increased monitoring and support.***

**9.24** Care coordinator 1 phoned Mr A on 19 April 2016. He told care coordinator 1 that he was at college. He reported that he was taking medication daily. He said that he felt fine and had not noticed any signs or symptoms of relapse. Three days later care coordinator 1 visited Mr A. He noted that Mr A's mental state had stabilised, he was able to focus, and his concentration had improved. He had been taking his antipsychotic medication. He was focused on work. In view of this improvement, Mr A was taken out of the red zone and placed in the amber zone.

*Comment*

***The decision to change Mr A from the red zone to amber was in line with the zoning policy as Mr A had been assessed and appeared settled. He was engaging and taking prescribed medication.***

**9.25** On 24 November 2016 the associate specialist psychiatrist and care coordinator 1 reviewed Mr A in the mental health services outpatient's department as Mr A wanted to discuss medication. He was accompanied by his mother and grandmother. At the review, the associate specialist psychiatrist mentioned to Mr A that he had been rude to the borough council housing officer at his housing assessment. Mr A responded that he did not think that the housing team needed to know about his mental health. Care coordinator 1 and the associate specialist psychiatrist as well as Mr A's mother attempted to explain to Mr A that the housing team would need to know about Mr A's mental health, but he appeared fixed in his opinion. The clinical team agreed that he should discuss this further with his mother. She said she would go to the next meeting with him.

**9.26** Mr A, when asked, said he did not have any issues with his mental health and stated he did not have any psychotic symptoms. He said he was eating and sleeping well. He said he had no problems with his levels of concentration or energy.

**9.27** Mr A went on to say that his mood was fine. He said he did not have any thoughts of deliberate self-harm or suicide. Mr A said he was not smoking cannabis.

**9.28** Mr A was annoyed that he was not offered other options other than medication when he was first treated by Mental Health services but since then he had not wished to access psychology, the Recovery College, EIS workshops or other interventions the team offered him. He had been offered formal family work, but this was not taken up, although his family had regular contact with the team. Mr A said he just wished to move on with his life. He said he had been reading up about medication and was worried about side effects including diabetes (his mother and grandmother both have diabetes), and sudden death. Whilst Mr A felt that medication did help him in the past with his muddled thinking and made him calm and focused, he felt he had recovered and no longer needed to take it. He was reminded that his relapse in April 2016 was due to not taking medication. He said that he was aware that if he felt unwell when he stops medication that he could contact care coordinator 1. He was informed if he did relapse he may need to be referred to the home treatment team or need admission to hospital. He did not wish to go through his relapse prevention plan (including relapse indicators) before stopping medication. Clinical records show that he was keen to stop taking medication.

**9.29** Mr A 's mother felt he should stay on the Olanzapine, as she felt he was calmer on medication.

9.30 The associate specialist psychiatrist found that Mr A's speech was of normal rate, volume and rhythm. Whilst Mr A said his mood was okay, objectively he appeared frustrated with his housing situation. He denied any thoughts of deliberate self-ham or suicide. He did not present with any psychotic symptoms.

9.31 Mr A said that he wanted to stop antipsychotic medication due to his concerns about potential side effects. He said he would contact his care coordinator 1 if he felt he was becoming unwell.

9.32 The associate specialist psychiatrist found that Mr A was able to understand the information given to him about the decision to stop medication and able to retain this information. He was able to weigh up the risks and benefits of stopping medication. Mr A stated he would restart his medication if his mental health was deteriorating or there were signs of self-neglect. The associate specialist psychiatrist concluded therefore that Mr A had capacity to make an informed decision about stopping antipsychotic medication. He was informed the decision to stop medication was against medical advice.

9.33 The associate specialist psychiatrist concluded that Mr A was a low risk of aggression to others, a low risk of deliberate self -harm/suicide and a medium risk of deterioration in mental state due to stopping medication.

9.34 The plan from the meeting was:

- For Mr A to stop Olanzapine 5mg although this was against medical advice
- To monitor Mr A in the community on a more regular basis
- Mr A to look through his relapse plan with care coordinator 1, and for his hostel and GP to be informed of his decision to stop medication
- Care coordinator 1, Mr A and his family to liaise with the borough council housing team
- A crisis plan was discussed to ensure Mr A 's family and the hostel had the contact details for EIS and the Mental Health Support Line
- for Mr A to remain in the Amber Zone at this point.

9.35 On 29 November 2016 Mr A was discussed in the EIS multi-disciplinary meeting. The clinical team agreed because he was asymptomatic, Mr A should remain in the amber zone

but that his care coordinator should monitor him closely in light of decision to stop medication. Mr A therefore remained in the amber zone.

*Comment*

***We understand the rationale for why they decided to keep Mr A in the amber zone at this point.***

**9.36** In the period following Mr A's November 2016 medical review and the incidents in early 2017, clinical records show that there were four phone calls between Mr A and care coordinator 1 during which Mr A seems to become increasingly frustrated by his housing situation. Notes show two occasions where staff expressed some concern about Mr A's mental state. On 30 November 2016 care coordinator 1 noted:

> *"I suggested to [Mr A] that his irritability could be a sign that he is relapsing"*

**9.37** Care coordinator 1 also notes from a conversation with key worker 1:

> *"[Key worker 1] reports that [Mr A] remains fixated about 2 weeks of benefits that have been over paid… [Key worker 1] was also reminded that he would need to continue to monitor the mental state of [Mr A] and report back to me."*

**9.38** Care coordinator 1 and key worker 1 also told us the Mr A was difficult to contact during this period due to his working pattern.

*Comment*

***The trust should have considered re-zoning Mr A into the red zone during this time. Given the plan to monitor Mr A more closely as he had stopped his medication, Mr A had been in sporadic contact with services, had not been seen face to face by the clinical team. Re-zoning Mr A to the red zone would have meant that he would be discussed three times a week at the zoning meeting and increased efforts made to monitor him.***

**9.39** Following the Monday incident with Mr B, the care coordinator discussed Mr A at the MDT zoning meeting. He was placed onto the red zone on the Wednesday. The red zone plan was:

- to arrange an urgent face to face meeting/medical review to be arranged with Mr A given his working hours (8am to 6pm Monday - Friday)
- to gain further detail from the incident report which had been completed by hostel staff
- for the hostel key worker to contact the police to find out if any further action would be taken in relation to the knife incident and
- to hold a discussion with the housing charity about moving Mr A or Mr B out of the hostel.

**9.40** On the Friday care coordinator 1 phoned Mr A to arrange an urgent review but he did not answer the call.

*Comment*

***Urgent intervention was required to mitigate any further risk of harm but there is no evidence within the records to show that the team discussed the problem of meeting Mr A when he was in full time work. Clinical records show that since starting full time work Mr A had reduced face to face contact from the care co-ordinator because the EIS worked predominantly 9am - 5pm. Under the EIS zoning policy, missing three face-to face meetings should trigger escalation to the red zone. The difficulty of contacting and seeing Mr A should have been discussed in supervision with the team leader, considered for the EIS red zone much earlier.***

***Moving Mr A to the red zone was appropriate, but it made little difference because he never had a face-to-face review because there was no system in place with EIS for out of hours visits. Not being able to see Mr A out of hours was a significant missed opportunity. As noted above, EIS should have a formal staffing model in place to enable clinical staff to work outside office hours so that service users can be visited, assessed and monitored face-to-face if necessary.***

*Care planning EIS and the housing charity*

**9.41** In this section we examine whether Mr A's care plan was developed jointly with the housing charity and EIS. Records show that there was regular joint working between the housing charity and the trust. There are entries in Mr A's progress notes that show that care coordinator 1 attended housing meetings with Mr A and that housing was discussed at MDT and CPA meetings where the housing charity key worker attended. Mr A's care plan shows that housing was a problem but there was no written plan outlining any goals or timescales.

**9.42** The trust care programme policy (dated November 2016) recommends that service users with a first episode psychosis have a CPA review every six months. The EIS operational policy states that reviews take place at a "*minimum of twelve months though more usually six*". The trust internal investigation panel found that there was a discrepancy between the policies which could cause confusion. They were told that if a service user was stable and in the green zone, they may only see their doctor once in a year. Mr A had a CPA review every year and reviews by medical staff and his care coordinator when necessary until November 2016. The trust internal investigation panel recommended that more regular CPA reviews would ensure robust multi-disciplinary information sharing.

*Comment*

***CPA records show that Mr A was on CPA and had a yearly CPA review and a crisis plan outlining what Mr A could do if he felt he was relapsing.***

*Recommendation*

**R3** The trust should carry out an audit to ensure that CPA reviews take place in line with trust policy.

**The housing charity support plans**

**9.43** We reviewed the most recent support plans for Mr A and Mr B completed by the housing charity. This is split into three sections: a needs assessment, risk assessment and support plan goals. Support plans are scheduled to be updated every six months. We also noted that goals and risks have been reviewed routinely and updates noted.

**9.44** We found the support plans to be detailed and comprehensive with a holistic approach to the residents' needs, risk profile and goal setting. There is evidence that EIS care coordinators participated in the support planning process. We note, that actions are assigned to care coordinators as well as hostel key workers and these are clearly stated. We found that the assessments made are largely in line with the trust's clinical and CPA records. This indicates a coordinated approach to care and support planning.

*Comment*

***Overall, we found the housing charity support plans to be of good quality and used as a key means of monitoring support given to residents. The collaborative approach to support planning between the housing charity and EIS care coordinators is in line with good practice.***

**The virtual risk team**

**9.45** The trust has a virtual risk team (VRT) which is a resource for clinical staff. At the time, this consisted of around 12 experienced practitioners who were available for staff to access when supporting a service user with complex needs. Where needed, members of the team could go and spend time directly with the service user and staff to offer guidance. Mr A and Mr B may have benefited support from the team, but EIS did not refer them.

*Comment*

***The failure to refer Mr A and Mr B to the VRT was a missed opportunity as they could have provided a fresh view and advice on management.***

**Overall comment in relation to Mr A's zoning and risk management**

***Mr A did not have a history of self-harm or harm to others and did not have a forensic history. He had never acted aggressively or lost control with members of the clinical team at any time throughout his care and treatment. In the light of this, we consider the rationale of keeping Mr A in the amber zone before November 2016 to be reasonable as he had a history of low risk of harm to self and others. Occasionally he was at medium risk of self-neglect. However, his non-concordance with medication and use of cannabis meant that Mr A required more contact than the green zone allowed.***

***We consider though that he should have been moved to the red zone when there were signs of disengagement in the period following November 2016 and the team should have been more assertive in putting plans in place to meet Mr A face-to-face to assess his mental state.***

**Allocation of service users to the amber zone**

**9.46** We have been asked to see if we can find out the rationale of why most service users were zoned as amber. The amber zone is for those who continue to present with increased levels of need but do not present with major risk factors. A service user within the amber zone should be seen at least every two weeks by the care coordinator. If a service user misses three face-to-face meetings, they should be moved into the red zone.

**9.47** The trust's internal investigation report flagged zoning up as an issue and recommended that EIS should review the use of the amber zone. We have since been advised that the zoning process has been improved since this incident. Care coordinator 4 told us:

> *"We tightened up our zoning, I think, is one of the main things that has come out of it [this incident]: I think as a team we are all more aware of the zoning criteria, for red, amber and green, and that's had quite significant changes in terms of the numbers in red, amber and green – there are many fewer amber-zoned people now. Also, there is an emphasis on having to have a face-to-face contact weekly with red-zoned clients, even if that means working out of hours and taking time owing in lieu".*

*Comment*

***We accept the recommendations made by the internal investigation report in relation to zoning. We welcome the changes that EIS have made to the zoning process. We note however, that the issue of zoning service users within the EIS team requires continuous monitoring.***

*Recommendation*

**R4** EIS should carry out regular audits to ensure that service users are placed within the correct zone in line with the risks that they present and that they are reviewed, and targeted mental health interventions are delivered in line with the standards within the zoning system.

**Protocol for management of weapons/knives at the housing charity hostel**

**9.48** The housing charity aims to promote independent living skills, including cooking. Residents are expected to prepare and cook meals for themselves, using their own kitchen equipment, so it is likely that residents will possess a kitchen knife of some kind for preparing food. We have been advised that there is not a standalone protocol for management of weapons and knives at the hostel. The team manager from the housing charity told us:

> *"I never saw the knife that Mr A had but as far as we are aware it would be a kitchen knife, to cut bread or stuff like that, or meat or something. Nothing out of the ordinary that you wouldn't have yourself at home".*

**9.49** The housing charity has a licence agreement with residents which sets out the terms under which they live in the property. The agreement sets out the rights and responsibilities of residents.

**9.50** The licence agreement makes it clear that residents must not:

- *"cause anti-social behaviour, nuisance to or annoy neighbours or any others visiting or engaged in a lawful activity in the locality of the property;*
- *bring any solvents, alcohol or unlawful drugs into the room, the property or its' vicinity. Tenants must not be intoxicated in the room, the property or its' vicinity as a result of consuming alcohol or taking solvents or drugs;*
- *be violent or exhibit threatening or behaviour;*
- *damage or threats of damage to property belonging to someone else;*
- *write any threatening or insulting graffiti; or*
- *do anything else which is intended to interfere with the peace or comfort of someone else or cause offence to them".*

**9.51** The agreement makes it clear that if the resident does not keep to this agreement legal action could be taken. Each resident must sign this agreement before taking up residence.

*Comment*

***We are satisfied that although the housing charity does not have a specific protocol relating to weapons, it does have a formal agreement in place to make it clear that residents must not carry out unlawful or violent acts.***

**Clinical management of Mr A's cannabis use**

**9.52** In this section we discuss Mr A's cannabis use and whether steps were taken to address his problem. Mr A had smoked cannabis for ten years and despite being informed by clinical staff of the detrimental effect it would have, he said that he felt it had little effect on his mental state. The EIS team were never really sure about the extent of use. When asked, Mr A denied using cannabis frequently, however he admitted taking it in January, April and July 2016. In early 2017, Mr A's room was searched, there was a strong smell of incense and it was suspected he had been using cannabis.

**9.53** The local community drug and alcohol service is self-directed and provides alcohol treatment and support services. The EIS team advised Mr A to address his cannabis use on several occasions. He was offered drug and alcohol service support by the local community

drug and alcohol service, but he refused it. While urine drug testing is standard practice within addiction treatment, it is not used routinely within community mental health centres. This is where most treatment occurs for individuals with co-occurring mental illnesses and substance use disorders.

*Comment*

***Our expert has advised that it would have been good practice to routinely include urine drug screening (UDS) into Mr A's care plan. This would have helped the team to get a better idea of the extent of Mr A's substance misuse.***

*Recommendation*

**R5** EIS should consider using urine or saliva testing as part of care planning where it is known that the service user regularly takes drugs.

## 10. Joint working between the trust and the housing charity

**10.1** In this chapter we review the communication between the trust and the housing charity hostel staff when there were signs that Mr A's mental health was deteriorating.

**10.2** The housing that the housing charity provide is meant to be a place where people can stay for a couple of years to get the skills needed such as budgeting, laundry, personal hygiene and developing positive relationships with people. The charity also provides support to get people into training and employment.

**10.3** The housing charity staff do not have a statutory role with regards to its residents. The Director of Operations at the housing charity told us:

> *"We have no statutory powers, we can't assess people, we can't arrest people, we can't evict people without the Housing Association's authority but what we can do is express our concerns, communicate clearly and follow the agreed processes around raising concerns and alerts."*

**10.4** There is a joint operating procedure between EIS and the housing charity. The procedure makes it clear that there should be collaboration, the sharing of information and joint working.

**10.5** We found that staff at the hostel and EIS had formed effective daily working relationships, characterised by consistent open dialogue and that they communicated and coordinated well throughout Mr A's tenancy. We found evidence that members of both the EIS and hostel teams were in regular phone, email and face-to-face contact about issues around their shared service users and that staff from the housing charity attended multi-disciplinary and care planning meetings.

*Comment*

***On the whole, staff from EIS and the housing charity hostel worked well together, meeting the expectations of a joint operating procedure between EIS and the housing charity.***

**Mr B's placement in the housing charity hostel**

**10.6** Mr B lived at a semi-independent unit for young people from early 2014 following his release from the youth offenders' institution. By mid-2016, Mr B was nearing the end of his tenancy placement at the semi-independent unit as he was approaching the upper age limit for the accommodation and length of stay.

**10.7** Care coordinator 2 arranged to meet Mr B at the semi-independent unit in spring 2016, but he did not attend. Staff from the Independent Living Service (ILS), and the semi-independent unit were present. It was noted that Mr B had not managed to reduce his rent arrears and that a full occupational therapy assessment (to assess his activities of daily living) had not been completed as Mr B missed several appointments. It was noted that Mr B recently separated from his partner Miss E and was spending most of his time at his mother's house. He was not using his room at the semi-independent unit. During the meeting, it was decided that semi-independent unit would send an eviction notice to Mr B asking him to leave the accommodation by early summer 2016. The meeting discussed the possibility of Mr B staying with his mother temporarily as well as other housing options. However, Mr B's tenancy at the semi-independent unit was later extended to mid-summer 2016.

**10.8** Care coordinator 2 made a referral and sent it to the local authority. The local authority gatekeeps and processes referrals because they pay for the provision and manage the referrals to available accommodation options in the borough. The local authority act as a single point of access for all supported accommodation placements and commissions organisations, such as the housing charity to provide the service. The housing charity policy is to interview referrals they receive from the local authority to see whether they are suitable for their accommodation.

**10.9** We have reviewed the form which was sent by the trust to the local authority. The form provides an overview of Mr B's needs, however there are parts of the referral form which have not been completed. One section includes information which appears to relate to a different service user.

**10.10** We also reviewed a referral form written by the leaving care personal advisor assigned to Mr B while he was living at the semi-independent unit. This form was not fully

completed either. The form stated, "*refer to risk assessment completed by the care coordinator and also attached*".

**10.11** We could find no evidence that a risk assessment was attached, as stated on the form.

**10.12** We have reviewed the protocol between South West London & St George's NHS Mental Health Trust and the local borough housing department. The protocol states that in addition to the application form, all referrals from the Mental Health Trust should be supported by:

- CPA documentation which must include a care plan, risk history, risk management plan and crisis and contingency plan
- a written report which provides a systematic assessment of the individual's health and social care needs including psychiatric, psychological and social functioning
- risk to self or others
- physical health needs
- assessments of co-morbidity
- financial, occupational and housing needs.

**10.13** The care plan should include contact details of the care co-ordinator and community care team. This is needed so that the supported accommodation provider can establish a relevant and progressive support plan for potential residents. The care plan can only be sent with the consent of the service user. There must be documentary evidence that the service user has agreed that their information can be shared with the provider. No applications can be considered without this documentation.

*Comment*

***Although the protocol makes it clear that no applications can be considered without a risk history, risk management plan and crisis and contingency plans, the referral form contained no information about Mr B's risk history or safeguarding issues.***

**10.14** The Mental Social Work Team carried out a social care needs assessment of Mr B on 7 July 2016. This concluded that Mr B was eligible for supported accommodation.

**10.15** Mr B attended an interview for a placement at the housing charity in the summer of 2016. In late summer 2016 care coordinator 2 received a letter from the housing charity indicating that they were not accepting Mr B in the supported accommodation for the following reasons:

- Mr B's substance use [alcohol, cannabis and cocaine]. During the initial interview with the housing charity Mr B was intoxicated. He admitted using alcohol but did not mention taking cannabis and cocaine.
- He did not show any insight into his mental health and he was not taking his medication.
- It was felt Mr B presented a risk of violence to other service users and staff due to recent history of physical altercation.

**10.16** Care coordinator 2 and Mr B's leaving care personal advisor appealed. Care coordinator 2 told us about the reasons for the appeal:

> *"I felt that was unreasonable and prejudicial, so the person who went with him on the bus to the interview said he didn't think that [Mr B] was intoxicated, he couldn't smell any alcohol on his breath. The fact that [Mr B] denied using cannabis and cocaine, it is complex, but it is not surprising that people deny using drugs.*
>
> *"As far as the accusation of not having good insight into his mental health problem, we work with multiple people who do not have what we refer to as good insight into their mental health problems, so I don't think that is a preclusion for people being in supported accommodation. As far as the issue about violence, it was true that there had been some situations where he had got into altercations but there had been no concerns from [the semi-independent unit] at all about safety of staff or of others in the accommodation, because they had been no altercations that they had been aware of. It just didn't feel that it was a well-founded reason to refuse. There was also a lot of pressure to move him on from [the semi-independent unit]."*

**10.17** Care coordinator 2 visited Mr B at the semi-independent unit on in early autumn2016. A hostel worker reported being concerned that Mr B was drinking alcohol regularly. Mr B reported that his paranoia was reasonably controlled with medication, but he was feeling depressed. He said he was taking Risperidone. Mr B did not think he had a problem with

alcohol abuse but reported drinking 2-3 cans of beer most days. He mentioned that he was disappointed about the decision by the housing charity not to accept him. He was seeing his daughter twice a week at Miss E's house.

**10.18** Mr B attended a second interview with the housing charity. He was not intoxicated and answered questions appropriately. He was subsequently offered a place at the housing charity supported accommodation hostel. He moved in in autumn 2016.

**10.19** Within three weeks of Mr B moving into the hostel, there were a number of incidents with his behaviour which included breaking house rules, for example:

- anti-social behaviour
- noise complaints
- unauthorised visitors and overnight guests
- arguments with his family at the hostel
- being naked and leaving used condoms in communal areas
- leaving rubbish in communal areas
- non-engagement with the support programme.

**10.20** In late 2016, key worker 2 told Mr B and care coordinator 2 that he was at risk of losing his tenancy.

**Management of Mr A from November 2016**

**10.21** Mr A was not seen face-to-face by care coordinator 1 after his medical review on 24 November 2016. Clinical records show that there were four phone calls between Mr A and care coordinator 1 between November 2016 and the incident during which Mr A seems to become increasingly frustrated by his housing situation. According to Mr A's clinical records, attempts were only made by care coordinator 1 to engage with Mr A on a weekly basis, indicating that EIS had not in fact increased monitoring as agreed at the medical review. This is however, in line with Mr A's amber zoning at this time (see chapter nine). Mr A said he was busy with work and could therefore not be seen. He was increasingly difficult to engage with services. These factors are further signs that Mr A was experiencing a relapse in his mental condition (as they are identified triggers). The team manager told us:

*"… we made the assumption that [Mr A] was well, because his relapse indicators, … would have been isolation, and obviously not going to work… As he was working we assumed that there was less risk of relapse, and he didn't have a significant risk history. Perhaps we were looking at the risk history and saying that there was no risk rather than the… immediate risk, which was the guy was waving a knife around."*

*Comment*

***EIS had agreed to monitor Mr A more regularly following the medical review. Any signs that this was becoming difficult should therefore have been flagged for a more urgent review. Warning signs were not picked up as Mr A was still engaging with work, which was a slight change in his usual presentation.***

***Up to November 2016 the EIS team regularly contacted his family for updates. However, this appears not to be the case between November 2016 and the incident. This was a missed opportunity as Mr A's family may have been able to give useful insight into his mental state.***

***Mr A could also have been referred to the home treatment team in November 2016 for a more assertive approach to his care and treatment.***

*Recommendation*

**R6** EIS should ensure that they engage all sources of information including families when trying to visit service users that are hard to engage.

# 11. Management of Mr A and Mr B: early 2017

**The Monday incident and the response**

**11.1** We have provided a detailed description of events that took place following the Monday incident in the chronology at chapter seven of this report. In this chapter we now examine the risk assessment and management plan for Mr A and Mr B to assess the immediate decisions and actions taken following the first incident and the feasibility of separating them at an earlier opportunity.

*The Monday incident*

**11.2** In the early hours of Monday morning, residents in adjoining properties heard shouting and called the police. Apparently, there was loud noise coming from Mr A's room which resulted in an altercation between Mr A and Mr B, during which Mr A threatened Mr B with a knife. When the police arrived, they established that there were three individuals involved, Mr A, Mr B and Miss H. Mr A told officers that Mr B and Miss H had been fighting and creating a disturbance. Mr A told officers that he had told Mr B and Miss H to stop at which point Mr B became abusive towards him. Officers witnessed Mr B holding Miss H tightly, refusing to let her go and suspected that Mr B had assaulted her. As a result, Mr B was arrested. Miss H refused to engage with police.

**11.3** During the Monday morning, a police officer phoned Miss H as part of the police investigation. She told the officer that the incident had occurred in a corridor inside the hostel and involved a black male who had a knife. Miss H refused to provide any further details about the incident or any details about Mr A and the knife.

**11.4** On Monday in the late afternoon, two police officers interviewed Mr B. He denied committing any offences and explained that he had not done anything wrong and could not understand why he had been arrested. He did not make any allegations against Mr A and did not disclose any matters of concern in relation to him or his safety. Following the interview and a review of the evidence, Mr B was released from custody with no further action being taken against him.

*After the incident*

**11.5** Following Mr B's release from police custody, hostel staff (key worker 1, key worker 2 and the team manager) arranged a meeting with him the following day (Tuesday) to discuss the incident. Mr B told the hostel staff about the incident, including details about Mr A and the knife. They told us that Mr B was *"very angry and upset"* that he had been arrested and that there had been no consequences for Mr A, who had been in the wrong. Key worker 2 told Mr B that as a result of the incident Miss H would not be allowed at the hostel and Mr B asked to be moved to different accommodation. Key worker 2 told us:

> *"What he was saying was he wanted to be scared, I am not too sure if it was about [Mr A] as much as his own behaviour, [Mr B's] possible reaction… It was a bit of a double thing. Obviously, he was scared because [Mr A] brandished a knife, but he also knew that he could react to it."*

**11.6** Hostel key worker 1 contacted care coordinator 1 on Tuesday indicating that the incident on the previous day was serious and that Mr A was mentally unwell and might not be taking his medications. It was agreed that the care coordinator 1 would meet with Mr A on the following day however they were unable to contact Mr A to confirm his attendance. Key worker 1 called the police to give them information about Mr A holding a knife. He was told the investigating officer would call back.

**11.7** On Wednesday both Mr A and Mr B were placed on the red zone and discussed in the Wednesday red zoning meeting. Care coordinator 1 went to the hostel and met key worker 1. Hostel key worker 1 contacted the police again to inform them about the knife incident and was told that he would receive a call back, but the police did not return the call.[1] Care coordinator 1 and hostel key worker 1 conducted a room search. They did not find a knife but suspected that Mr A had been using cannabis. Care coordinator 1 and key worker 1 discussed Mr A more generally. Key worker 1 reported that Mr A had been becoming fixated on issues related to his housing situation.

**11.8** While hostel key worker 1 and care coordinator 1 were together, hostel key worker 1 contacted Mr A and told Mr A that a warning letter had been placed under his door

[1] From a report commissioned by the Metropolitan Police Service directorate of professional standards, we learned that the investigating officer had also received an email from Miss H's care coordinator and mistakenly called him back instead of key worker 1.

regarding the incident in which he threatened another resident with a knife. Mr A said that he had done this in self-defence because Mr B came knocking at his door and he was unsure what he was going to do. Care coordinator 1 conducted a mental state assessment. Care coordinator 1 asked Mr A if he was using alcohol or drugs, but he refused to talk about it. Mr A said that he wanted to get his own flat and that this needed to be sorted out as soon as possible. Mr A was asked when he would be available to meet for an urgent meeting, and he said that he would not be free until the following Monday. The plan was to visit for Mr A as soon as possible but he was working 5 days a week from 8 am and was coming back home at 5:30 pm. Care coordinator 1 was also to arrange a medical review.

**11.9** That afternoon, care coordinator 2 and care coordinator 4 attempted to visit Mr B at the hostel, but he was not there. They instead met with key worker 2, key worker 1 and care coordinator 1 (who was still on site), to discuss their understanding of the Monday incident and to coordinate their plans going forwards.

**11.10** The plan was to:

- Key worker 1 to update the police with facts about Mr A being in possession of the knife
- Key worker 2 to give Mr B a second written warning
- Key worker 1 to issue Mr A with a final written warning
- Care coordinator 1 to meet urgently with Mr A and key worker 1 at the hostel to discuss the incident and carry out a risk assessment
- Care coordinator 1 to expedite for Mr A to be moved into a new accommodation
- Care coordinator 2 to try to move Mr B placement with social worker 1

**11.11** Shortly after the meeting, care coordinator 2 informed social worker 1 about the incident and that the housing charity hostel staff were concerned about the impact that Mr B's presence had on the house. Care coordinator 2 suggested a review of the placement and that Mr B had also requested this.

**11.12** On Thursday care coordinator 1 phoned Mr A but he did not respond. Care coordinator 1 then phoned Mr A's father to discuss the incident on Monday. Mr A's father told him that, in his view, Mr A had every right to defend himself. Mr A's father said that Mr A was anxious about his housing situation and requested for him to be moved quickly.

**11.13** At 3:30 pm on Thursday, Mr B called care coordinator 2 about the incident and said that he did not feel safe in the hostel. Care coordinator 2 arranged to see Mr B with care coordinator 4 at 4:00 pm that day at his mother's house where he said he was staying. He complained that staff were taking sides and he felt he had been blamed despite having done nothing wrong.

**11.14** Unfortunately care coordinator 2 had a family emergency and was unable to see Mr B as originally planned. Care coordinator 3 and care coordinator 4 attended instead.

**11.15** Care coordinator 4 and care coordinator 3 met Mr B as he was coming out from his mother's house with his girlfriend Miss H. Mr B said that he was unhappy about the incident in the hostel, that he felt that no one was taking him seriously and that his life was threatened. He was calm when talking about this. Mr B said that he was feeling blamed as the other resident involved did not have any implications. He did not feel that staff at the hostel were on his side. He was angry that his girlfriend (Miss H) was banned from the house following repeated incidents of breaking house rules and that he had been accused of domestic violence, which both had denied. Care coordinator 3 assessed Mr B's mental state. She noted that Mr B was calm and that he made good eye contact. Mr B reported feeling angry about the Monday incident. Care coordinator 3 saw no signs of paranoid thoughts. Mr B did not report that strangers were out to get him as he had done previously when unwell. His speech was normal in rate, tone and volume. There was no evidence of perceptive abnormalities. Care coordinator 3 was not able to elicit any positive signs of psychosis. Mr B said that he was feeling mentally well despite feeling stressed. Care coordinator 3 thought that Mr B's anger was proportionate considering the recent event. He appeared happy about his relationship with Miss H. There was no evidence of depressed mood.

**11.16** Mr B said that if he saw Mr A again he would retaliate. Care coordinator 3 and a care coordinator 4 talked through the possible consequences of this approach with Mr B. Mr B appeared able to understand the discussion and he concluded that revenge was not a positive strategy and it would be better to walk away if met Mr A again. Care coordinator 3 and a care coordinator 4 also encouraged Mr A to talk with hostel key worker 2 for support. Mr B agreed that this was sensible advice and Miss H was also supportive of these suggestions. Mr B was encouraged to call the police if he had any problems and he said that he might do it if he felt unsafe. Care coordinator 3 and care coordinator 4 discussed with Mr B whether it would be helpful for him to stay somewhere else that evening such as his mother's house. Mr B said he would think about it. The care coordinators' safety plan was for Mr B to:

- Avoid further contact with Mr A if possible
- Call the police if he felt unsafe
- Consider staying somewhere else such as his mother's house.

**11.17** Mr B said that he wanted to move into different accommodation. Care coordinator 3 and care coordinator 4 informed him that he had been re-referred to social services for alternative accommodation. They told Mr B that care coordinator 2 would be in touch on the following Tuesday to arrange to see him again and that there was a meeting planned with social worker 1 to discuss his placement and the possibility of moving out. Miss H gave care coordinator 4 her phone number as Mr B did not have a phone at the time. Both care coordinators concluded that Mr B was relatively stable in his mental state despite being distressed about the Monday incident. They felt he had no signs of psychosis and he had mental capacity to understand, decide and consent to the safety plan. Care coordinator 3 and care coordinator 4 agreed that the assessment would be discussed with the rest of the team at the Friday red zoning meeting on the following day.

**11.18** Care coordinator 3 updated hostel key worker 2 regarding Mr B's mental state and shared the advice that they gave Mr B regarding the recent incident. Care coordinator 3 told us:

> *"after the appointment with Mr B on the Thursday evening, I had a conversation with the key worker [2] at [the hostel], and updated her on his mental state…His mental state was actually, I'd say, one of the best times I'd seen him because he can be sometimes quite thought-disordered and distracted, and comes across visibly quite paranoid, and not really very together, but apart from this incident he was quite positive: he was positive about his relationship, he was able to concentrate on the conversation, there weren't really any signs of any paranoia, so from that aspect it was quite positive."*

**11.19** Care coordinator 3 also told us:

> *"the conversation I had with [key worker 2] was not one where we were saying, we've seen [Mr B], everything's going to be fine - we were acknowledging that there was still a potentially risky situation"*

**11.20** Mr B's mother has told us that the last time she saw her son was during the day on Thursday. It therefore appears likely Mr B stayed at the hostel on the Thursday and Friday nights until the early hours of Saturday morning.

**11.21** On Friday, Mr B's case was discussed in the EIS red zoning meeting. It was agreed that the housing charity hostel was not suitable accommodation for Mr B. A multi-professional meeting was arranged for the following Wednesday to discuss alternative accommodation. In the meantime, Mr B's social worker sent care coordinator 2 details of some accommodation options she was contacting to for discussion at the Wednesday meeting.

**11.22** Care coordinator 4 called Mr B's girlfriend, Miss H (as Mr B had no phone) but she had not seen Mr B all day because he was having contact with his daughter. She said that she spoke to him briefly and he had not mentioned any problems at the hostel. Miss H gave care coordinator 4 Miss E's number (Mr B's ex-partner). Care coordinator 4 called her but she did not respond. Care coordinator 4's plan was to call Miss H again on the following Monday to ask her to inform Mr B about the meeting with his social worker on Wednesday.

**11.23** It was agreed that Mr A's care-coordinator would review him and assess whether he needed a medical review. On Friday at 3:00 pm, care coordinator 1 phoned Mr A but he did not respond and there was no opportunity to leave a message.

*Comment*

***The evidence shows that EIS and the housing charity, took the Monday incident on seriously. Both agencies acknowledged the apparent tension between Mr A and Mr B, made efforts to try to understand the details of the incident and put plans in place to reduce risk.***

***We are encouraged that EIS maintained the effective use of it's zoning structures and supervision strategy throughout the week following the Monday incident. We found that care coordinators and key workers for Mr A and Mr B worked well to share information with plans for each service user. This helped to create a more coordinated approach.***

*We note that plans to hasten a separation were largely focussed on moving Mr B as no interim plan seems to have been discussed with regards to Mr A. However, we acknowledge the significant difficulties care coordinator 1 and key worker 1 faced in contacting Mr A and that Mr A had been non-compliant with scheduled attempts at arranging new accommodation.*

*It was good practice that care coordinator 1 made repeated attempt to try to contact Mr A, although, he did not respond.*

*It was useful that two care coordinators were able to meet with Mr B as they were able to complete a full mental state and risk assessment and put a plan in place to reduce risk. We agree with care coordinator 3's assessment that the safety plan was imperfect as this relied on Mr B's perception of his own risk and compliance in staying at his mother's house.*

*Nevertheless, we find there were two significant missed opportunities in the week following the Monday incident.*

*The first, was the inability to meet Mr A out of hours. The Monday incident involving the knife was out of character for Mr A. This should have raised significant concerns about his mental state. Despite numerous attempts to contact Mr A to arrange a face-to-face meeting after the incident, none took place. We find this scheduling conflict was largely caused by the incompatibility of the operating hours of EIS and the housing charity with those of people working full time.*

*The second, were the several opportunities to separate Mr A and Mr B after the Monday incident by finding alternative accommodation. Discussions took place within and between agencies, but no firm arrangements were made so both Mr A and B remained at the hostel which put them both at risk.*

*We have been told by staff at EIS that they have since learned that emergency bed and breakfast accommodation could have been requested, however, staff were not aware of this at the time of the incident. This could have resulted in Mr A and Mr B being separated at an earlier time.*

*Recommendation*

**R7** EIS and the housing charity should ensure that all staff are aware of all emergency accommodation options available to them.

*Overall comment on response to the Monday incident*

***We agree with the trust internal investigation report that it was predictable that there would have been a further altercation between Mr A and B after the near miss incident on the Monday. We accept that staff recognised the existence of a risk of further incidents. We also agree that it was not possible to predict the severity or nature of the subsequent fatal incident.***

***We also agree that the second incident may have been prevented had EIS and the housing charity mitigated the risks and developed plans to separate Mr A and B during the intervening week.***

**Details known about the fatal Saturday incident**

**11.24** At around 3.00 am on Saturday, Mr A stabbed Mr B at the hostel they both lived in. Police and paramedics arrived at the house and tried to save Mr B, but he was later pronounced dead in hospital. A post-mortem examination concluded that he died as a result of stab wounds to the heart and neck.

**11.25** During Mr A's attack, Miss H also sustained knife injuries to her hands and arms.

**11.26** Mr A was arrested at the scene on suspicion of murder and admitted to fatally wounding Mr B but said that he acted in self-defence.

**11.27** Mr A was transferred from prison to an NHS medium secure unit on 16 March 2017. Upon arrival he was held in seclusion and assessed by a psychiatrist who found Mr A to have evidence of perplexity, formal thought disorder, paranoia and persecutory ideation, as well as associated irritability and aggression. He was considered to pose a high risk of violence

to others if challenged. Effective antipsychotic treatment was commenced to reduce the risk.

**11.28** Mr A was found guilty of Mr B's manslaughter and grievous bodily harm towards Miss H. we have reviewed the judge's summing up from Mr A's sentencing on 4 August 2017. In describing the night of the homicide the judge remarked to Mr A:

> *"I am satisfied that [Mr B] did nothing to provoke you. He merely came down the stairs… not expecting to meet you, and at a time when he would not have expected to meet you, unaware that you had worked yourself up to such a degree of anger…*
>
> *"You were, as you said yourself in evidence, definitely frantic at the time, and as you told [a doctor] when he saw you on 26 June this year, and I will quote again, 'I felt he was trying to commit suicide using me to kill him… It was like having a tarantula on my shoulder. I panicked' and then this telling observation, 'I had a moment of madness. I lost control'.*
>
> *"Having heard all of the evidence in this case I am satisfied that that is the truth of what happened."*

**11.29** The judge also concluded that in the week following the incident on Monday, Mr A had developed increasingly hostile feelings towards Mr B. The judge said:

> *"I am satisfied that during the intervening period you became increasingly angry at what you decided was a matter of his [Mr B's] fault, and the resulting warning that you received from the staff at [the hostel]."*

**11.30** In coming to a conclusion on Mr A's disposal, the judge concluded:

> *"You are a serious danger, perhaps to yourself but certainly to others. The contrast between the picture of your behaviour at the time of this killing, and your ordinary presentation is starkly demonstrated by the statement of… your former employer."*
>
> *"And so it is, first of all, my decision that in respect of each of these offences for which you have been convicted there should be a hospital order under Section 37 of the Mental Health Act because I am satisfied… that you are suffering from a*

*disorder, and that the mental disorder from which you are suffering, that being paranoid schizophrenia, is of a nature or degree which makes it appropriate for you to be detained in hospital having regard to all the circumstances, but particularly the nature of this offence…"*

*"But I am also satisfied that in respect of each sentence there should also be a restriction order under Section 41 of the Mental Health Act… 'To restrict your discharge without the consent of the Secretary of State'… it is necessary for the protection of the public from serious harm for you to be subject to special restrictions because of the nature of the offence and because… of your lack of insight and your poor response to medication if the risk of you committing further offences is significant if you were at large."*

*Comment*

***Upon admission to the medium secure unit Mr A displayed signs that his mental health had deteriorated significantly over recent time. He displayed overt psychotic symptoms and aggressive behaviour and was managed in line with the risk he posed.***

***Psychiatrists presenting evidence at Mr A's trial confirmed a new diagnosis of paranoid schizophrenia. This is a change from his previous diagnosis of unspecified non-organic psychosis and mental and behavioural disorder due to cannabis (harmful use) while he was under the EIS team.***

***It was apparently clear to the court that Mr A's mental state had deteriorated in the time before the incident. As we have explained above, despite numerous attempts to contact and see Mr A from November 2016, this did not happen so the EIS team were not able to observe and assess Mr A for themselves.***

***The judge concluded that at the time of the incident on Saturday, Mr A was experiencing an acute phase of his mental illness and agreed that this was a significant factor in his behaviour on the night of the incident. Mr A was therefore given an indefinite hospital order under sections 37 and 41 of the Mental Health Act.***

**Incident reporting**

**11.31** In this section we examine whether the Monday incident on should have been reported by the trust under the serious incident framework. The frameworks states that it could be appropriate for a near miss to be a classed as a serious incident because the outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. Deciding whether a near miss should be classified as a serious incident should therefore be based on an assessment of risk that considers:

- The likelihood of the incident occurring again if current systems/process remain unchanged;
- The potential for harm to staff, service users, and the organisation should the incident occur again.

**11.32** A near miss should be reported as a serious incident where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.

**11.33** As stated in the trust internal investigation report, the incident on the Monday was never reported as a serious incident by the trust staff involved. It is likely that if this incident had been reported it would have prompted a review of the case by the operational manager and community matron. That would have flagged up the absence of face-to-face contacts with Mr A by trust staff.

**11.34** The housing charity did report the incident under their serious incident policy. They also informed the trust about the incident.

*Comment*

***There appears to have been a misinterpretation over the 'ownership' of the incident. Although the housing charity had reported the incident, this should not have precluded EIS from also reporting it as it met the criteria of a near miss.***

***It is likely that if this incident had been reported it would have prompted a review of the case by the operational manager and community matron. That would have flagged up the absence of face-to-face contacts with Mr A by trust staff.***

*Recommendation*

**R8** EIS should ensure that all incidents that meet the criteria are reported and investigated so improvements can be put in place where necessary.

# 12. Support for Mr B's and Mr A's family

**12.1** In this chapter we discuss how the trust and the housing charity supported Mr A's and Mr B's families following the incident in line with openness and the statutory duty of candour.

**The trust's communication with families**

**12.2** We start by examining whether the trust met the requirements of the statutory duty of candour regulation (2014). This duty makes it clear that healthcare providers must promote a culture that encourages candour, openness and honesty at all levels. When a notifiable incident occurs, the trust must:

- tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident
- provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification
- advise the relevant person what further enquiries the provider believes are appropriate
- offer an apology
- follow up the apology by giving the same information in writing, and providing an update on the enquiries and
- keep a written record of all communication with the relevant person.

**12.3** We also refer to the NHS Serious Incident Framework. This outlines the need for the family to:

- be made aware, in person and in writing, as soon as possible of the process of the investigation to be held, the rationale for the investigation and the purpose of the investigation
- have the opportunity to express any concerns and questions
- have an opportunity to inform the terms of reference for investigations

- be provided with the terms of reference to ensure their questions are reflected and
- know how they will be able to contribute to the process of investigation, for example by giving evidence.

*Mr A's family*

**12.4** The trust did have some contact with Mr A's family after the fatal incident. There is no record though to show that a duty of candour letter was sent out, an apology was made or that an opportunity was provided to Mr A's family to inform them of the terms of reference for the trust investigation. There is evidence however, that the trust sent Mr A's mother a copy of the trust internal investigation report.

*Mr B's family*

**12.5** A 'Gold Group' meeting took place with the police shortly after the fatal incident. This group is a strategic forum designed to support the response to an internal or external critical incident by bringing appropriately skilled or qualified stakeholders together. The central aim of the meeting is to consider the needs of the victim, family and community.

**12.6** At this meeting, the trust was advised that contact with Mr B's family should be through the police family liaison. The trust provided the police with the contact details for the trust family liaison team to be passed to Mr B's family.

**12.7** It is not known what discussions were held in relation to contact with Miss H (who was also a victim of the incidents) and her family. We were told by Miss H's mother that they were not contacted by the trust after the incident. There was no direct communication between the trust and Mr B's family until spring/ summer 2020.

**12.8** Mr B's family and Miss H were not contacted to advise them that the trust was internally investigating the incident, nor were they invited to contribute to the investigation. The trust did not share the final report with Mr B's family or Miss H. Mr B's solicitor has since requested and received a copy of the trust internal investigation via the

coroner's office.

**12.9** Miss H and her family received a copy of the trust report and an earlier draft of this independent investigation report from NHS England London regional mental health team in the spring of 2020. Miss H is now receiving support from the trust.

**12.10** Mr B's family have confirmed to us that nobody from the trust contacted them after the incident other than care coordinator 2 who asked if she could attend Mr B's funeral.

**12.11** Mr B's family also advised us that a police liaison officer initially provided support, but the support role was then carried out by victim support services who only visited a couple of times and did not provide adequate support. Mr B's family told us that the victim support officer did not fulfil her role, but instead asked them for help in a personal employment issue.

*Comment*

***The support provided to Mr B's family was of poor quality by all accounts and did not meet the expectations of the family. Miss H also did not receive any support or communication from the trust directly following the incident. We are pleased to hear that Miss H is now receiving support from the trust.***

***Mr B's family and Miss H should have had the opportunity to express any concerns and questions about his care and treatment, and comment on the terms of reference for the trust investigation. They should have also been informed how they could contribute to the process of the investigation, for example by giving evidence.***

***The trust could have written to Mr B's family and Miss H directly or through the police family liaison to see if they needed any other support and signposted them accordingly.***

***We are disappointed to find out that the trust has never apologised to Mr B's family and Miss H and her family despite the internal investigation finding that that fatal incident may have been prevented if Mr A and B had been separated during the intervening week.***

***The trust has breached the statutory duty of candour.***

**12.12** The trust has told us that the circumstances around this incident were very challenging but acknowledge that they did not fulfil the requirements of statutory duty of candour. They have also told us that they have since developed the family liaison role within the trust and have recently contributed to the development of national guidance.

*Recommendations*

**R9** The trust should ensure that those affected by an incident are offered support in a timely manner.

**R10** The trust must ensure that they use the systems in place for complying with duty of candour and carry out regular audits to ensure they are meeting the requirements of the act.

**The housing charity's communication with families**

**12.13** We now examine the role of the housing charity in communicating and supporting Mr B's family. As a social enterprise, the housing charity do not have a statutory duty to offer support to families, but they do have a death and bereavement policy which sets out what to do in the event of a death. We were told by managers at the housing charity that if there has been a sudden death, it would be dealt with sensitively and staff would work at the pace of those affected by the death.

**12.14** Following the fatal Saturday incident, the hostel became a crime scene. All residents were temporarily relocated. The police and the CID attended to carry out forensic examinations. Once they had finished their investigation, the property was handed back to the housing charity. There was a lot of blood at the scene, so specialist contractors were used to remove the blood and chemicals that the forensic team had used on walls and the doors. All the carpets were replaced but the old carpets were left in black bags outside the property. One of the bags was on its side and there was a corner which was stuck out that had a blood splatter on it. Mr B's sister told us they went to Mr B's room after the incident:

*"When we went to clear the house out, Mum couldn't go in. She was upset, so she waited outside. I had to go up and clear [Mr B's] room, but from when I went in the house there was still blood. My brother's blood was still on the doors…. Outside the house there was bloodstained carpet. They said that it was rust from the radiators, but you could see that it was a bloodstained carpet."*

**12.15** The team manager from the housing charity conceded that there were bags with the blood-stained carpets outside. He told us:

*"I and others apologised for that at the time. There were a lot of things going on and lots of ins and outs and stuff like that, so that actually is a truth, that on that carpet out of one of the bags there was blood. In hindsight, it would probably be better for the company to have taken all the carpet in the first instance".*

*Comment*

***We understand that the incident was unprecedented, and the housing charity did their best to get all the carpets replaced so Mr B's relatives could visit his room and other tenants could return to their homes. No family should have to see items which contain the blood stains of their loved one following a violent incident. The housing charity staff should have ensured that it did not happen.***

*Support offered by the housing charity*

**12.16** The housing charity apologised to Mr B's family and contributed towards his funeral. Mr B's family thought that they had sold some of his furniture to do this, but we have been advised that this was not the case and the funds came from the housing charity budget.

**Appendix A**

# Team biographies

**Chris Brougham**

Chris is a Verita director and one of Verita's most experienced investigators. She has substantial experience in the field of general management, professional nursing, clinical governance, mental health, and patient safety. She has worked at national, regional and local level within the NHS and the private sector.

Whilst at Verita, she has led and conducted some of its most high-profile investigations and reviews. Recent work includes:

- An independent investigation into the care and treatment of a young man with a complex neurological condition,
- A review of young people with learning disabilities presenting at emergency departments,
- carrying out serious incident investigations occurring in acute hospitals on behalf of the trust,
- Child and adult safeguarding reviews.

Chris is also head of training at Verita. She has developed a CPD accredited RCA systematic incident investigation training course. She has delivered these courses across a range of NHS organisations and sectors and has consistently received excellent feedback.

**Nicola Salmon**

Nicola is a senior consultant having worked at Verita for four years. Nicola has conducted patient care reviews for acute and mental health NHS trusts and investigated human resources and governance issues for clients such as Public Health England, NHS England and The Open University. She has also carried out complaint audits for the GMC and the CAA. She has worked with Ed Marsden & Kate Lampard on a review of an immigration removal centre for G4S. Before joining Verita, Nicola worked at the Royal College of Music as an office coordinator and at Healix Health Services, a corporate private healthcare trust provider, as a claims administrator. She has a first-class degree in history from the University of Essex.

**Dr Junais Puthiyarackal**

Junais works as a consultant psychiatrist in General Adult Psychiatry. Junais has expertise in managing complex psychiatric cases with the dual problem of mental illness and substance misuse disorder and he had worked as a consultant psychiatrist in Addictions previously. Junais collaborates in national research projects with experts in the field of addictions.

Junais qualified as a doctor in 2000. Junais has CCT (Certificate of Completion of Training) in general adult psychiatry and substance misuse psychiatry. Junais has provided advice to the Verita in some of their previous investigations.

**Kieran Seale**

Kieran Seale joined Verita in 2014. He is an experienced consultant with a passion for improving public services. Following a varied career encompassing local government, government agencies and the private sector, Kieran spent five years working in NHS commissioning. He was involved in the setting up of four central London Clinical Commissioning Groups, advising on areas such as governance, risk management and conflicts of interest. Legally qualified, he has wide experience of delivering solutions to governance issues in the NHS and outside. While at Verita he has led reviews of conflict of interest issues for NHS England, the investigation following the suicide of a nurse at Imperial, and supported GPs setting up a 'super-partnership' as well as leading investigations in the charity and not-for-profit sector. He manages Verita's work supporting the British Council and the Lottery Forum in handling complaints.

**Appendix B**

# Terms of reference

**Specific Terms of Reference for Independent Investigation into the Care and Treatment of Mr A and Mr B (2017/2165) by South West London and St George's Mental Health NHS Trust**

The investigation team will use the trust internal investigation as a starting point to examine the care and treatment of Mr A from August 2016 until the time of the offence. The investigation will focus on the areas that have not already been fully reviewed or analysed. These include the following:

**Mr A**

- To understand the outcome of Mr A's Mental Health Assessment following the Saturday incident.
- The risk assessment and risk management system in place and whether Mr A was zoned correctly, and risk managed appropriately. This will include:
    - the rationale for Mr A remaining in the amber zone for months prior to the offence;
    - the effectiveness of the escalation process/ communication during zoning meetings;
    - the clinical management of Mr A's cannabis use
    - the response and plan by EIS when Mr A was not seen individually after his medical review in November 2016;
    - the process for re-assessing Mr A's mental health following the Monday incident

**Joint care**

- Examine whether Mr A's care plan was developed jointly with housing and EIS;
- Review the communication between the trust and hostel staff when there were signs that Mr A's mental health was deteriorating.

**Mr B**

- Review the appropriateness of Mr B being accepted into the housing charity hostel.

**Mr A and Mr B**

- To obtain further information about their whereabouts/behaviours from housing staff/relatives/ visitors/other residents during in the days between the first incident on the Monday until the fatal incident on the Saturday.
- To review the process for re-assessing Mr A's mental health and their presentation and understanding of the incident on the Monday.
- To review the incident that took place on Monday.
- To review the Risk Assessment and Management plan for each patient following the first incident.
- To review the immediate decisions and actions taken following the first incident and the feasibility of the two patients being separated at an earlier opportunity.
- How agencies involved and supported Mr B's and Mr A's families following the incident in line with openness and the statutory duty of candour.

**Processes / protocols**

**12.17** We will review the following:

- The rational for majority of patients being zoned as amber and how the patients are reviewed at present.
- The drug and alcohol policies/ procedures and clinical guidelines.
- The current protocol/process for management of weapons/knives at the accommodation where both patients were residing.
- The caseloads management and dynamics of EIS.
- The process/system in regard to EIS arranging appointments or planned meetings with service users who have a noted increase in risk and are unable to attend due

to work commitments, in particular when their care coordinator is unable to see them at alternative times.

- The process of developing a joint care plan with housing and EIS.
- Staff understanding of reporting incidents and escalating concerns in the hostel.
- Staff understanding of reporting incidents and escalating concerns including referral to the trust Virtual Risk Team and referral to Home Treatment Team processes.
- The effectiveness of supervision processes in both the housing charity hostel and EIS team.
- To review commissioning arrangement of the supported housing project in London.
- To review the role of the local authority in decision making processes around referral and acceptance of potential tenants.

**The report**

We will build on the chronology of events to identify any missed opportunities and any other care and service delivery issues not found or fully analysed by the trust internal investigation.

The investigation report will, if necessary, provide clear, measurable recommendations based on the evidence and the assessments made.

**Appendix C**

# List of interviewees

**The housing charity**

Director of operations
Team manager
Area manager supported housing
Key worker 1
Key worker 2

**South West London and St Georges' Mental Health NHS Trust**

Team manager
Consultant psychiatrist 1
Consultant psychiatrist 2
Community psychiatric nurse – care coordinator 1
Community psychiatric nurse/ CBTp therapist – care coordinator 2
Community psychiatric nurse – care coordinator 4
Community psychiatric nurse – care coordinator 3
Virtual risk and family liaison lead

**Local Borough Council**

Commissioning manager, housing
Assistant team manager for accommodation and projects
Social worker 1

**Victims' family and friends**

Mr B's mother
Mr B's sister
Mr B's aunt

Miss H

Miss H's mother

**Perpetrator's family**

Mr A's mother

Mr A's grandmother

**Perpetrator**

Mr A

**Appendix D**

# List of documentary evidence

### National guidance

- NHS England serious incident framework
- Standards for early intervention in psychosis services, Early Intervention in Psychosis Network, Royal College of Psychiatrists

### South West London and St Georges' Mental Health NHS Trust

- Trust policies and procedures including:
    - Clinical and professional supervision policy for psychology and psychotherapies staff
    - Early intervention services operational policy
    - Care planning and care programme approach (CPA) policy
    - Protocol for using zoning system for targeting interventions
    - Clinical risk assessment and risk management
    - Standard operating procedure/ guidance for referring patients to the trust virtual risk team
    - Early intervention service joint operating procedure with the housing charity (supported housing provider)
- The trust internal investigation report
- Mr A and Mr B's clinical records, progress notes, care plans medical reports and crisis plans
- Medical reports to the coroner's office
- Witness statements to coroner's office
- Correspondence with Mr A's family

### The housing charity

- The housing charity policies and procedures including:

    - Protocol between South West London & St George's NHS Mental Health Trust and the South London supporting people mental health supported housing providers
    - Referral procedure
    - Service user risk assessment and management procedures
    - Substance misuse policy
    - Supervision – code of practise
    - Serious incident reporting procedure
    - Tenant's license agreement
    - Support agreement
    - Key working contract
    - Death and bereavement policy
- Serious incident report for the Monday incident
- Mr A and Mr B's case notes
- Mr A and Mr B's support plans
- Correspondence with the local borough council
- Original housing referral form for Mr B

**Metropolitan Police**

- Directorate Of Professional Standards Specialist Investigations report

**Crown Court**

- Sentencing remarks in the case of Mr A (4 August 2017)

**Documents from Mr B's family**

- Trial notes
- Mr B phone call recordings and transcripts
- Report from a post-mortem toxicology exam on Mr B

**Appendix E**

## Trust internal investigation recommendations

**1.** EIS Zoning and clinical review processes require review and revision.

   a. Consider closer alignment with LEO if this is the adopted model
   b. Particular review of the use of 'amber zone'
   c. Review of roles and responsibilities regarding leadership of zoning
   d. Clarity about attendance, recording and tasks to be carried out

**2.** EIS Operational policy and Trust CPA policy need to be aligned

**3.** EIS to improve process of clinical supervision and escalation of concerns.

**4.** Improve joint working, information sharing and risk management between EIS and the housing charity

**5.** Improved and measurable involvement of families, friends and carers.

**6.** Develop Trust wide Early Intervention Services knowledge and implementation of risk assessment and risk management.