An independent investigation into the care and treatment of mental health service users (N and G) in North London

February 2022

Author: Dr Carol Rooney, Associate Director

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

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Our Report has been written in line with the Terms of Reference as set out in the Terms of Reference on the independent investigation into the care and treatment of Gary and Nigel. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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Niche Health and Social Care Consulting Ltd
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000
Email: info@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

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1 Executive summary

1.1 NHS England London, commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of two mental health service users Nigel and Gary.[1] Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[2] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights, and the investigation of serious incidents in mental health services.[3] The terms of reference for this investigation are given in full in Appendix A.

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

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

Incident

1.5 Nigel and Gary were both tenants in a house provided for local authority emergency temporary accommodation in North London.

1.6 The police were called to and entered an address in Brent in the early hours of 17 March 2015. They found the body of Nigel, who had been stabbed. The two other residents of the house, Gary, and another resident, were arrested and placed into police custody. Gary was arrested on suspicion of the murder of his house mate, Nigel.

1.7 Gary was remanded to prison, and he was transferred to a secure mental health unit in May 2015. He told police he had carried out the stabbing because he believed Nigel had been 'bullying' his family.

1.8 On 11 September 2015 he pleaded guilty to 'manslaughter by means of diminished responsibility' and the Court made an indefinite detention order under Section 37 of the Mental Health Act 1983 along with a Section 41 restriction order.[4]

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[1] *Nigel's family have requested that we refer to him by his given name. Gary is a pseudonym.*

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

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

[4] *Section 37/41 Mental Health Act 1983, where a person is convicted before the Crown Court of an offence punishable with imprisonment the court may by order his admission to and detention in hospital. Section 41 'restriction order' provides special*

1.9 We would like to express our condolences to both families. It is our sincere wish that this report does not add to their pain and distress and goes some way in addressing any outstanding issues and questions.

Mental health histories

1.10 Nigel first came into contact with mental health services in London in 2006. At this time, he had become socially withdrawn and suspicious about his friends. He was also suspicious that his food had been tampered with and would ask his mother to try the food first. His first admission was in April 2006 to Park Royal Centre for Mental Health[5] in Brent. Before admission he had been aggressive towards his parents. Nigel remained under the care of Brent South Community Recovery Team (CRT), which is provided by Central and North West London NHS Foundation Trust (CNWL) until his death in March 2015. He had a diagnosis of paranoid schizophrenia and was known to abuse crack cocaine, heroin, and cannabis.

1.11 Gary was noted to have said he had suffered depression from the age of 19. When he was at Kings College London he was referred by the University GP for assessment of his mental health. At age 23 Gary was referred by his GP to Community Mental Health services in Windsor. There appears to have been an opinion that Gary fitted the criteria for a diagnosis of adult attention deficit hyperactivity disorder (ADHD)[6] and that he would benefit from a trial of medication. Gary's first documented experience of psychosis was in 2013, when he made threats to kill and damaged property at his workplace because of bizarre beliefs about harm to his family. His first admission was to Park Royal Centre for Mental Health in 2013, under Section 3 of the Mental Health Act (MHA)1983. He was discharged to the care of Brent Early Intervention in Psychosis service (EIS). He had a diagnosis of paranoid schizophrenia and harmful use of substances.

CNWL internal investigation

1.12 CNWL commissioned a 'panel of inquiry' chaired by a Non-Executive Director to carry out an internal investigation.

1.13 Three care delivery problems were identified for Nigel:

i. Risk and safety at the accommodation.
ii. Medication changes not actioned.
iii. Recording of medication administration.

1.14 Seven care delivery problems were identified for Gary:

i. Risk assessment.

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restrictions on discharge.https://www.legislation.gov.uk/ukpga/1983/20/section/37; https://www.legislation.gov.uk/ukpga/1983/20/section/41

[5] Pond Ward, Pine Ward and Shore Ward at Park Royal Mental Health Centre in Brent are adult inpatient wards providing a therapeutic environment for people with acute mental health problems. Provided by Central and North West London NHS Foundation Trust.

[6] Attention deficit hyperactivity disorder (ADHD) is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity, and impulsiveness.

ii. Forensic assessment.
iii. Safeguarding.
iv. Housing.
v. EIS service provision and communication.
vi. Handover.
vii. Access to Cognitive Behavioural therapy (CBT).

1.15 The internal report made 16 individual recommendations, and there were also two fixed standard Trust recommendations. These are communicating with families, and feedback to the teams concerned, then sharing lessons learned.

1.16 We were supplied with an updated action plan which had been signed off in August 2018. Updates on actions identified were received in 2019.

Independent investigation

1.17 The investigation was carried out by Dr Carol Rooney, Associate Director for Niche, with expert advice provided by Dr Mark Potter, Consultant Psychiatrist. Professor David Taylor provided mental health pharmaceutical expertise.

1.18 This independent investigation has drawn up on the internal investigation and has studied clinical information and policies. The team has also interviewed staff who had been responsible for Nigel and Gary's care and treatment.

1.19 We have provided a review of the internal investigation and associated action plan, including oversight by NHS North West London Clinical Commissioning Groups (NWL CCG) of the improvements required.

Conclusions

1.20 The Trust's internal investigation identified a number of care delivery problems in relation to the care and treatment of Nigel and Gary and developed an action plan to address these. In our view this action plan is not complete, however the Trust can evidence some positive changes that have been made.

1.21 The inappropriateness of the housing was of great concern to both families, and our investigation has shown that the Trust has recognised this and made wide-ranging changes to how housing is managed at discharge for vulnerable people.

1.22 It was recognised that there was insufficient support for both Gary and Nigel with regard to financial exploitation, and this has also been addressed by the Trust.

1.23 The safe administration and management of medication was of significant concern in both cases. Systems have been put in place to address the depot administration issues highlighted in Nigel's care.

1.24 The diagnosis and treatment of adult ADHD in Berkshire Healthcare NHS Trust (BHFT) and CNWL remains an outstanding issue. We consider that there was a lack of evidence-based treatment following the diagnosis of

ADHD, and we have made a recommendation about this aspect (recommendation 6).

1.25 The terms of reference require us to consider whether there were gaps or deficiencies which could have avoided the homicide from happening. In our view the private accommodation must be seen as a contributory factor, affecting the daily lives of both young men, but there is no obvious causal link to the homicide.

1.26 The concerns about Nigel's care which have been identified certainly impacted on the quality of his care, but we cannot link these to an increase in his vulnerability to assault. It is clear that he had a care coordinator (CCO) who knew him well and made great efforts to improve his quality of care, and that there was a therapeutic relationship in place. Nigel did not always agree with plans of care and was believed to have capacity to make choices.

1.27 The significant contributory factors in Gary's care were the lack of evidence-based treatment by the Early Intervention Service (EIS), associated with the lack of appropriate staffing resources. This meant that Gary did not receive appropriate care during his recovery from a significant psychotic episode.

1.28 Gary was seen however in March 2015, when he showed signs of relapse and an increase in paranoia. In our view the service response to his relapse indicators was insufficient to reduce his risk of full relapse and did not address the potential increased risk of violence. He refused to take antipsychotic medication and was felt to be close to a full relapse. There was insufficient follow up after this review, which led to an increased possibility of violence.

Recommendations

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

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

Recommendation 1
The commissioners of services and CNWL should ensure that the care and treatment of people with psychosis is delivered to meet the expectations of NICE guidance 'Psychosis and schizophrenia in adults: prevention and management' (CG178) in Brent community teams.

Recommendation 2
CNWL must ensure that there are clear standards for the accuracy, quality, and timeliness of discharge letters from Park Royal Centre for Mental Health, and that measures are in place to maintain these standards.

Recommendation 3
CNWL must demonstrate that the expectations of the Care Programme Approach (CPA) policy with respect to regular timely documented CPA reviews are met, and there is a system in place to maintain these standards.

Recommendation 4
NHS North West London CCG and CNWL must demonstrate that the guidance in 'Coexisting severe mental illness and substance misuse: community health and social care services' (NICE 2016) is implemented in Brent EIS.

Recommendation 5
CNWL should provide assurance that the clinical risk assessment policy is applied consistently in community teams and ensure there are systems in place to monitor its application.

Recommendation 7
Where there is a question of capacity to consent to treatment, CNWL must ensure there is a structured process used to assess and record capacity, with action plans as appropriate.

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

Recommendation 6
Commissioners of services (NHS NW London CCG and NHS East Berkshire CCG) must ensure that there are clear pathways for the diagnosis, medication prescription and management of ADHD in adults.

Good practice

1.30 We commend the quality improvements made in the CNWL inpatient services in Park Royal Centre for Mental Health, which have been recognised internally in the Trust [7] and by the CQC.[8]

1.31 We consider that the provision of support for individuals with mental health issues who have housing needs within the Brent CNWL catchment areas has been transformed and now provides a positive person-centred approach.

[7] *Pine Ward wins Project of the Year Award for quality improvement project, TWIST.* https://www.cnwl.nhs.uk/news/pine-ward-wins-project-year-award-quality-improvement-project-twist/

[8] *Central and North West London NHS Foundation Trust inspection report June 2019.* https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ0605.pdf

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[9] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[10] The terms of reference for this investigation are given in full in Appendix A.

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

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

2.4 The investigation was carried out by Dr Carol Rooney, Deputy Director for Niche, with expert advice provided by Dr Mark Potter, Consultant Psychiatrist. Professor David Taylor provided expert mental health pharmacy advice. The investigation team will be referred to in the first-person plural in the report.

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

2.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[11]

2.7 Access to relevant records was obtained by consent and through the Trust Caldicott Guardian.[12]

2.8 As part of our investigation and review, we met or had telephone interviews with:

CNWL

- Head of Serious Incidents.
- Service Manager, Brent Mental Health Services.
- Deputy Borough Director, Brent Mental Health Services.
- Safeguarding Lead, Brent Mental Health Services.

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

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

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

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

- Consultant psychiatrist, Jameson Division.[13]
- Clinical Director, Jameson Division.
- Director of Nursing, Jameson Division.
- Lead pharmacist, Brent Mental Health Service.
- Ward Manager, Pine ward.
- Modern Matron, Shore & Caspian wards.
- Care coordinator, Community Recovery Team (CRT) Brent.

NHS North West London (NWL) CCG

- Assistant Director of Quality and Safety, NHS Harrow Clinical Commissioning Group (CCG), representing North West London Collaboration of Clinical Commissioning Groups (NWL CCGs).

NHS East Berkshire CCG

- Associate Director - Mental Health, LD, Children & Families.

Berkshire Healthcare NHS Foundation Trust (BHFT).

- Consultant psychiatrist.

2.9 We were informed that none of the medical staff who had treated either Nigel or Gary were still employed by the Trust, therefore we were unable to interview them.

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

2.11 The draft report was shared with CNWL, BHFT, NHS East Berkshire CCG, NHS NWL CCG and NHS England. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

2.12 Both families had an opportunity to comment on the terms of reference, and the final terms of reference reflect questions that the families wished us to address.

Contact with Nigel's family

2.13 Nigel's family live abroad, and we had an initial conversation via 'Skype' to hear their concerns.

2.14 Nigel's parents spoke of their worries about him living in the Brent accommodation. They spoke to him by telephone most days and were worried in particular that he was always short of money and gave his mobile phone to other people to use.

2.15 Nigel's care coordinator kept in touch with them regularly which they appreciated, but they remained concerned about the accommodation he was living in, which they believed was not safe or good for him. They believe that more should have been done to make sure the accommodation was not used

[13] *CNWL mental health services are provided by Jameson Division.* https://www.cnwl.nhs.uk/services/mental-health-services/acute/

by drug dealers who took money from the residents. They were also worried about him having the wrong dose of medication for several weeks and wanted to know how that could have happened.

2.16 Nigel's parents received a formal apology from the Chief Executive of CNWL after communication errors occurred when letting them know about Nigel's death. His parents say they have never received an apology to acknowledge Nigel's death, and would appreciate this.

2.17 Nigel's family have requested that we refer to him by his given name in this report.

2.18 A 'Skype' meeting was held with Nigel's parents in March 2019 to listen to their feedback on the draft report. They confirmed that they wished the report to refer to Nigel by his given name. They said they thought that the draft report was fair and were glad to hear that changes have been made to the service, particularly regarding accommodation. Their overall feeling is that they would not want another family to go through a similar experience.

2.19 A further 'Skype' meeting was held with Nigel's parents, NHSE, CNWL and Niche in October 2021. A formal apology for Nigel's death was offered by the Trust, followed by an update on lessons that have been learned and changes made since this tragic event.

Contact with Gary's family

2.20 Gary is a pseudonym. Contact with Gary's family was made by writing to them and arranging an initial meeting to hear their concerns and discuss the draft terms of reference. They were concerned about Gary's diagnosis, the management of risk after the decision was made to admit him to hospital in 2013, and had specific questions about his medication regime, which are addressed in this report.

2.21 We met Gary and his parents in March 2019 to listen to their feedback on the draft report. Gary's parents remain concerned about how his care was managed in relation to risk, and particularly the management of his medication. His parents made a number of detailed comments which we have responded to, and which have been incorporated into this report.

Contact with Gary

2.22 We contacted Gary through his clinical team, and we met him on 14 January 2019, and also had the opportunity to speak to his consultant forensic psychiatrist.

2.23 Gary described how he now knows that he was very unwell at the time of the homicide and had developed a number of beliefs about Nigel being evil and having influence over him. He now knows that these were not true but did not tell anyone about them because he believed that others could read his mind anyway, so knew his thoughts. He was quite clear that he did not talk to any professionals about his beliefs about Nigel because of this.

2.24 Gary said that he and Nigel were initially friends, and used to spend time together, but Nigel used to borrow money from him and not pay it back. On one occasion Gary called the police[14] because Nigel allegedly punched him in an argument about money.

2.25 Gary's concerns about the accommodation were more focussed on other people in the house, and visitors to the house. He said there was a couple who would argue loudly, and others coming and going dealing drugs. He was concerned about the time that his bank account was frozen. At the time of the homicide he was waiting to hear when he could move to another property.

2.26 He admitted he did not keep his room very tidy, but he felt he had good contact with doctors and with his care coordinator.

Structure of the report

2.27 Section 3 describes Nigel's background and summarises the care and treatment provided to Nigel, with a detailed review of the six months prior to his death.

2.28 Section 4 examines the issues arising from the care and treatment provided to Nigel. This includes comment and analysis with respect to the terms of reference for the independent investigation.

2.29 Section 5 describes Gary's background and summarises the care and treatment provided to him, with a detailed review of the six months prior to the homicide.

2.30 Section 6 examines the issues arising from the care and treatment provided to Gary. This includes comment and analysis with respect to the terms of reference for the independent investigation.

2.31 Section 7 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.32 Section 8 sets out our overall analysis and recommendations.

The incident

2.33 The police were called to and entered an address in Brent in the early hours of 17 March 2015. They found the body of Nigel, who had been stabbed. The two other residents of the house, Gary, and another resident, were arrested and placed in police custody. Gary was arrested on suspicion of the murder of his house mate, Nigel.

2.34 Gary was remanded to prison, and he was transferred to a secure mental health unit in May 2015. He told police he had carried out the stabbing because he believed Nigel had been 'bullying' his family.

[14] *According to the clinical records this was in February 2014.*

2.35 On 11 September 2015 he pleaded guilty to 'manslaughter by means of diminished responsibility' and the Court made an indefinite detention order under Section 37 of the Mental Health Act 1983 along with a Section 41 restriction order.[15]

[15] *Section 37/41 Mental Health Act 1983, where a person is convicted before the Crown Court of an offence punishable with imprisonment the court may by order his admission to and detention in hospital. Section 41 'restriction order' provides special restrictions on discharge.* https://www.legislation.gov.uk/ukpga/1983/20/section/37; https://www.legislation.gov.uk/ukpga/1983/20/section/41

3 Background, care and treatment of Nigel

Childhood and family background

3.1 Nigel was 34 years old when he died. He lived in temporary accommodation in Brent and had lived there for several years; he had his own en-suite room and there were shared cooking facilities. He was unemployed and in receipt of welfare benefits.

3.2 Nigel's family moved to the UK from St Helena in the late 1970's, and he was born in 1980. He has an older brother who has lived in New Zealand for many years. Nigel was described as a 'hyperactive' child who had a food intolerance. His mother reported he seemed to become withdrawn aged nine.

3.3 When Nigel was aged 15 the family emigrated to New Zealand, and it was felt he got in with a 'bad crowd' and stood out because he was English. He was unsettled and his parents reported that he started to smoke tobacco and cannabis from aged 15.

3.4 The family moved back to the UK when Nigel was aged 17. Nigel left school shortly after his return to the UK, achieving basic qualifications. He was in the army cadets and achieved medals and certificates for rifle shooting.

3.5 At the time of his death Nigel's parents lived in Portugal. They later retired to St Helena, their country of origin.

3.6 Nigel had described his relationship with his parents as close, even though it could be difficult at times. His parents told us that there was usually very regular, often daily, telephone contact between Nigel and his parents. Records indicate that Nigel had a daughter but had no contact with either his daughter or her mother. At times he had talked to staff of wanting to make contact and being upset about having no contact. He made a request to speak to a psychologist to talk through these issues.

3.7 Nigel had various jobs; working as a mechanic, a driver and a taxi company call handler. In September 2014 he began an introductory college course in painting and decorating. It was noted that this had given him purpose and focus on something that he felt he could do in the future.

Contact with police and criminal justice system

3.8 This section includes times when Nigel was investigated by police, and when he was the victim of other criminal acts.

Date	Incident	Outcome
Unknown	Spat at ex-girlfriend.	Conviction/restraining order.
July 2010	Assaulted by flat mates with a hammer and shards of broken mirror. Flat mate thought he was planning to poison their dog.	Unknown, moved as emergency to Brent, then detained under the MHA.

Date	Incident	Outcome
January 2013	Attacked in public, broken jaw.	Unknown.
February 2014	Another house resident (Gary) called the police and Nigel was arrested, the issue was about money, he said he was defending himself. Later said the argument was about cutlery, believed by landlord to be about drugs. Discussed with care coordinator (CCO) later, said his cutlery was taken, but it was resolved, and they were talking again.	Initially charged with Actual Bodily Harm, but no further police action.
April 2014	Bank account frozen because of alleged fraudulent deposits (£7,000).	Bailed, attended police station November 2014, court February 2015, outcome unknown.
August 2014	Arrested and charged with burglary.	Charges dropped, possible mistaken identity
December 2014	Kidnapped by a gang that he owed money to, beaten up.	Not prepared to talk to police, allegedly knew the gang members. Referred to CNWL safeguarding but closed because Nigel would not discuss it.
January 2015	Arrested for theft of a purse.	Charges dropped.
February 2015	Mugged on the way back from Essex to London.	Unknown

Summary of mental health care

3.9 Nigel first came into contact with mental health services in London in 2006. At this time, he had become socially withdrawn and suspicious about his friends. He was also suspicious that his food had been tampered with and would ask his mother to try the food first. His first admission was in April 2006 to Park Royal Centre for Mental Health[16] under Section 3 MHA, after he had been aggressive towards his parents. Nigel remained under the care of CNWL Brent South Community Recovery Team (CRT) until his death in March 2015. He had a diagnosis of paranoid schizophrenia and was known to abuse crack cocaine, heroin and cannabis.

3.10 We have summarised his care since 2006 below, and detailed the care provided from October 2014 to March 2015.

[16] *Pond Ward, Pine Ward and Shore Ward at Park Royal Mental Health Centre in Brent are adult inpatient wards providing a therapeutic environment for people with acute mental health problems. Provided by Central and North West London NHS Foundation Trust.*

Date	Care and treatment	Legal status
April - June 2006	First admission, acute psychotic episode, diagnosis of schizophrenia, following social withdrawal and aggression to parents.	Section 2 MHA
2006 - 2008	Supported in the community by CCO.	
2008	Supported in the community by CCO, concerns about use of cannabis and cocaine, noncompliance with medication.	
2009	Supported in the community by CCO, concerns about noncompliance with medication. Became paranoid at work and lost his job.	
March - July 2010	Assaulted by flat mates with a hammer and shards of broken mirror, prior to admission. Flat mate thought he was planning to poison their dog. Prior to this, concerns had already been expressed by CCO and parents about not taking medication, smoking cannabis and becoming unwell.	Section 3 MHA
July 2010 - June 2011	Supported in the community by CCO.	
June - August 2011	Admitted to Park Royal. Believed he had been attacked by 'eyes' that come through the walls, had a sharp knife on his bed during assessment and said he would use it to protect himself.	Section 3 MHA, discharged on Community Treatment order (CTO)
August 2011 - February 2012	Supported in the community by CCO.	
February 2012	No longer liable to be detained, CTO lapsed on 8 February.	Informal
April 2013	Supported in the community by CCO, refusing depot since April 2013.	
October 2013 - February 2014	Admitted to Park Royal. Refusing medication, unkempt, declining mental state, threatening demeanour, MHA assessment agreed, declined informal admission, placed on Section 2 MHA. Urine Drug Screen (UDS) positive for cocaine and morphine.	Section 2 MHA

Date	Care and treatment	Legal status
November 2013	Restless, agitated, asking friends to deliver items, and demanding to go to the cash machine. Psychotic, bizarre, demanding. Transferred to the Psychiatric Intensive Care Unit (PICU) after becoming aggressive and demanding money from others.	Section converted to Section 3 MHA on 19/11/13
January 2014	On home leave from ward for a week, seen by Brent Home Treatment Team (BHTT) at home.	
January 2014	Discharged from Section 3 MHA by Tribunal, discharged from Park Royal. Supported in the community by CCO, seeing substance misuse services. Support worker provided to assist with housing issues.	Informal
February 2014	Supported in the community by CCO, seeing substance misuse services. Drinking cans of caffeine drinks every day, and smoking crack regularly, borrowing money, in debt. Accepting depot every two weeks. Allegations of dealing drugs from the property, damage to doors.	
August 2014	Depot zuclopenthixol decanoate 200 mg reduced to 150 mg but not actioned.	
January 2015	Staying in Essex, whereabouts unknown.	
March 2015	Admitted to Royal Free Hospital after overdose of co-codamol, reported hearing voices telling him to kill himself. Took tablets then woke up the following day. Referred to BHTT when medically fit.	
March 2015	Visits from BHTT not successful; not at home, not taking calls; four unsuccessful attempts, discharged back to CCO. Seen by CCO 13/3/15. CCO on leave from 14/3/15.	

October 2014 to March 2015

3.11 During October 2014 Nigel continued to attend the team base in Brondesbury Road to be given his depot. The depot dose had been reduced in August 2014 from 160 mg every two weeks, to 150 mg every two weeks. This had not been actioned by a prescription change, and Nigel queried this in September 2014. He was told that the change had not been documented, so he would have to continue with the current dose until the change was made, which he accepted. He continued to receive a further nine doses at 160 mg.

3.12 Nigel was attending a college course at this time and required funding for some safety boots. His CCO contacted the college and arranged for him to continue attending until funding could be provided for the equipment.

3.13 He saw his CCO regularly and he informed his CCO in November 2014 that his bank account had been frozen in relation to allegedly fraudulent transactions. He had had to attend a police station and was on bail.

3.14 Nigel was also considerably in debt (to about £5,550) and he was supported to contact a debt support agency and allocated a support worker to help with this. This agency was unable to help him because he did not attend any appointments. This apparently clashed with him having to attend court in relation to the fraud allegation. Nigel said he had legal representation and was due to attend court again in December 2014.

3.15 Housing was discussed with him, and he was encouraged to consider supported accommodation. Nigel was adamant he wanted to live independently. He also said he had not taken any illicit drugs for four weeks.

3.16 It was arranged that he would be contacted by another debt support charity 'Step Change'[17] and he was supported to supply them with documents to assist with his debt management.

3.17 In December 2014, the notes record that he was administered 160 mg flupentixol decanoate,[18] despite the notes in August which record the decision to reduce it to 150 mg.

3.18 In late December 2014, the CCO was contacted by a police officer from the Human Trafficking Team. Apparently, Nigel had been kidnapped on 21 December in relation to owing people money and drugs. Police believed that Nigel knew his kidnappers, but he refused to disclose any names. Nigel was beaten up and had bruising to his face and body. He told his CCO that the debt was now paid, and he refused to discuss this any further.

3.19 On 5 January 2015 Nigel's father called the CCO to inform her that Nigel had been arrested for stealing or taking a purse that he had found. Concerns about Nigel's vulnerability and the incident with the police were discussed in the CRT Clinical Team meeting on 8 January 2015, and it was agreed that the CCO would undertake a home visit to review him.

3.20 The CCO saw him at his home on 9 January 2015 and discussed his current situation. He admitted to taking crack the night before this but was calm and apologetic and did say he was safe even though he now owed some more money. Regarding police matters it was noted that Nigel said he picked up the purse but did not steal it, and no further action was to be taken. The CCO clarified that he had legal representation for the alleged fraud. This apparently involved someone Nigel and Gary both knew, who had now disappeared. There was a sum of about £7,000 that was allegedly transferred into Nigel's account, which was then frozen, and Nigel had been charged with fraud.

[17] *Step Change is a charity which offers tailored advice and practical solutions to problem debt.* https://www.stepchange.org/

[18] *Flupentixol decanoate is a long acting injection for the treatment of psychotic symptoms.* https://www.medicines.org.uk/emc/product/995/smpc

3.21 Nigel had a shoulder injury which he said he sustained doing a 'back flip' and he was waiting for an MRI which his GP had arranged.

3.22 Supported accommodation was noted to have been discussed again, and it was planned to work on this further with the support worker. The CCO noted that Nigel appeared mentally stable but was making unwise decisions regarding his drug taking, and he is quoted as saying he does not feel he needs the support of drug agencies currently. He was noted to be stable in mental and physical health, was coherent in conversation and able to rationalise his actions. He was reminded that continuing to take drugs is likely to affect his health, debts, and accommodation.

3.23 Appointments were made with 'Start Plus'[19] supported accommodation service during January, and it was arranged that Nigel was to be reminded before the first appointment. He did not attend on 21 January, and a further appointment was arranged on 28 January with the same support, but he did not attend. His CCO made many telephone calls and a home visit between 28 and 29 January to try to find out how he was. Nigel answered the phone on 29 January, and said he was staying with a friend in Essex and would be back in London briefly before returning to Essex.

3.24 It was recorded that Nigel's parents were updated by email. In early February 2015, his parents contacted the CCO to say Nigel was back in London and was worried about possible future accommodation options, it was explained that he had not in fact been assessed yet. Nigel's father was informed that Nigel had been out of contact with the CCO for the past week, his telephone was ringing but was not answered. His parents confirmed this had been happening to them also, although they had spoken to him that day.

3.25 Nigel attended for his depot injection on 6 February 2015, and it appeared he then returned to Essex. The support worker contacted him to try to arrange a further meeting with 'Start Plus', but Nigel said he was still in Essex and would be back the following week. He later told his CCO that he wanted to look for a place on the coast, but would not disclose where he was staying, apart from saying it was in Clacton on Sea. The CCO asked his parents to let him know (if he was in touch with them) that he cannot be living in two places and there is concern that he is currently out of contact with services.

3.26 Nigel did not respond to calls from the CCO between 11 February to 15 February 2015, he answered on 16 February 2015 saying he will be back in London the next week. His father called the following day to inform the CCO that Nigel said he had been mugged on the way to London and his jacket and keys were stolen, and he had arrived at the Brent house. The CCO attempted to call him but there was no facility to leave a message on his phone, and no telephone line in the Brent house. Nigel did not call the CCO, and there was a further message from his father on 3 March 2015 expressing concerns about Nigel's mental health.

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[19] *Start Plus is a Brent central referral team co-ordinating access to supported housing for single homeless people with support needs and floating support services. http://www.brent.gov.uk*

3.27 The next contact was on 5 March 2015 from a Psychiatric Liaison Nurse at the Royal Free Hospital. Brent Home Treatment Team (BHTT) received a message stating that Nigel had self-presented to A&E complaining of feeling unwell and unable to cope. Later that day the CCO attended the Brent house as agreed to check on Nigel's mental health after his father's concerns. On hearing he was in hospital the CCO called him, and then spoke to nursing staff. Nigel was at this point not medically fit for discharge and a mental health assessment would be carried out before decisions about discharge.

3.28 The assessment by psychiatric liaison services[20] noted that Nigel said he had been hearing voices over the past four or five days, and he had not heard voices like this before. He said he took 100 co-codamol tablets two days earlier with an intention to die and make the voices stop. He did not call an ambulance or seek help; he went to bed and woke up after one and a half days feeling low in mood. He said he wanted to die at the time and was stressed about a court case regarding fraud. Nigel also said he tried to kill himself because he is sick of having schizophrenia hanging over his head, and the voices were driving him 'crazy'.

3.29 The BHTT had an update from staff at the Royal Free. Nigel had told them that voices told him to kill himself and he felt actively suicidal. He took an overdose of co-codamol on 4 March, but currently had no active plans to commit suicide or harm himself. It was agreed that BHTT would provide support on discharge. Nigel had to buy a new phone and promised to call the BHTT after he was discharged on 8 March. The psychiatric liaison notes from his assessment were faxed to the Brent South CRT on 8 March 2015.

3.30 BHTT staff called Nigel on 10 March 2015, but there was no facility to leave messages. A call was made to a friend of Nigel's, as recorded in his notes, to try to contact him. A message was left, and a further message was left on 11 March. An unannounced visit was made by BHTT on the morning of 12 March 2015. There was no answer, and a note was left asking Nigel to contact the BHTT. It was planned to try a further unannounced visit, and this was done on 13 March 2015, with no answer at the property.

3.31 BHTT attempted to see him for the fourth time on 13 March 2015 and found the front door to the property open. There was no response to calls and knocks. The BHTT noted it was planned to hand his care back to the CCO and close the referral because they had made four attempts to assess him without success.

3.32 On 13 March 2015 BHTT called the CCO to hand back his care, as they had been unable to contact him. The CCO had seen him that morning, having made an unannounced visit. He said he had no phone. Supported accommodation was mentioned but it was noted that Nigel did not agree with this. The CCO was about to go on leave and noted they would ask the CRT duty team to follow up with him.

[20] *Provided at Royal Free Hospital by Camden & Islington NHS Foundation Trust.* https://www.candi.nhs.uk/services/royal-free-liaison-psychiatry-service

3.33 A telephone call was made on 16 March to Brent South CRT by BHTT to inform them of this, and a message was left with a student social worker, who discussed this with a senior member of staff. It was noted that the CCO was on leave, and the CRT duty team was requested to follow up.

3.34 The CRT duty team made a call to Nigel's father on 16 March, who said Nigel did not have a phone, but he had spoken to him last Friday (13 March) and he appeared slightly low. It was acknowledged that Nigel would regularly attend the team base to have his medication, and it was planned that if he had not attended by the following day, an appointment letter would be sent to him.

3.35 On 17 March 2015, the Trust was informed that police had been called to the Brent address in the early hours of the morning, Gary had been arrested and Nigel had died.

4 Arising issues, comment and analysis – Nigel

4.1 Analysis of Nigel's care and treatment is provided below, using the headings of the detailed terms of reference. We have referenced the findings of the internal investigation as part of this analysis.

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

4.2 Nigel was cared for under the Trust Care Programme Approach (CPA) policy,[21] and because he had been admitted to hospital under Section 3 MHA, he was entitled to Section 117 MHA aftercare.[22] The expectation would be that he had a formal care plan, with planned multidisciplinary reviews at appropriate intervals.

4.3 The most recent CPA review took place on 8 August 2014, attended by Nigel, his CCO and consultant psychiatrist. The previous CPA review was in February 2014, which is in line with the policy expectations of at least annual review. In August 2014 it was noted that he continued to use illicit drugs, although he was attending Addaction[23] and he requested to reduce the depot injection. Nigel was noted to be somewhat hostile during the meeting and continued to state that he did not accept that he had a diagnosis of schizophrenia. It was agreed that there would be a gradual reduction in medication, starting with reducing from 160 mg to 150 mg every two weeks.

4.4 The other elements of the care plan were: to continue to remain in contact with his CCO for mental state monitoring; Nigel would like to return to work, and to be provided with support from the CRT to address this; CCO to continue to support him with his efforts to be housed in more appropriate accommodation; and to have regular reviews.

4.5 We have discussed the individual issues below under the headings of care planning, medication, and NICE guidance.

Care planning

4.6 We found that the CCO was proactive in their contact with Nigel, providing regular planned meetings as well as reacting to changes in his presentation, increasing contact and adjusting plans where necessary.

4.7 He was encouraged to reduce his use of illicit drugs, and to use the support available through Addaction. Nigel frequently voiced concerns about debts and money worries, and he was referred to two providers of debt management support, the second was after Nigel did not attend appointments with the first provider.

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[21] *CNWL CPA policy January 2015, ref TW/00070/15-17a.*

[22] *Section 117 MHA obliges local authorities and CCGs to provide aftercare if someone has been discharged from some sections of the MHA, including Section 3.* https://www.legislation.gov.uk/ukpga/1983/20/section/117

[23] *Addaction are a drug, alcohol, and mental health charity.* https://www.addaction.org.uk/

4.8 He was allocated a support worker to assist with accessing debt and housing advice, and to facilitate attendance at college.

4.9 Considerable efforts were made to maintain contact with Nigel, managing to maintain this despite his frequent changes of phone.

Medication

4.10 The internal investigation noted that the agreed reduction to the depot zuclopenthixol decanoate from 160 mg to 150 mg did not occur. The reference to this recorded in the notes of the CPA review in August 2014, but this decision does not appear to have been translated into practice. Nigel received a further nine doses at 160 mg, the last being 6 February 2015. It is not known whether the prescription chart was amended but not actioned, as the most recent prescription chart had not been uploaded to Jade,[24] and could not be found.

4.11 The CNWL Medicines policy[25] states that 'a change of treatment (e.g. such as change of dose or frequency) implies cancellation of previous treatment. Prescriptions must not be amended but written up as a new entry and the old treatment cancelled'. If the prescription was changed, it was not actioned at the depot clinic. Depot prescriptions in Brent are completed by the psychiatrist, then the patient takes this to the GP to be actioned.

4.12 The internal investigation also highlighted that the entries made regarding his depot injection administration were varied in quality: there was no entry on Jade and no record of a follow up plan when Nigel missed his depot injection on 13 January 2015 or 20 February 2015, there was no record of administration of his depot on the medication chart on 6 February 2015, although it was recorded on Jade. The CNWL Medicines policy states that 'a record of all medicines administered must be made immediately, clearly, accurately and indicate, where applicable, if medication was intentionally withheld or refused by the patient. Documentation must be done immediately after administration and not at the end of the medicine administration session'. We found that many of the records of administration of his depot did not give the detail of the dose or administration site.

4.13 Contributory factors identified were difficulties in nurse recruitment in the depot clinic leading to use of agency staff, pressurised care coordinator caseload, and inaccurate record keeping. The internal report has made a recommendation about this aspect which we review in Section 7.

NICE guidance[26]

4.14 We have reviewed relevant sections of the expectations of NICE guidance, "Psychosis and schizophrenia in adults: prevention and management", with reference to Nigel's care and treatment.

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[24] *Jade is the electronic patient record system in use at the time in CNWL.*

[25] *CNWL MEDICINES POLICY February 2014, TW/0039/14-17a.*

[26] *NICE: Psychosis and schizophrenia in adults: prevention and management. Clinical guideline [CG178] Published date: February 2014*

Standards	Available to Nigel
Service user experience	
Use this guideline in conjunction with service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • work in partnership with people with schizophrenia and their carers • offer help, treatment, and care in an atmosphere of hope and optimism • take time to build supportive and empathic relationships as an essential part of care.	Yes, continuity of care coordinator and well-developed relationships with Nigel and parents.
Race, culture, and ethnicity	
Healthcare professionals working with people with psychosis or schizophrenia should ensure they are competent in: • assessment skills for people from diverse ethnic and cultural backgrounds • using explanatory models of illness for people from diverse ethnic and cultural backgrounds • explaining the causes of psychosis or schizophrenia and treatment options • addressing cultural and ethnic differences in treatment expectations and adherence • addressing cultural and ethnic differences in beliefs regarding biological, social, and family influences on the causes of abnormal mental states • negotiating skills for working with families of people with psychosis or schizophrenia • conflict management and conflict resolution.	While it is clear there was good communication, Nigel had a black and ethnic minority background, with various moves across continents when younger. We found no evidence that there was consideration of the effects or influences of this.
Mental health services should work with local voluntary black, Asian and minority ethnic groups to jointly ensure that culturally appropriate psychological and psychosocial treatment, consistent with this guideline and delivered by competent practitioners, is provided to people from diverse ethnic and cultural backgrounds	Yes.
Physical health	
People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	No.
If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see obesity [NICE clinical guideline 43], lipid modification [NICE clinical guideline 67] and preventing type 2 diabetes.	Not applicable.

Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.	No.
Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.	Yes, carried out by the GP, but no evidence of team routine monitoring of results.
Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.	The Trust currently has developed over the last two years a physical healthcare oversight group chaired by the Executive Director of Nursing. Reports are received by the quality and performance committee, a sub-group of the board on a regular basis around the Trust's performance around cardio metabolic tests and interventions which is monitored at a Trust-wide level and Borough level and forms part of regular reporting to each of the divisions operational boards. Over recent months the Trust has developed a reporting system which allows teams now to log-on to "tableau" in order to seek their performance at a given time.
Support for carers	
Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any	Difficult as carers (parents) lived abroad.

identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.	Contact was maintained but it was not possible to arrange carers assessments.
Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this	Difficult as carers (parents) lived abroad. Contact was maintained but it was not possible to arrange carers assessments.
Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. When providing information, offer the carer support if necessary.	No.
As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users, and carers, and respects their individual needs and interdependence.	Yes.
Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.	Yes.
Offer a carer focussed education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should be available as needed, have a positive message about recovery.	No.
Include carers in decision-making if the service user agrees.	Yes.
Peer support and self-management	
Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their	Not available at that time.

whole team, and support and mentorship from experienced peer workers.	
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	
Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it	Yes.
Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.	Yes.
Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.	Yes.
If a person with psychosis or schizophrenia needs hospital care, think about the impact on the person, their carers and other family members, especially if the inpatient unit is a long way from where they live. If hospital admission is unavoidable, ensure that the setting is suitable for the person's age, gender, and level of vulnerability, support their carers and follow the recommendations in service user experience in adult mental health (NICE clinical guidance 136).	Yes.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer: • oral antipsychotic medication in conjunction with • psychological interventions (family intervention and individual CBT).	Yes. No.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment. Take into account the clinical response and side effects of the service user's current and previous medication.	Yes.
Offer CBT to all people with psychosis or schizophrenia. This can be started either during the acute phase or later, including in inpatient settings.	No.
Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings.	No.

Consider offering arts therapies to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings.	No.
Behaviour that challenges	
Occasionally people with psychosis or schizophrenia pose an immediate risk to themselves or others during an acute episode and may need rapid tranquillisation. The management of immediate risk should follow the relevant NICE guidelines.	Yes.
Follow the recommendations in self-harm (NICE clinical guideline 16) when managing acts of self-harm in people with psychosis or schizophrenia.	Yes.
Psychological interventions	
Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described.	No.
Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described.	No, and latterly not possible.
Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms	No.
Pharmacological interventions	
The choice of drug should be influenced by the same criteria recommended for starting treatment	Yes.
Do not use targeted, intermittent dosage maintenance strategies routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity.	Yes.
Consider offering depot/long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: • who would prefer such treatment after an acute episode? • where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.	Yes.
Using depot/long-acting injectable antipsychotic medication	
When initiating depot/long-acting injectable antipsychotic medication: • take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and	Yes.

organisational procedures (for example, home visits and location of clinics) • take into account the same criteria recommended for the use of oral antipsychotic medication particularly in relation to the risks and benefits of the drug regimen • initially use a small test dose as set out in the BNF.[27]	
Employment, education, and occupational activities	
Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.	Yes.
Mental health services should work in partnership with local stakeholders, including those representing black, Asian and minority ethnic groups, to enable people with mental health problems, including psychosis or schizophrenia, to stay in work or education and to access new employment (including self-employment), volunteering and educational opportunities.	Yes.
Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes.	Yes.

4.15 There is evidence that some of the NICE guidance had been followed in Nigel's care. There were gaps particularly in the area of psychological interventions in relation to the care of Gary, which was acknowledged in the internal investigation.

Recommendation 1
The commissioners of services and CNWL should ensure that the care and treatment of people with psychosis is delivered to meet the expectations of NICE guidance 'Psychosis and schizophrenia in adults: prevention and management' (CG178) CG178 in Brent community teams.

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

4.16 There is evidence of regular recording and updating of risk assessments in Nigel's clinical record, over many years.

4.17 We have separated out risk assessment and plans regarding Nigel's risk from others, risk to others and risk to self.

Risk from others

[27] *British National Formulary.* https://bnf.nice.org.uk/drug/

4.18 It was apparent that Nigel's lifestyle made him vulnerable to harm from others, and the accommodation in which he lived was a contributory factor (discussed from section 4.55 below).

4.19 The clinical records include a number of references to him being attacked or assaulted:

Date	Incident
July 2010	Assaulted by flat mates with a hammer and shards of broken mirror, prior to admission. Flat mate thought he was planning to poison their dog.
September 2011	Said he had been mugged but not seriously injured.
May 2013	Father told CCO Nigel had been threatened by drug dealers.
June 2013	Father told CCO Nigel had been attacked and taken to hospital.
January 2014	Attacked in public, broken jaw.
February 2014	Father told CCO Nigel had been beaten up.
February 2014	Gary called the police and Nigel was arrested for attacking him. The issue was about money, Nigel said he was defending himself. Later said the argument was about cutlery, believed by landlord to be about drugs.
June 2014	Father told CCO Nigel had been beaten up and his money and phone had been taken.
December 2014	Kidnapped by a gang that he allegedly owed money to, beaten up.
February 2015	Mugged on the way back from Essex to London.

4.20 There had been concerns discussed between the property manager and the CCO about vulnerable people being targeted by drug dealers. There is clear evidence that the CCO regularly discussed the concerns about his safety in relation to drug taking with the CRT clinical team, and with Nigel himself.

4.21 There was no indication that Nigel did not have capacity to make decisions about his lifestyle, and as expected his CCO reinforced reduction of consumption of drugs, and to use the support from Addaction. Nigel attended Addaction intermittently, and told staff that he considered that he was able to protect himself. He was clear that he did not want safeguarding adult procedures to be initiated.

4.22 After the kidnapping incident in December 2014 a safeguarding referral was made. However this was later closed because Nigel refused to co-operate with further enquiries.

4.23 The internal investigation concluded that there was no evidence to suggest that there should have been a more assertive approach to safeguarding. We agree with this conclusion.

4.24 We also agree with the conclusion that there was a lack of action in relation to concerns about criminal activity at the property. This is addressed in the internal investigation report, reviewed below in Section 7, therefore we have not made a recommendation about this aspect.

Risk to others

4.25 Nigel did not have a history of causing serious harm to others and had no convictions for harming others. There are allegations of theft from a shop and stealing a purse from a member of the public.

4.26 It was recorded that Gary had called the police in February 2014, and he alleged that Nigel had punched him, in an argument over money or cutlery. This was identified in the internal report as a missed opportunity to communicate between teams, as it was known that Nigel was also under the care of CNWL mental health services.

Risk to self

4.27 Nigel had no documented history of self-harm. His substance misuse could be seen as self-destructive behaviour, but there is no evidence that this was motivated by suicidal ideation.

4.28 On 5 March 2015 Nigel presented at A&E, Royal Free Hospital stating he had taken 100 co-codamol two days earlier. The medication was prescribed for some shoulder pain, and he said he took the tablets with tea, then went to sleep. He was assessed by the psychiatric liaison team, and he told them that he had been having difficulty eating and sleeping over the past week, he said he intended to die but it was not a pre-planned act. Nigel said he had been hearing voices telling him to kill himself and these were '*driving him crazy'*, and he had thought of drowning himself, getting run over by a car or hanging himself to make the voices go away. He also said he was sick of having schizophrenia 'hanging over his head', he had not been taking his depot medication for the past six weeks and these voices were a new experience.

4.29 At this time the risk to himself was thought to be 'moderate' due to noncompliance with medication over the past couple of weeks, and he did not appear to be relapsing in his mental state, although his presentation was thought likely to have been influenced by having taken crack cocaine. Risk to others was assessed as low.

4.30 Brent CRT were informed, and contact was made with Royal Free by the CCO for an update and to give a background history. He was reviewed daily by the psychiatric liaison team, and it was noted that his liver function[28] had decreased since admission, signifying that there was possible damage to his liver. Because of this he could only take antipsychotic medication in small doses. He was distressed by continuing hallucinations and was prescribed

[28] *Liver function tests.* https://www.nhs.uk/conditions/blood-tests/types/

haloperidol 5 mg[29] to be taken as required. He was allocated a nurse on one-to-one observations and was to be assessed under the Mental Health Act if he tried to leave. The plan was to get the history and current care plan from the CRT and plan next steps.

4.31 An assessment from the psychiatric liaison team was requested before he could be discharged. On 8 March 2015 he was medically cleared for discharge and was seen by the psychiatric liaison team doctor. Nigel said he had been responding to external auditory commands telling him to end his life as a result of financial difficulties and the pending court case in October 2015.

4.32 He said his suicidal act was impulsive when he realised he could afford no more to eat than a cup of tea and sugar. Prior to the overdose he had gone to a neighbour to ask for a phone to call for help but the neighbour had no phone. He was remorseful at what he had done and shocked but relieved at his life being saved when he woke up. His intention had been to end it all then, but he said the voices had not been present for the past 24 hours. The impression was that he was now at low risk of harming himself and understood the importance of compliance with medication. The plan agreed was to discontinue one-to-one observations, discharge him home with follow up from the Brent Home Treatment Team (BHTT), continue taking haloperidol until he could have a depot review, and contact the Psychiatric Liaison Team if there were any concerns overnight. Nigel had the emergency crisis numbers, although he did not have a phone, and planned to buy one as soon as he was out of hospital. A referral was made to BHTT and accepted before his discharge. The Psychiatric Liaison doctor spoke to a BHTT Community Nurse and handed over Nigel's care and presentation since admission.

4.33 It was arranged that BHTT would speak to Nigel on the ward and agree that he would call them after discharge when he had a phone, and arrange a time to see them at home the following day, ideally with his CCO. Nigel gave BHTT a number, but he did not answer when they called, twice on 10 March and once on 11 March 2015. They were unable to leave a message because the voicemail was full. BHTT staff tried calling friends and made two unannounced visits to Nigel's address on 12 and 13 March 2015. His CCO was informed on 13 March 2015 that they could not locate him, and it transpired that the CCO had seen Nigel at home that morning. He had promised to be in the following evening for BHTT to see him. The CCO was going on leave from this date, and discussed future plans with him, it was noted he was encouraged to consider supported accommodation but was resistive. The voluntary debt agency was helping him with debts. It was noted that he was reminded that he needs to communicate with the team. The plan was to ask the duty team to follow up while the CCO was away, for Nigel to be seen for a review, and for further discussion about housing support.

4.34 A further visit was made by BHTT on the evening of 13 March 2015, the property front door was open but there was no response to calls. It was

[29] *Haloperidol is used to relieve the symptoms of schizophrenia.* https://patient.info/medicine/haloperidol-haldol-serenace

decided to discharge him back to the care of Brent South CRT and the CCO, because BHTT had been unable to make an assessment.

4.35 BHTT phoned the Brent South CRT on 16 March to discharge him back to their care as they had been unable to make an assessment. The CCO had emailed handover notes to senior practitioners in the team and left messages for the duty team to follow up. The duty social worker on 16 March 2015 noted that Nigel often attended the team base unannounced but had not done so and tried to contact him. When this was unsuccessful a call was made to Nigel's father, who said he had spoken to him on 13 March and he appeared slightly low. A decision was made to send him an appointment letter if he did not attend the team base in the next two days. On 17 March 2015, the Trust was contacted by police with the information that Nigel had died.

4.36 In our view Nigel was assessed and treated appropriately by psychiatric liaison staff at Royal Free Hospital, and there were clear arrangements in place to ensure he had access to support on discharge.

4.37 The internal investigation reviewed whether a more assertive approach to follow-up should have been taken after his discharge from Royal Free Hospital. The conclusion was that the care and treatment provided to him after discharge was reasonable, and there was evidence of a follow up plan for the CCO's leave.

4.38 We concur with this view; however, we note that the risk assessment was last updated on 8 March 2015. This updated risk assessment is not recorded as completed in the clinical record.

4.39 The Trust Clinical Risk Assessment and Management policy[30] requires the clinical risk assessment to be updated:

- Following a significant risk event.
- On transfer to another service (including discharge).
- As part of a CPA Review.
- At the discretion of staff.[31]

4.40 The two previous risk assessments were carried out in February 2014 and August 2014. These were both carried out to policy expectations in terms of timeliness, regarding the February 2014 incident of assault with Gary, and his CPA review of August 2014.

4.41 However, the February 2014 assessment recorded the altercation between Nigel and Gary but did not update the crisis plans or interventions. The completion of the risk assessment is not recorded in the clinical record. The records do note contact between the CCO and the property manager, a

[30] *CNWL Trust-wide Clinical Risk Assessment and Management Policy for all Mental Health and Allied Specialties (MHAS) clinical staff. December 2014, TW/00022/14-17b.*

[31] *CNWL Trustwide Clinical Risk Assessment and Management Policy, 6.3.4.*

Clinical Team meeting discussion, and a medical review on 25 February 2014.

4.42 The 8 August 2014 risk assessment was completed after his CPA review. This was a comprehensive review which included sections one and two.

The risks noted were:

- harm from others, harm to others or to property;
- harm through self-neglect; and
- high risk posed through substance misuse.

'None known' is recorded for:

- deliberate harm to self;
- risk to physical health;
- regular contact with children; and
- risk of harm to children.

The crisis plans and medium/long term plans are comprehensively completed, and it is noted that 'Nigel and the team share differing views regarding his mental health and medication administering. Nigel has agreed to keep on the medication; however, he does not acknowledge that it makes him well'.

4.43 In August 2014, the Bromley Screening Tool[32] and Glasgow Antipsychotic Side Effect Scale[33] were also completed, and the results of these were incorporated into discussion at the CPA review. Nigel's 'Glasgow' score was 27, which is evidence of 'moderate side effects'. Nigel complained of feeling drowsy with restlessness and shaky limbs at times, and regular uncontrollable movements of his face and body. A reduction of his depot medication was agreed, to start gradually with a reduction to flupentixol decanoate 150 mg every two weeks initially. He agreed to this with the agreement that should professionals notice a deterioration in his presentation, that he would resume the full dose. As discussed above/below (from paragraph 4.10) this was not acted upon, and he continued to receive the 160 mg.

4.44 A Bromley Screening Tool assessment was also carried out on 8 August 2014, and this showed that Nigel showed positive for drugs at screening and admitted taking substances. He said he had been using drugs since he was 16, and acknowledged it was a problem. The plan was to keep this under discussion with the CCO, attend Addaction, and discuss the possibility of a residential placement with Addaction.

4.45 In summary, the August 2014 risk assessments were completed thoroughly, and as required by policy. It is not clear why a new risk assessment was

[32] *Dual diagnosis screening: preliminary findings on the comparison of 50 clients attending community mental health services and 50 clients attending community substance misuse services. Manning et al 2009. Journal of Substance Use Volume 7, 2002 - Issue 4.*

[33] *Glasgow Antipsychotic Side Effect Scale, 2007.* https://mentalhealthpartnerships.com/resource/glasgow-antipsychotic-side-effect-scale/

started in March 2015. It was not recorded in the clinical records, as would be expected in the Clinical Risk Assessment and Management policy.

4.46 The risks noted were unchanged, in particular 'none known' to 'risk of deliberate harm to self'. Information about Nigel's overdose and admission to Royal Free Hospital was conveyed to the CCO on the same day, 5 March 2015. There were continued discussions between the psychiatric liaison team, CCO and BHTT about managing Nigel's risk to himself over the next few days, up to and after his discharge on 8 March 2015. It is clear that the risk assessment should have been updated with the information about his overdose and suicidal thoughts, however the services did attempt to provide him with follow up and support by BHTT and the CCO. As stated above, we consider that the input following his discharge was reasonable. However the expectations of the Clinical Risk Assessment policy were not followed, and although we do not consider that this had any direct influence on Nigel's death, we suggest there is a need for the Trust to provide assurance that the policy is implemented in Brent South CRT. See recommendation 5.

Family involvement

4.47 Nigel's family had lived abroad for several years, and it was difficult for them to visit the UK. Face to face contact with either Nigel or health professionals was infrequent latterly. His parents knew the CCO well and received regular telephone and email contact.

4.48 Given the distance it was difficult for Nigel's parents to feel they had any influence on his care, and they continued to worry about the Brent accommodation.

4.49 Our impression is that Nigel's parents would have liked to have seen a more assertive approach to Nigel's care, particularly about accommodation and medication. Nigel's CCO however notes that there were no concerns about his capacity, and he was adamant that he did not want to move to more supported accommodation.

4.50 Nigel's parents said they appreciated the efforts made by the CCO to maintain their involvement in Nigel's care.

Appropriateness of the temporary accommodation

4.51 Nigel had been housed in the temporary accommodation in which he died since 2010. He was moved there as an emergency in 2010 following an assault by his then flatmates when he was undergoing a relapse in his mental state. The house was situated on a busy road in Brent and was set up as a house of multiple occupancy,[34] with individual en-suite studio flats, with shared cooking facilities. The house was temporary accommodation provided to Brent Council by a private company.

[34] *A house is termed of multiple occupation (HMO) if both of the following apply: at least three tenants live there, forming more than one household; shared toilet, bathroom or kitchen facilities with other tenants.* https://www.gov.uk/private-renting/houses-in-multiple-occupation

4.52 There had been a decision made by Brent Council in the previous two years that people who were in temporary accommodation were no longer considered 'homeless' therefore the accommodation was no longer considered temporary. This meant that Nigel and others were not prioritised for local authority rental properties. The property was described informally as 'bed & breakfast' accommodation, and Nigel's parents were under the impression that breakfast would be provided. This aspect was clarified during the internal investigation because the family had explicitly asked about this.

4.53 The internal investigation noted that Nigel had been provided with support to seek alternative housing in 2011, 2012, 2013 and 2014. In late 2014 he was referred to a support worker specifically related to seeking accommodation. Nigel wanted to have private rented accommodation and was resistive to encouragement by the CCO to apply for supported accommodation. The CCO's view was that Nigel was struggling to look after himself in independent accommodation, although Nigel did not agree.

4.54 Private rental accommodation was not possible because either the landlords would not accept people on housing benefit, or a large deposit was required. In January 2015, the CCO referred Nigel to 'Start Plus', which was a local authority service that coordinates access to supported housing, floating support and moving to independent accommodation. Although Nigel expressed misgivings about this, he agreed for appointments to be arranged. As discussed earlier, several appointments were arranged in January and February, none of which Nigel attended.

4.55 We consider that the Brent South CRT was supporting Nigel to move on from the temporary accommodation. The question of how temporary accommodation was managed, and the changes made since the internal investigation, are discussed in Section 7 below.

4.56 In summary, we consider that while the accommodation was certainly unsuitable for vulnerable people with mental health issues, the team were attempting to source alternative accommodation for Nigel.

4.57 What should have occurred was a more considered multi agency approach to the illegal activity and drug use in the property, as discussed in Section 7 below.

5 Background, care, and treatment of Gary

Childhood and family background

5.1 Gary was 27 years old when he committed the homicide. He lived in temporary accommodation in Brent since being discharged from hospital in August 2013, until the homicide in March 2015. He had his own en-suite room and there were shared cooking facilities. He was unemployed and in receipt of welfare benefits.

5.2 Gary was born in London and is the eldest of four children: with two brothers and a sister. He did very well academically. He attended school in Maidenhead from 1998 to 2005 and obtained 12 GCSEs and three A-levels.

5.3 He then went to the University of East Anglia to study history. Gary's father noted that Gary was finding it really difficult to cope. At the end of his first year, his family noticed a significant change in his personality. Gary was very unhappy in his second year, was prescribed an antidepressant medication (citalopram) and at the end of that year decided to leave university. He lived at the family home from 2007 to 2008 and then moved to London to study Computer Science at Kings College. However, he missed some of these exams in January 2008 and failed his retakes. He lived at the family home for his second year and retook his exams, which he passed, but chose not to return to university.

5.4 In 2010, while living in the family home, Gary started an agricultural course at a nearby college. However, after failing his exams, he decided to leave. In 2011 Gary moved to a shared house in North London and started work at a contract research organisation working in the medicines research sector based at a North London hospital. He later moved into a flat (within the hospital grounds) where he lived by himself.

5.5 Following his return to work after the 2012 Christmas break, Gary became increasingly withdrawn and isolated. For example, he didn't always go to work, and rarely socialised or answered his phone. Gary's father noted that Gary declined several invitations to family events, which was very uncharacteristic as he had very much enjoyed family get-togethers.

5.6 He was working for this company when he was referred to Brent Home Treatment Team (BHTT) in March 2013.

Contact with police and criminal justice system

5.7 Gary had no history of contact with police or the criminal justice system until after his mental health deteriorated in 2013.

Date	Incident	Outcome
April 2013	Criminal damage to place of work – smashed windows, broke bottles, broken computer and made threats.	Bailed to appear in court.

Date	Incident	Outcome
April 2013	Allegation of sending threatening text messages to ex-boss.	No further police action.
May 2013	Charges of threats to kill dropped, but charges of criminal damage remain (£14,500).	Community order for 18 months, monitored by probation.
March 2015	Charged with homicide of Nigel.	Section 37 of the Mental Health Act along with a Section 41 restriction order.

Summary of mental health care

5.8 We have summarised Gary's mental health services contact between 2009 and 2014, and detailed the care provided from October 2014 to March 2015.

5.9 According to records Gary said he had suffered depression from the age of 19. Gary's father noted that when he was at Kings College, he was referred by the University GP for assessment of his mental health. He was given a diagnosis of attention deficit hyperactivity disorder (ADHD) by clinicians at Berkshire Healthcare NHS Foundation Trust in 2010. Methylphenidate[35] was then first prescribed by his GP in Berkshire.

5.10 Gary undertook a screening for educational support needs at Kings College and was referred for a psychology assessment of his learning needs.

Date	Service	Summary of involvement
July 2009	Private psychology report for Kings College, London	The psychology report from July 2009 recommended that Gary have access to learning support, and stated that he had a high intellectual ability, but had weaknesses in the way that he processed both auditory and visual information. It was suggested that he had dyslexia[36] and difficulties with concentration and attention.
2010	Community Mental Health Services in Windsor	Aged 23 Gary was referred by his GP to Community Mental Health services in Windsor. This appears to be as a result of an assessment by 'Qb Test'[37] which '*felt that Gary did fit the criteria for a diagnosis of*

[35] *Methylphenidate is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control and is used to treat the symptoms of attention deficit hyperactivity disorder.* https://bnf.nice.org.uk/drug/methylphenidate-hydrochloride.html

[36] *Dyslexia is a common learning difficulty that can cause problems with reading, writing, and spelling.* https://www.nhs.uk/conditions/dyslexia/

[37] *QbTest is an FDA-cleared device used for assessing the core symptoms of ADHD: hyperactivity, inattention, and impulsivity.* https://www.qbtech.com/qbtest

Date	Service	Summary of involvement
		ADHD and that he would benefit from a trial of medication'. A GP letter (December 2010) stated that the assessor was not specific about what kind of medication, and the GP requested that mental health services recommended what medication they would like the GP to prescribe and monitor.
November 2012	Berkshire Mental Health Services	A Berkshire mental health services letter in November 2012 to his London GP was sent in response to the new GP querying Gary's need for long term prescription of 'ritalin'.[38] The psychiatrist noted that they did not claim to be an expert in the treatment of ADHD, but recommended that Gary continue to receive it *'presuming that he still derives benefit from it'.* He was prescribed methylphenidate[39] 20 mg three times a day.
November 2012	Ealing Assessment Team, West London Mental Health Trust	Referred by his London GP to mental health services in Ealing, with a diagnosis of depression and ADHD, and he was prescribed citalopram[40] and methylphenidate 20 mg three times a day. The request was for local follow up as advised by the Berkshire psychiatrist. He did not attend appointments and care reverted to the GP.
February 2013	Ealing Assessment Team, West London Mental Health Trust	GP re-referred to Ealing Mental Health Services, which was followed up by a GP letter stating that Gary's father was very concerned about Gary's mental health. Reported to be delusional, telling people family members had been raped, injured his hand throwing crockery at a flatmate and withdrawn from family. Urgent assessment requested, which was forwarded to the Brent Assessment and Brief Treatment Team as he had recently moved.
March 2013	Brent Assessment and Brief	Brent Assessment and Brief Treatment Team initial assessment appointment. Presented

[38] *Ritalin is a brand name for methylphenidate.*

[39] *Methylphenidate is prescribed to treat the symptoms of attention deficit hyperactivity disorder.* https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/treatment/

[40] *Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor.* https://www.nhs.uk/medicines/citalopram/

Date	Service	Summary of involvement
	Treatment Team, CNWL	with delusional ideas, ideas of reference[41] and possible voices. Willing to engage with mental health services, referred to Early Intervention Team (EIS).
March 2013	Brent Assessment and Brief Treatment Team, CNWL	Did not attend, referred to BHTT because of his presentation, while awaiting assessment by EIS. Evidence of thought disorder, psychotic experiences, delayed speech, asking for hospital admission but agreed to home treatment. Assessed by BHTT doctor on 27 March 2013, passivity phenomenon, convinced his family had been sexually abused, extracampine hallucinations,[42] upset that his experiences may not be normal. Using cannabis and cocaine. Agreed to informal admission. Methylphenidate stopped at father's request. Between agreeing to an informal admission and going home to gather his possessions, Gary went to his workplace, smashed windows, broke a computer, threatened to kill others. Police were called. BHTT staff met Gary at his flat and escorted him to Shore ward, Park Royal Hospital.
April 2013	Shore ward, Park Royal Hospital.	Left the ward to go to shops on 3 April 2013. Ward staff called his father to ask if he knew where he was when he did not return. Father phoned later saying Gary may have thrown a brick through a window and may be driving dangerously. Information given to police. He was apprehended by the police at the Keele services on the M6. In custody in Stoke on Trent later that evening, he had damaged windows on his way driving North allegedly planning to kill his uncle. Brought back to London by police and assessed under the MHA 1983. Agreed to return, found not to be detainable under the MHA. On bail for damage caused. Accepted by EIS while an inpatient on Shore ward, then seen regularly by the EIS care coordinator.

[41] *Ideas of reference and delusions of reference describe the phenomenon of an individual experiencing innocuous events or mere coincidences and believing they have strong personal significance.* https://psychcentral.com/encyclopedia/ideas-of-reference/

[42] *A sensory experience of something that does not exist outside the mind, caused by various physical and mental disorders, or by reaction to certain toxic substances, and usually manifested as visual or auditory images.* https://www.thefreedictionary.com/extracampine+hallucination

Date	Service	Summary of involvement
April 2013	Caspian ward PICU, Park Royal Centre for Mental Health	Allegedly sent threatening messages to his ex-boss. It was judged that although he was compliant with medication, in view of the risk presented to others, and his lack of insight, he needed to be cared for in a secure environment (psychiatric intensive care unit or PICU). Detained on Section 2 MHA and transferred to Caspian Ward PICU 11 April 2013. Initial diagnosis unspecified nonorganic psychosis.
May 2013	Pine ward, Park Royal Centre for Mental Health	Section 2 MHA due to expire, initial plan to remain informally, however police required interview and heightened concerns about continuing risk, placed on Section 3 MHA 7 May 2013. Transferred to open ward (Pine) on 8 May 2013.
May 2013	Pine ward, Park Royal Centre for Mental Health	Disclosed to EIS CCO that he had been feeling suicidal, very worried about court appearance and experiencing mild tremor of his hands, possibly due to side effects of medication (olanzapine 20 mg and citalopram 20 mg). Placed on close observation and prescribed procyclidine to counter the side effects. Still feeling flat and hopeless, asking for methylphenidate, informed that the team are awaiting information from Maidenhead about his ADHD diagnosis. Parents attended ward round, very concerned about side effects (parkinsonism), querying ADHD diagnosis, and stating he seemed sedated now on zuclopenthixol depot. This was high dose antipsychotic therapy (combined doses of antipsychotics over 100% of the BNF maximum). Found with illicit substance (possibly cannabis) on two occasions which he readily handed to staff. Seen by police, cautioned and leave stopped.
June 2013	Pine ward, Park Royal Hospital	Pleaded guilty to four charges of criminal damage at Hendon Magistrates Court, transferred to Wood Green Crown Court for sentencing 29/7/13 due to the cost of the damages.
July 2013	Pine ward, Park Royal Hospital	Consultant wrote to EIS to start planning discharge and recommended a mental health order rather than a custodial sentence. Now

Date	Service	Summary of involvement
		denies any psychotic ideas, no longer believes his family have been harmed, no voices heard. Continuing on citalopram and olanzapine. Accommodation discussion started with EIS. Is bailed to Park Royal so cannot be discharged until this is resolved. No longer psychotic, more alert, parents say he is much better, but the diagnosis of ADHD was still uncertain. Discharged from Section 3. Court case adjourned on 29/7/13.
August 2013	Pine ward, Park Royal Hospital	Went missing from Pine ward, breach of bail conditions. Returned by police, UDS positive for cannabis, was visiting an ex-patient who was known to use cannabis. Positive UDS for cannabis a week later. 13/8/13 Crown Court sentenced to community supervision and mental health treatment order; probation officer allocated. Discharge plans to be finalised with EIS CCO. Accommodation allocated at private provider in Brent. Went on leave, assessed by BHTT before leave, and accepted. Discharged to care of EIS, CPA conducted 19/8/13. Accommodation regarded as temporary. Support worker allocated to assist with finding independent tenancy.
August 2013 to January 2014		Happy with current accommodation, seen by EIS CCO but did not attend (DNA) some appointments with CCO, MIND, support worker for employment and accommodation. Unkempt at times but appears mentally well. Asking for methylphenidate, feels it keeps him alert and he can be more organised and alert.
May 2014	Brent EIS, CNWL	CPA review, well kempt, no psychotic or depressive thoughts, partial insight as he believes it was a breakdown that is unlikely to recur if he stopped taking medication. Diagnosis F23.1 acute and transient psychotic disorder, F19 mental and behavioural disorders due to multiple drug use (cocaine, cannabis, and methylphenidate). Olanzapine 15 mg, citalopram 20 mg. Later in May seen by CCO, feeling paranoid that people think he is stupid. Discussed using alcohol and methylphenidate to cope with social situations, '*things have not been the same*'

Date	Service	Summary of involvement
		since stopping methylphenidate. Bank account issues mentioned, being investigated for fraud after allowing someone to deposit money in his account. Advised to go to citizens advice, and meeting support worker about housing.
June to July 2014	Brent EIS, CNWL	Feeling low in mood, asking for urgent medical review to ask consultant to prescribe methylphenidate. Seen for medical review, feeling unmotivated and struggling to organise his day. Olanzapine reduced to 10 mg, citalopram increased to 30 mg. CCO to monitor, refer for activities of daily living (ADL) skills assessment, employment specialist. Several DNA's July to September.
September 2014	Brent EIS, CNWL	Dishevelled, thoughts muddled and chaotic, motivation low, not attending to personal hygiene. Feeling hopeless but denied thoughts or plans of suicide. Bank account suspended because of the fraudulent deposits, and afraid he will be arrested. Agreed to try to develop daytime structure, attending football group. Still asking for methylphenidate, consultant agreed to discuss with ADHD specialist.

October 2014 to March 2015

5.11 In late September 2014, Gary came to see his EIS CCO with a list of his concerns. He was described as dishevelled, with long uncut hair and dirty clothing. He reported feeling generally well but with low mood and thinking his life was useless. He denied any thoughts of self-harm or suicide. He requested food vouchers and said he had been spending his benefit money on junk food and cigarettes. He asked for an advocate as he said he felt his requests to be prescribed methylphenidate were not being heard. He was adamant that without methylphenidate he was unable to enjoy life or do very much and planned to carry out some library research about ADHD.

5.12 Suggestions for daytime structured activity were made, such as the football group, but Gary felt unable to engage in other activities or look for employment without methylphenidate. It was agreed that methylphenidate would be discussed by the consultant at his next medical review. He was not seen again until late October, despite the CCO calling him and leaving messages to try to arrange attendance at the football group, and an employment fair. Gary did respond back with texts and calls; he had been visiting his parents and staying over so was unable to attend the suggested activities.

5.13 At the medical review on 22 October 2014, the consultant noted that Gary said he had stopped taking olanzapine 10 mg two months earlier but felt no better. He said he felt his memory and ability to focus his thoughts were better when he was on methylphenidate. He was being seen by the employment specialist, but he said he would like to look for work but finds it difficult to focus his thoughts and makes silly mistakes and was struggling to socialise. He was informed that his CCO would be leaving the service, and care coordinator 2 (CCO2) would be taking over temporarily.

5.14 The plan agreed was to continue citalopram 30 mg, discontinue olanzapine 10 mg, start amisulpride[43] 100 mg twice daily, and the CCO to monitor progress. The consultant agreed to '*discuss treatment of his adult ADHD with colleague who has a special interest in ADHD'*. There was no evidence that this was done, however.

5.15 Gary was not seen by CCO2 between this appointment in October 2014 and the next medical review on 4 December 2014. There is only one entry in November 2014, which was a call back to Gary after he left a message asking for a medication review. The notes give no explanation for this.

5.16 At the medical review on 4 December 2014 Gary said he was taking citalopram 30 mg but had some side effects (not listed). He said he had not collected any amisulpride because he did not currently have psychotic symptoms, just low mood. It was explained that the amisulpride prescription was to help with problems of motivation, not to treat psychotic symptoms. Gary agreed to provide a copy of the report confirming the diagnosis of adult ADHD from Berkshire, and an assessment was to be requested locally to confirm his ADHD diagnosis. Gary said he was spending a lot of time with family, and had difficulty concentrating and was tearful. He agreed to a six-week trial of amisulpride, then an assessment of the evidence to support a diagnosis of adult ADHD was planned, to decide whether treatment was appropriate.

5.17 At this review CCO2 noted that Gary appeared clean but unkempt. He reported low mood and passive suicidal ideas, but no plans or intent to act. It was noted that he '*denied homicidal ideation*', and said he was not taking cannabis, but he drinks alcohol occasionally. He spoke of hoping to attend college next year to do an IT course, but said he still finds concentration difficult. He did say he would still like to attend the football group, but despite this being arranged with the support worker several times, he has not been able to engage with this. He agreed to a re-referral to the support worker and to a confidence building group.

5.18 The support worker made contact by calling him and arranging to meet three times. Once Nigel answered Gary's phone and said Gary was not there. Gary later said that he does allow housemates to have his phone sometimes and it

[43] *Amisulpride is a selective dopamine receptor antagonist which is used to treat symptoms of schizophrenia.* https://bnf.nice.org.uk/drug/amisulpride.html

was not a problem. He decided to spend the Christmas holiday period at his parents' and agreed to meet the support worker soon (i.e. early January).

5.19 CCO2 attempted to call Gary on 14 January 2015 to arrange to meet. It was not possible to leave a message, so it was planned to keep trying, and to call his probation officer for an update.

5.20 Gary's father called CCO2 the same day expressing concern about Gary's mental state, said he had been solemn and withdrawn over Christmas and spent a lot of time in his room. The following day his father called again and said Gary had asked him not to collect him to take him home, and he was concerned that Gary seemed to have some delusional ideas which were reminiscent of his first breakdown. He was advised that CCO2 planned to go to the house to see Gary, and there was a medical review planned for 29 January 2015.

5.21 He was discussed in the EIS morning meeting on 16 January 2015. CCO2 had seen him the previous day (15 January 2015) and reported that he was drinking alcohol, not eating well and not taking medication regularly. His room was dirty and messy, and he said he wanted to move out of the accommodation. The plan was for a medical review on 29 January, CCO2 to see him, arrange with the property provider to arrange a deep clean of his room and explore moving to another property.

5.22 The property provider had agreed to arrange a deep clean. On 16 January 2015 Gary was seen by CCO2, he was noted to make better eye contact and rapport than at the previous meeting. Some poverty of speech[44] was observed, and he was still not attending to his personal hygiene. Gary reported feeling depressed, socially isolated and with low self-esteem. He gave verbal consent to share care information with his father. His father had suggested it may be helpful to transfer to Berkshire to be nearer to his family, and Gary said he would like to move. The plan was for CCO2 to monitor him weekly, to refer for confidence building and social support, help him to apply for a gym card, and attend the medical review on 29 January 2015.

5.23 CCO2 maintained contact by telephone, speaking to Gary on 19, 21, 23 and 27 January 2015, but did not see him. Gary reported that a DVD player had been taken from his room over the Christmas holidays, but he did not want to report it to the police. CCO2 discussed this with the property manager, who reported that it was possible that one of the other tenants whom Gary regarded as a friend may be involved. A request was made again by CCO2 to the property provider to move him from the Brent property.

5.24 Gary's mother attended the medical review with Gary and the consultant psychiatrist on 29 January 2015. Gary's mother reported that he was struggling to organise his day. She expressed her opinion that Gary did not have a diagnosis of ADHD, although he strongly believes it. It was agreed that Gary would forward the psychological assessment done in Berkshire

[44] *Poverty of speech is a general lack of additional, unprompted content seen in normal speech. As a symptom, it is commonly seen in patients suffering from schizophrenia, and is considered a negative symptom.*
https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_Psychiatry_Guide/787025/all/Thought_Disorder

regarding the diagnosis of ADHD and attend for a physical health check. It was agreed he would be referred for a further ADHD assessment at the specialist clinic when the report was received. Gary was keen to move to another property, and also to transfer to Berkshire.

5.25 Later that week Gary called CCO2 to say he was no longer sure about transferring to Berkshire, and it was agreed to discuss this with him further. He reported feeling unsafe in the property and it was agreed that locks would be changed, however it transpired that Gary had in fact given keys to a house mate, so he was charged for the changed locks.

5.26 CCO2 saw Gary on 12 February 2015 at the team base, for the first time since 16 January. He was well groomed and was much easier to engage, with better eye contact and warmer rapport. Tremor in his hands was noticed to be '*considerably less than before*', although tremor had not been mentioned in previous notes (first mention of tremor). He said he had been using cannabis and alcohol, though less than before, sleeping too much and only eating when he was hungry. He had spent the weekend at his parents and now confirmed he wished to transfer to Berkshire. The parent's approach to this was gathered by phone, and they were noted to be happy to support him if he wished to move.

5.27 Gary called CCO2 on 19 February 2015 to say he had been admitted to a hospital for two days after having a bad reaction to amisulpride. The CNWL notes do not record any details of this episode, or any efforts to find out more detail.

5.28 This reaction was discussed by CCO2 with the consultant psychiatrist on 20 February 2015, who confirmed that no changes were made to the medication on 29 January 2015. The consultant advised that Gary stop the amisulpride, and the GP was emailed to inform them of this. On the telephone Gary seemed well, he was helping his uncle with some painting and enjoying keeping busy. It was planned that a support worker would visit him at the accommodation on 27 February, a medical review to be done on 4 March 2015, and CCO2 to discuss in the EIS morning meeting.

5.29 At the home visit on 27 February 2015 Gary was pleasant and welcoming, however the flat was untidy, and his kitchen area was unhygienic. He was helped to clean up, and said that some of his stuff was missing, although there had not been a break in, but he had not given his keys to anyone.

5.30 This was discussed at the EIS morning meeting on 2 March 2015. It was noted that he was mentally stable, with no concerns, he had good personal hygiene, although concerned about missing items, and now said he does not want to transfer to Berkshire. The medical review was planned for 4 March 2015.

5.31 The EIS team consultant was unavailable for the medical review, so Gary was seen on 4 March by a speciality doctor from the team, accompanied by CCO2. Gary was alert and reactive and smiling appropriately. He confirmed that he had not been on any psychotic medication since being hospitalised after his reaction to amisulpride '*around 15 February'*, and he was not taking

citalopram regularly. He was reluctant to start any medication, saying his mood was the best it had been for some time. Gary said he had been out to a museum, helped his uncle with some painting and attended the football group. He said he was keeping his room tidy and sleeping well, his appetite was okay, and it was noted that he *'denied any suicidal or homicidal ideation'*.

5.32 It is noted that he denied worries or preoccupations though eventually admitted to some worries about a housemate who was also a service user (which was Nigel). He had previously allegedly punched Gary, who called the police, and he had called the police the previous night after there was a complaint about loud music. Gary said he felt intimidated by him and felt he could '*sort of'* interfere with his thoughts. Gary said he had accidentally opened a letter addressed to Nigel but had taped it up again. He was convinced these events were linked (and that Nigel was therefore responsible for his reaction to amisulpride) and was described as *'clearly preoccupied with the possibility'* (that the events were linked*)*. He denied that this was possibly a psychotic symptom. Gary said he had a small amount of cannabis earlier but had not used stimulants for some time.

5.33 He was reported to be pleased to be off antipsychotics, saying that amisulpride caused him to be sedated but had no other benefits. He minimised the severity of the length of time of his illness and his symptoms in 2013. He was able to identify early warning signs of psychosis as hearing voices and having paranoid thoughts such as being raped, although he accepted that his overvalued ideas are on the same psychotic spectrum. He also expressed concerns about other tenants borrowing money from him and borrowing property without returning items.

5.34 Gary was reluctant to restart antipsychotic medication, though said he appreciated that medication might be needed if he suffered a major relapse. Aripiprazole was suggested, as it is less likely to cause sedation and extra pyramidal[45] side effects. Gary struggled to make a decision, feeling that current or preventative antipsychotic treatments were unnecessary. He was reported to have said he had no suicidal or homicidal ideation. Reference was again made to checking whether the Berkshire reports had arrived, and if so to refer to the specialist clinic for an ADHD opinion.

5.35 The speciality doctor's summary was that Gary had early psychotic symptoms, with a high likelihood of relapse without antipsychotics especially if using cannabis. It was noted that he currently lacks insight but *'marginally retains capacity'.* A test of capacity was described in the notes, and the opinion was that he has capacity to consent to or refuse treatment. This determination was described as *'marginal and it would take only a small increase in illness risk level for [Gary] to lack capacity, if he continued to*

[45] *Extrapyramidal symptoms consist of: parkinsonian symptoms (including tremor), which may occur more commonly in adults or the elderly and may appear gradually; dystonia (abnormal face and body movements) and dyskinesia, which occur more commonly in children or young adults and appear after only a few doses; akathisia (restlessness), which characteristically occurs after large initial doses and may resemble an exacerbation of the condition being treated; tardive dyskinesia (rhythmic, involuntary movements of tongue, face, and jaw), which usually develops on long-term therapy or with high dosage, but it may develop on short-term treatment with low doses - short-lived tardive dyskinesia may occur after withdrawal of the drug.* https://bnf.nice.org.uk/treatment-summary/psychoses-and-related-disorders.html

refuse treatment'. There was no evidence of a detailed capacity assessment, or a plan for a formal review of capacity.

5.36 The plan was for Gary to meet with CCO2 on 12 March (eight days after this assessment), with regular CCO reviews every two weeks, blood tests and ECG forms given which Gary was to arrange with his GP. He was given information about aripiprazole to consider, advised to report thefts to the police, and not lend belongings or money. Risk was noted as *'currently low to self or others. Historical risk of violence when acutely psychotic'.*

5.37 It was noted '*may need to consider safeguarding referral re vulnerability to financial exploitation*'. There is no evidence of this being actioned, however. A further medical review was to be arranged for one month.

5.38 This plan was discussed in the EIS morning meeting on 5 March, it was noted he had had a dystonic[46] reaction, had stopped oral medication, and was likely to relapse. His father had reported he seemed perplexed. The plan was for *'close monitoring'.* There was no detail about the frequency or focus of '*close monitoring'*.

5.39 On 9 March 2015, CCO2 contacted the property manager and was told that Gary would be moving out of the Brent property by the end of that week. A telephone call was also made to his father about this and Gary's decision to decline antipsychotic medication, and to advise that CCO2 would telephone him weekly and see him fortnightly to monitor his mental state. An appointment was made to see the speciality doctor on 6 May 2015.

5.40 CCO2 saw Gary at the team base on 12 March 2015. He presented as *'elated but stable'*, had been spending time with family and been out more. He said he was keen to get back to work and would be approaching his former employer to enquire as he would like to get a job in the pharmaceutical industry again.

5.41 Gary was still keen to move, enquiries to the property manager were made, and it seemed that the previous request had not been communicated between the company staff, so no plans were in fact in progress. CCO2 asked for an update to be provided.

5.42 The next contact about Gary was a call from the police to inform the Trust that Gary was in custody having been arrested on suspicion of attempted murder of a tenant in the same house, later confirmed to be Nigel.

[46] *Dystonic reactions (i.e. dyskinesias) are characterised by intermittent spasmodic or sustained involuntary contractions of muscles in the face, neck, trunk, pelvis, extremities, and even the larynx.* https://www.ncbi.nlm.nih.gov/books/NBK531466/

6 Arising issues, comment and analysis – Gary

6.1 Analysis of Gary's care and treatment is provided below, using the headings of the detailed terms of reference. We have referenced the detailed findings of the internal investigation as part of this analysis.

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

6.2 Gary was cared for under the Trust Care Programme Approach (CPA) policy,[47] and because he had been admitted to hospital under Section 3 MHA, he was entitled to Section 117 MHA aftercare.[48] The expectation would be that he had a formal care plan, with planned multidisciplinary reviews at appropriate intervals.

6.3 We have discussed the individual issues below under the headings of care planning and NICE guidance. Medication is discussed in the relevant sections below.

6.4 A '*mental health core assessment*' document was completed as expected by the EIS CCO after Gary was referred in March 2013. This was started while he was an inpatient, which is good practice. The diagnosis was:

- F20.0 paranoid schizophrenia.
- F29 unspecified non-organic psychosis.
- The cluster identified was Cluster 10 - first episode psychosis.[49]

6.5 Gary was reported to state that he had suffered from ADHD for his whole life, being diagnosed at the age of 21. He started to take methylphenidate, use drugs and started to feel paranoid, and which escalated to having '*weird thoughts*' that he had been raped by certain people.

6.6 It was noted that he said he felt safe living at the Brent accommodation and outside, felt able to protect himself, but when he is paranoid he is less in control of his actions and more likely to put himself and others at risk. He was unable to identify any strengths, although he did say he could cook, but was not good at household chores, and struggled to do laundry or attend to his personal hygiene if his motivation was low.

6.7 At the CPA review of May 2014 Gary was noted to say he felt he had made a good recovery; he denied any depressive or psychotic symptoms and felt his thoughts were clear. Partial insight was noted in that he said he believed his breakdown was brief and unlikely to reoccur if he stopped taking medication. He was however able to identify his early warning signs, which were '*paranoid*

[47] *CNWL CPA policy January 2015, ref TW/00070/15-17a.*

[48] *Section 117 MHA obliges local Authorities and CCGs to provide aftercare if someone has been discharged from some sections of the MHA, including Section 3. https://www.legislation.gov.uk/ukpga/1983/20/section/117*

[49] *First Episode Psychosis: This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety or other behaviours. Drinking or drug -taking may be present but will not be the only problem. http://www.mednetconsult.co.uk/imhsec/index.php/clusters/psychosis/cluster-10*

and irrational thoughts, feeling irritable, low mood, not leaving the house, not communicating with friends, family or care team, hearing voices, strange thoughts, not attending to my personal hygiene, negative thoughts of suicide and self-harm'. The diagnosis was F23.1 acute & transient psychotic disorder, F19 mental & behavioural disorders due to multiple drug use (cocaine, cannabis, and methylphenidate). He was prescribed olanzapine 15 mg and citalopram 20 mg.

6.8 Gary was discharged from Park Royal Centre for Mental Health in August 2013 however the discharge letter appears to have been typed on 5 May 2014, and sent on 6 May 2014, nine months after his discharge. This letter contains a significant amount of typographical errors in relation to dates, with many occurrences attributed to dates in 2014, when he was in fact discharged in August 2013.

Recommendation 2
CNWL must ensure that there are clear standards for the accuracy, quality, and timeliness of discharge letters from Park Royal Centre for Mental Health, and that measures are in place to maintain these standards.

Care planning

6.9 A CPA review was held in May 2014, which is within policy expectations. The records show that there were no further CPA reviews planned. It would be expected that a CPA review meeting should have taken place in early 2015. None of Gary's family were invited to attend, which would be expected by the CPA policy.[50]

6.10 The internal report notes this omission but did not make a recommendation about it. The analysis noted that it is the CCO's responsibility to '*trigger and coordinate the medical and CPA review processes'* and lists the temporary care coordinator's (CCO2) high case load and team pressures as contributory factors. The focus of the recommendation made is on allowing time at MDT and morning meetings for discussion of patients including others who are not in the *'red zone'.*

6.11 We consider that the Trust should demonstrate that it is meeting policy expectations with respect to CPA reviews.

Recommendation 3
CNWL must demonstrate that the expectations of the Care Programme Approach policy with respect to regular timely documented CPA reviews are met, and there is a system in place to maintain these standards.

6.12 The care plan described at the CPA review in May 2014 included a reduction of olanzapine from 20 mg to 17.5 mg daily because he was feeling sedated. He also described feeling unmotivated, and the citalopram was maintained at 20 mg once daily, CCO to monitor progress, liaise with his family and help him

[50] *Carers' contributions must be recognised, carers must be involved wherever practicable and their own needs as carers must be assessed and supported. CNWL CPA policy January 2015, ref TW/00070/15-17a, p5.*

structure his day. The next medical review was to be in six weeks. It was noted that it was not recommended that he restarts methylphenidate, as this '*may precipitate a relapse of his psychotic disorder*'.

6.13 A physical health check was requested and carried out the following day, he was noted to be mildly overweight (BMI 26.2)[51] and with blood pressure in the normal range. He was given advice on exercise and healthy eating, and he asked for a referral for smoking cessation support and advised to discuss discount gym membership with his CCO.

6.14 He was referred by his CCO to an employment specialist, and to Brent 'MIND'[52] and the Recovery College.[53]

6.15 As noted below, it would be expected that a care plan for someone experiencing a first episode psychosis would include a significant amount of psycho-education about psychosis, the nature of the diagnosis and the need for a range of measures focussed on relapse prevention. There is no evidence of this in his community care plans or contacts.

6.16 There are references to encouraging him to attend healthy living groups such as the football group, and courses at the Recovery College. These appear to be in response to his expressions of his low motivation, rather than a service user focussed care plan which would encourage him to develop his thoughts and plans for the future.

6.17 The term 'dual diagnosis' is used to refer to a person with two conditions and having both mental health and substance misuse problems is an example of a dual diagnosis. The diagnosis ascribed to Gary in May 2014 clearly stated, *'acute and transient psychotic disorder*', and mental and behavioural disorders due to multiple drug use (cocaine, cannabis and methylphenidate), although it was stated that he was '*now abstinent'*.

6.18 There is a reference to him being offered support to access drug and alcohol services in 2013 when taken on by EIS, but he declined this intervention. A Bromley Screening tool was completed by the EIS CCO in May 2014. The form lists his stated alcohol consumption as '*5 or 6 units a week, 4 times weekly*', with a total alcohol score of 6. This was described as a 'positive' score. Gary's perception was recorded as he felt he did not have a problem with alcohol and only drinks occasionally with friends.

6.19 The questions about drug use ask, 'in the last 12 months has the service user used the following drugs?'

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[51] *Body mass index (BMI) is a measure that uses height and weight to work out if weight is healthy. For most adults, an ideal BMI is in the 18.5 to 24.9 range, below 18.5 – underweight range, between 18.5 and 24.9 – healthy weight range, between 25 and 29.9 – overweight range* https://www.nhs.uk/common-health-questions/lifestyle/what-is-the-body-mass-index-bmi/

[52] *Brent MIND is a charity delivering local mental health services.* https://www.bwwmind.org.uk/

[53] *CNWL Recovery & Wellbeing College has a range of educational courses, workshops, and resources available to people who use CNWL services or have been discharged from these services in the previous 12 months, their supporters (friends, family or carers) and CNWL staff.* https://www.cnwl.nhs.uk/recovery-college/

6.20 There follows a list of drugs of abuse, starting with cannabis. It is stated that he has not used cannabis in the previous 12 months. This is plainly untrue, as he admitted cannabis use as an inpatient, and tested positive for cannabis several times whilst an inpatient in Park Royal during late 2013.

6.21 All the other illicit drugs are marked as not used in the last 12 months, and the Bromley Screening Tool for drug use was negative, indicating no issues. Gary is noted to have said he had not used cannabis since his admission to hospital in January 2013. This is untrue, and furthermore he was admitted to hospital in March 2013, not January. There is no reference to previous concerns that he may be abusing or overusing methylphenidate.

6.22 There are no recorded care plans in relation to his abuse of cannabis, cocaine or methylphenidate. There is also no evidence base for the consultant psychiatrist' statement '*currently abstinent*' in May 2014, as this appears to be based purely on Gary's own report.

6.23 We are aware that the Trust no longer uses the Bromley Screening Tool and has introduced a new tool: 'Substance Use Frequency Amount Risk-Identification' (SUFARI)[54] which complies with NICE dual diagnosis guidance.

NICE guidance [55] and [56]

6.24 We have reviewed relevant sections of the expectations of NICE guidance, with reference to Gary's care and treatment:

'Psychosis and schizophrenia in adults: prevention and management', and 'Coexisting severe mental illness and substance misuse: community health and social care services.'

6.25 It is recognised that new NICE guidance[57] was issued in 2016 in relation to *'coexisting severe mental illness and substance misuse: community health and social care services'*, and Gary's care predates this guidance.

6.26 We have therefore not benchmarked Gary's care against the new guidance but suggest that the Trust ensures that care plans follow guidance where there is a presentation of coexisting severe mental illness and substance misuse.

Recommendation 4
NHS NW London CCG and CNWL must demonstrate that the guidance in 'Coexisting severe mental illness and substance misuse: community health and social care services (NICE 2016) is implemented in Brent EIS.

[54] *SUFARI: https://www.nice.org.uk/sharedlearning/sufari-a-substance-use-tool-for-mental-health-services*

[55] *Psychosis and schizophrenia in adults: prevention and management, NICE 2014. https://www.nice.org.uk/guidance/cg178/chapter/1-recommendations.*

[56] *Psychosis with coexisting substance misuse, Assessment and management in adults and young people. NICE 2011. https://pubmed.ncbi.nlm.nih.gov/23115814/*

[57] *Coexisting severe mental illness and substance misuse: community health and social care services. NICE 2016. https://www.nice.org.uk/guidance/ng58*

6.27 Below is a benchmarking review of Gary's care in relation to psychosis and schizophrenia in adults: prevention and management, NICE 2014.

Standards	Available to Gary
Service user experience	
Use this guideline in conjunction with service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • work in partnership with people with schizophrenia and their carers • offer help, treatment, and care in an atmosphere of hope and optimism • take time to build supportive and empathic relationships as an essential part of care.	No. Family not closely involved by the care team as inpatient or EIS. Lack of care coordinator continuity, limited face to face time with Gary.
Physical health	
People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	Yes.
If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see obesity [NICE clinical guideline 43], lipid modification [NICE clinical guideline 67] and preventing type 2 diabetes.	Not applicable.
Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.	Yes, although Gary said he did not need help to give up smoking.
Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.	Yes, carried out by the GP, but no evidence of team routine monitoring of results.
Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.	The Trust currently has developed over the last two years a physical healthcare oversight group chaired by the Executive Director of Nursing. Reports are received by the quality and

Standards	Available to Gary
	performance committee a sub-group of the board on a regular basis around the Trust's performance around cardio metabolic tests and interventions which is monitored at a Trust-wide level and Borough level and forms part of regular reporting to each of the divisions operational boards. Over recent months the Trust has developed a reporting system which allows teams now to log-on to "tableau" in order to seek their performance at a given time.
Support for carers	
Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.	Not offered.
Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.	Not offered.
Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. When providing information, offer the carer support if necessary.	Not offered.

Standards	Available to Gary
As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers and respects their individual needs and interdependence.	Yes.
Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.	Yes.
Offer a carer focussed education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should be available as needed, have a positive message about recovery.	Not offered.
Include carers in decision-making if the service user agrees.	Not routinely.
Peer support and self-management	
Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their whole team, and support and mentorship from experienced peer workers.	Not available at that time.
First episode psychosis	
Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis.	Yes.
People presenting to early intervention in psychosis services should be assessed without delay. If the service cannot provide urgent intervention for people in a crisis, refer the person to a crisis resolution and home treatment team (with support from early intervention in psychosis services). Referral may be from primary or secondary care (including other community services) or a self or carer-referral.	Yes.
Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational, and educational interventions for people with psychosis, consistent with this guideline.	No.
Consider extending the availability of early intervention in psychosis services beyond three years if the person has not made a stable recovery from psychosis or schizophrenia.	Not applicable.

Standards	Available to Gary
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	
Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it.	Yes.
Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.	Yes.
Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.	Yes.
If a person with psychosis or schizophrenia needs hospital care, think about the impact on the person, their carers, and other family members, especially if the inpatient unit is a long way from where they live. If hospital admission is unavoidable, ensure that the setting is suitable for the person's age, gender, and level of vulnerability, support their carers, and follow the recommendations in service user experience in adult mental health (NICE clinical guidance 136).	Yes.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer: • oral antipsychotic medication in conjunction with • psychological interventions (family intervention and individual CBT).	Yes. No.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment. Take into account the clinical response and side effects of the service user's current and previous medication.	Yes.
Offer CBT to all people with psychosis or schizophrenia. This can be started either during the acute phase or later, including in inpatient settings.	No.
Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings.	No.

Standards	Available to Gary
Consider offering arts therapies to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings.	No.
Behaviour that challenges	
Occasionally people with psychosis or schizophrenia pose an immediate risk to themselves or others during an acute episode and may need rapid tranquillisation. The management of immediate risk should follow the relevant NICE guidelines.	Yes.
Follow the recommendations in self-harm (NICE clinical guideline 16) when managing acts of self-harm in people with psychosis or schizophrenia.	Yes.
Psychological interventions	
Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described.	No.
Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described.	No.
Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms	No.
Pharmacological interventions	
The choice of drug should be influenced by the same criteria recommended for starting treatment.	No.
Do not use targeted, intermittent dosage maintenance strategies routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity.	Yes.
Consider offering depot/long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: • who would prefer such treatment after an acute episode? • where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.	No.
Using depot/long-acting injectable antipsychotic medication	
When initiating depot/long-acting injectable antipsychotic medication: • take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics)	Yes.

Standards	Available to Gary
• take into account the same criteria recommended for the use of oral antipsychotic medication, particularly in relation to the risks and benefits of the drug regimen • initially use a small test dose as set out in the BNF.	
Employment, education, and occupational activities	
Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.	No.
Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes	No.

6.28 The internal report made it clear that there were service problems in the EIS, and made two recommendations about the work of the EIS:

Recommendation 12:
A review and benchmarking exercise of the Brent EIS to be undertaken against demand, national guidelines, skill mix and other CNWL EIS teams with conclusions of the review to be presented to divisional management.

Recommendation 13:
The Brent EIS Operational Policy is to be updated in line with the exercise above and to meet National Guidance and commissioner contract standards.

6.29 We have therefore not made any recommendations in respect of treatment of psychosis, but we review the implementation of these recommendations in Section 7.

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

6.30 There is evidence of regular recording and updating of risk assessments in Gary's clinical record from 2013 to January 2015.

6.31 We have separated out risk assessment and plans regarding Gary's risk to self, risk from others and to others.

6.32 The most recent risk assessment before the homicide was conducted in January 2015. The risk domains are listed below with the entries made by the CCO on 19 January 2015, with commentary.

Risk domain: Has there ever been an event/period which resulted in:	Entry	Commentary
Harm or exploitation from others?	None known	Untrue - Gary had disclosed several times that he had money deposited in his account, had money and property borrowed off him and not paid back.
Harm to others or property?	Yes	True - previous threats and criminal damage.
Deliberate harm to self?	None known	True.
Harm to self through self-neglect?	Yes	True - neglecting his diet, environment, and personal hygiene.
High risk posed through substance misuse?	Yes	True - history of methylphenidate, cannabis and cocaine use.
Risk to physical health?	Yes	True - self-neglect as above, and use of drugs.
Regular contact with children under 18?	None known	Unknown, not assessed.
Risk of harm to children?	None known	Unknown, not assessed.

6.33 There is a section (Section 2) to record the detail of the risk issues and action taken to mitigate the risk. There are two entries:

1. *'Prior to hospital admission, circa 2013, [Gary] became violent and aggressive towards others and threatened to kill his uncle and then himself. He is currently showing negative symptoms of schizophrenia, is not eating well, and finding it difficult to motivate himself. During a recent visit to the accommodation, his room was in abject squalor. It was noted that he had not been taking his medication regularly, but he agreed to take it regularly from then onwards and has had more contact with the CCO and his parents. It was reported that having better nutritional intake and taking medication regularly had resulted in an improvement in his mood'.*

The outcome was noted as '*[Gary] has had more contact with his interim CCO, and his family have rallied round him during this episode*'.

2. *'He has been neglecting his personal care and ADLs. His landlord will now be organising a deep clean of his room, he will be referred over to secondary services to enable him to build his confidence and for support to manage his ADLs better. During a recent meeting [Gary] denied substance abuse, he is keen to get involved with all support services that will enable him to make a meaningful recovery'.*

The outcome was noted as *'[Gary] has agreed to take his medications as prescribed and is keen for all support from services to stay healthy and well*'.

6.34 The service user perspective noted that '[Gary]'s mood has improved with increased contact with services. He is keen to maintain this and has requested to be transferred back to Kent to be near his family'.

6.35 In Section 3 of the risk assessment there is a section for medium/long term risk and crisis management plans. These include a list of early warning signs, things that have been helpful in a crisis, things that have not been helpful in a crisis, things that have helped him to stay well, and his own and the team's role in keeping safe and managing risk.

6.36 The structure of this risk assessment document is intended to provide an overview, with detail of recent risks, how they have been managed, and a section for management plans.

6.37 The Trust Clinical Risk Assessment and Management Policy for Mental Health and Allied Specialties[58] clarifies how risk assessment forms should be completed, and how plans should be developed.

6.38 The risk assessment forms completed on 19 January 2015 lack detail of previous risks, such as his previous suicidal thoughts, the detail of his violence towards others in March 2013, his abuse of cannabis, cocaine and methylphenidate, and his disclosure of other people borrowing money and possessions without returning them, placing money in his account and being accused of fraud.

6.39 There is no formulation of an understanding of what precipitated these incidents, or how he could be supported to mitigate these risks. There are frank inaccuracies such as the reference to moving back to Kent (when his family lived in Berkshire), and recording harm or exploitation as '*unknown*'. A history of violence and aggression is referred to, with no detail, or reference to his conviction.

6.40 While there are detailed mitigation and crisis management plans, the focus of the mitigation plans were around keeping in contact with services, keeping himself healthy and taking prescribed medication. There is no proactive focus on educating him about his diagnosis, developing his understanding of the possible future course of his mental illness, and increasing his ability to keep himself well. The risk management plans do not acknowledge that Gary denied that he needed any help with substance abuse.

6.41 The Clinical Risk Assessment and Management Policy has a section (Appendix A) called 'monitoring compliance and effectiveness of this policy'. The elements to be monitored are staff training, compliance with authorised tools and timescales, and the review of risk assessment plans. The compliance clinical and review elements are to be monitored by quarterly *'spot check audits'* by the Clinical Safety Manager, which are reported on to the Clinical Safety Group, quarterly for compliance with authorised tools, and annually for the review of clinical risk assessments.

[58] *CNWL Clinical Risk Assessment and Management Policy for Mental Health and Allied Specialties, TW/00022/14-17b 2014.*

6.42 This was not identified as an issue in the internal investigation report.

Recommendation 5
CNWL should provide assurance that the clinical risk assessment policy is applied consistently in community teams and ensure there are systems in place to monitor its application.

Risk to self

6.43 There was no documented history of self-harm or suicidal ideation before Gary's admission to Park Royal Centre for Mental Health in 2013.

6.44 In May 2013 whilst an inpatient he disclosed that he had been feeling suicidal, and he was very worried about his upcoming court appearance. He was placed on close observations and this appeared to resolve over the following four weeks. Although he described thinking about hanging himself, there were no suicidal attempts made, and he said he did not want to die and had no intention of acting on these thoughts.

6.45 While suicidal ideas were not a continuing feature of his presentation, when living in the community he regularly reported passive suicidal thoughts with no intent. This was seen as part of an ongoing depressed mood, and low motivation due to negative symptoms of psychosis. He was prescribed citalopram, and the focus was on trying to encourage wellbeing, healthy living and occupation, which appeared reasonable.

Risk from others

6.46 The incident where Gary called the police in February 2014 because of an alleged assault by Nigel was noted, but not explored in any depth.

6.47 He also disclosed concerns about money being deposited in his bank account, discussed below from paragraph 6.59.

Risk to others

6.48 In June 2013 Gary pleaded guilty to four counts of criminal damage valued at £14,500 (on 27/03/13: damage to a car, 03/04/13: damage to two properties, 04/04/13: damage to an office building). Charges of threats to kill had been dropped. He was sentenced to 18 months Community Order and was seen at least monthly by a probation officer after that.

6.49 On 27 March 2013, after Gary had been seen and assessed as requiring admission to Park Royal, he went to his flat ostensibly to collect his belongings before being admitted informally. Gary went to his employer's offices and smashed windows with a spanner and broken bottles, broke a computer and threatened to kill people. According to Gary, he was distressed by the thought that he and his father had been raped by his boss, and his mother had been raped by another family member.

6.50 On 2 April 2013, he threw his laptop at the wall in his bedroom because he was upset by another patient pestering him.

6.51 On 3 April 2013 Gary asked to leave the ward to go to the shops, agreeing to return to the ward half an hour later. He did not return, and on 4 April 2013

police informed the ward that he had been arrested whilst driving near Stoke on Trent. He had apparently damaged three windows of a house and was driving north with the intention of killing his uncle. He was bailed to Shore ward, Park Royal.

6.52 There is no exploration of these actions in later clinical records. Reference is made to '*historical risk of violence when acutely psychotic*'. There is no reference made to later threats he made via text and by letter to his previous employers. It is acknowledged that there is no previous history of violence, but no attempt to understand the context in which the violence occurred, beyond him being psychotic.

6.53 The internal report acknowledged that the assessment made on 4 March 2015 did not take Gary's risk history into consideration. The internal report made a recommendation about this aspect; hence we have not made a recommendation in this regard but will review the implementation of this in Section 7.

Recommendation 6: (internal)
'Brent Mental Health Service to devise a system to ensure that any action recorded in a risk assessment or a core assessment is transferred to the care plan and clear steps for achievement of that action are recorded'.

6.54 The assessment on 4 March 2015 described Gary as '*marginally retains capacity'*. A test of capacity was described in the notes, but not detailed, and the opinion was that he had capacity to consent to or refuse treatment. This determination was described as '*marginal and it would take only a small increase in illness risk level for [Gary] to lack capacity, if he continued to refuse treatment'*. The risk assessment was not reviewed after this, and clear early warning signs of relapse were not taken into consideration. In particular his stated intention to approach his former employer about a job should have been seen as a potential risk, because Gary's previous threats and criminal damages were aimed at this workplace.

6.55 There should have been a clear plan developed to closely monitor his increasing relapse so that a service response could be mobilised to prevent further deterioration.

Appropriateness of the temporary accommodation

6.56 The internal report states that:

'The accommodation that [Nigel] and [Gary] shared was not ideal for either of them. There were different reasons for [Nigel] and [Gary] remaining in the temporary accommodation but it was clear that, while the accommodation may have been the only option at the point of discharge from hospital, it was not a particularly suitable long term option. The shortage of suitable accommodation in Brent (and across London) was acknowledged.'

6.57 There is no doubt that this was not suitable safe accommodation for either Nigel or Gary. In 2018 Gary told us that he was happy enough there, as he enjoyed the freedom he had. However, his parents recall him as very unhappy

there, and there are many clinical records referring to requests he made to move from the property.

6.58 We agree with the findings of the internal report in this aspect, and in our assurance review of the action plan, we have found that the way in which accommodation is accessed and 'bed & breakfast' accommodation is sourced has been positively transformed.

Actions taken following bank account being suspended

6.59 In May 2014 Gary disclosed to the CCO that he had been asked by some people (unnamed) for his bank details so they could deposit money for him. He repeated this to the CCO in September 2014, and Gary's understanding was that his bank account had been suspended and he was accused of fraud, which he was very worried about.

6.60 A possible safeguarding referral was discussed in March 2015 after Gary disclosed that others in the house were taking his property.

6.61 The internal investigation identified a number of occasions when it would have been reasonable to make a safeguarding referral, particularly in respect of other occupants of the house taking items or borrowing money.

6.62 A safeguarding referral should have been made at the time of Gary's disclosure about possible financial exploitation. The internal investigation made a recommendation about ensuring safeguarding systems are in place in the EIS to ensure compliance with policy.

6.63 We have reviewed actions taken against this recommendation (internal recommendation 7) and note that there is evidence of completeness and embeddedness. We have not therefore made a recommendation about this aspect.

ADHD diagnosis and management of methylphenidate prescription

6.64 Gary was assessed by an educational psychologist at Kings College in 2009, after presenting with concerns about learning needs. The psychology report from July 2009 recommended that Gary have access to learning support, and stated that he had a high intellectual ability, but had weaknesses in the way that he processed both auditory and visual information. It was suggested that he had dyslexia and difficulties with concentration and attention.

6.65 Following this Gary appears to have formed the belief that he must have ADHD and approached his GP to request a diagnosis and prescription. The GP referred him to mental health services provided by Berkshire Healthcare NHS Foundation Trust (BHFT) and he was seen by a community psychiatrist in June 2010. The psychiatrist did not consider that he fulfilled the criteria for an ADHD diagnosis on clinical interview. It was felt that he was depressed and would benefit from cognitive behaviour therapy and antidepressant medication. Gary asked to do a self-assessment and requested further tests.

6.66 At this time BHFT was not commissioned to diagnose and/or treat adult ADHD, however after discussion the local child and adolescent mental health

service agreed to offer Gary a structured assessment for ADHD. This 'Qb' Test showed that there were features of ADHD, and the consultant psychiatrist summarised this in a letter to the GP. The advice was to start medication, and review to see whether it was effective, and arrange for a further 'Qb' Test to assess efficacy.

6.67 There is no evidence that the diagnosis was reassessed, or that the effects of methylphenidate were ever objectively assessed by subsequent GP services.

6.68 It was noted at the BHTT referral assessment in March 2013 that Gary had been prescribed methylphenidate since 2010, apparently for a diagnosis of ADHD. There is reference to a GP referring him to a psychiatrist in Berkshire in 2011 regarding the methylphenidate prescription. It was noted that there was no further information available about previous prescriptions, and that Gary was known to abuse methylphenidate, but it is not clear where this information came from.

6.69 In 2012, Gary was prescribed methylphenidate 20 mg three times daily for ADHD via his GP in London. This prescription was continued when he was admitted to Shore ward in March 2013, but this was stopped after a few days to carry out a medication-free assessment, at the request of his father.

6.70 The prescription of methylphenidate was a frequent request made by Gary, during 2014 and early 2015. He requested advocacy support to attend his medical review because he thought his requests for methylphenidate were not being heard.

6.71 There are several entries where Gary has been asked by the EIS team to provide the psychology report which he said made the diagnosis of ADHD in 2009. This was not forthcoming until February 2015, when it was uploaded to Jade. There are no records of any discussion about this report, which in our view is insufficient support for a formal diagnosis of ADHD and the prescription of medication.

6.72 The medication review[59] carried out for the internal report in October 2015 notes that:

'The psychologist who authored the (2009) report advised that [Gary] had learning difficulties in line with dyslexia. The psychologist does not report a probable diagnosis of ADHD. From that limited report, methylphenidate as treatment for ADHD would not be indicated. Furthermore, methylphenidate (and other stimulants) can cause psychotic symptoms and there is a caution in use in those with psychiatric disorders.'

6.73 It was noted in several medical reviews that Gary should be referred to the Trust's specialist adult ADHD clinic when the Berkshire report was received. In our view this was a missed opportunity to clarify the diagnosis of ADHD

[59] *Medication history, October 2015. Advanced Specialist Pharmacist, St Charles Hospital.*

which was never fully explored. His current diagnosis (in 2018) does not include adult ADHD.

6.74 CNWL now has a specialist ADHD clinic, where referrals from GPs can be assessed, diagnosed, and have treatment initiated.

Recommendation 6
Commissioners of services (NHS NW London CCG and NHS East Berkshire CCG) must ensure that there are clear pathways for the diagnosis, medication prescription and management of ADHD in adults.

Risk management during Park Royal admission

6.75 Including whether a more restrictive regime was appropriate in light of acts of violence.

6.76 Both Gary and Nigel's parents were concerned about safety and the management of risk while they were each inpatient's in Park Royal.

6.77 Gary's parents were particularly concerned about the approach taken when he was offered voluntary admission in the first instance, and then later not detained under the MHA after going missing and engaging in threats and physical aggression.

6.78 These questions were addressed in detail in the internal investigation. At the time of the first suggestion of admission, there was no direct evidence of risk of harm to either Gary or others, and he had agreed to be admitted to hospital. After he committed the criminal damage, Gary was still agreeable to staying in hospital and taking medication, so was regarded as not detainable under the MHA. It was subsequently agreed that he could leave the ward unescorted, and he did not return. We do question the risk assessment that led to this decision. The internal investigation highlighted that Gary appeared calm and gave a reasonable reason for leaving the ward. He left at 15.40 and was called and later advised to return at 21.00. When he did not his parents were contacted. This arrangement did not in our view give sufficient weight to the risk he had recently posed to member of the public such as his employers. It was acknowledged however that the risk assessment was incomplete, and there was no explanation found for this.

6.79 During the authorised leave, he threw a brick through a window and was found driving dangerously. He was allegedly planning to kill an uncle and sent threatening messages to his ex-employer. He was assessed for detention under the MHA and found not to be detainable. We have not been able to review the reports made at the time, however.

6.80 We note later however that the focus of decision making about detention became less about Gary's own agreement to stay in hospital, and more about insight and the management of risk. It was judged that although he was compliant with medication, in view of the risk presented to others and his lack of insight, he needed to be cared for in a secure environment (psychiatric intensive care unit or PICU), and he was detained under Section 2 MHA.

6.81 As part of this investigation we visited Park Royal inpatient units to review how risks and challenges are managed within the current ward environments.

6.82 At Park Royal Centre for Mental Health there has been a substantial programme of redesign and refurbishment, which was still in progress in February 2019. It is of note that the CQC inspection report of June 2019[60] rated the Trust as 'good' across the domains of effective, safe, responsive, and well led, with caring rated as 'outstanding'. The service is part of the Accreditation for Inpatient Mental Health Services[61] (AIMS) quality network and has a number of associated quality improvement projects.

6.83 Pine ward had a quality improvement project entitled 'TWIST[62]', which focussed on patient safety, aiming to reduce restrictive practices by 50% by May 2018. This was achieved by involving carers, patients, and staff; and focussing on clinical leadership, the quality of care, and staff wellbeing. A number of monitoring tools to measure outcomes are in place such as carers feedback forums, patient community meetings, complaints data, audit results, and staff surveys. This project won a Trust quality improvement award in 2018.[63]

6.84 A number of improvements have been established in the areas of design and structure, risk management, safeguarding and medication, and housing.

6.85 Design and structure:

- Wards have been redesigned to provide individual en-suite bedrooms, replacing four-bed dormitories, with no mixed-sex areas. The bed numbers on each admission ward has reduced, and Shore ward provides a triage service for all admissions.
- Each ward has designated indoor and outdoor space, and there is CCTV in all corridor areas. Night and day staffing figures have been increased, with increased numbers of nursing team leaders.
- Doors, locks, and double doors have all been redesigned, incorporating feedback from the police about risk areas in relation to absconding. External windows are no longer accessible to decrease the likelihood of illicit substances being passed in.
- In 2013/2014 there were weekly ward rounds on each ward to review and plan patient care. In 2019 the systems have been changed to ensure regular reviews and information sharing. The Trust has adopted the 'red to green' system which endeavours to make every day of a hospital admission productive and a step towards recovery and discharge.
- There is a daily handover meeting where incidents and reviews are discussed, and there is a daily multidisciplinary (MDT) meeting. A

[60] https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ0605.pdf

[61] *Accreditation for Inpatient Mental Health Services.* https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/assessment-and-triage-wards-AIMS

[62] *TWIST: 'team working is safer together'*

[63] https://www.cnwl.nhs.uk/news/pine-ward-wins-project-year-award-quality-improvement-project-twist/

representative from the community mental health team and crisis resolution home treatment team attends daily.

- The progress of recovery towards discharge is discussed every week, and there is a weekly 'cases of concern' meeting to discuss reasons why discharges cannot occur if a patient is ready. A weekly bed management meeting reviews all beds available, and there is a bed management team on daily duty to manage beds across London.

6.86 Risk management, safeguarding and medication

- There is a safeguarding adults (SGA) champion nominated in each service, with positive links to Brent Local Authority Safeguarding Team, and the CCG Safeguarding Team. The SGA champion for Park Royal attends morning meetings and clinical reviews where required. All SGA alerts are discussed with the SGA champion, who can also advise on safeguarding queries.
- Links to police have also been formally established, and there is CNWL representation on local multiagency structures such as CHANNEL,[64] PREVENT[65] and addressing County Lines.
- A project to increase awareness of risk and sexual safety has been completed, educating patients and staff about how to recognise and reduce risk. A leaflet is available for patients advising on how to keep themselves safe, and how staff can help.
- Figures for absconding have reduced, and there is a focussed approach to the abuse of illicit drugs on the wards. At admission, all patients are asked to have drug screens, and these are then care planned. There are planned drug detection dog visits. A drug and alcohol worker attends the wards each week and there is Trust-wide development work on the assessments for substance misuse.
- All prescribing in the community areas is now done on the electronic clinical record system. Paper systems are still in use in the inpatient areas, but there is a system for uploading these onto the electronic patient record.
- At admission there is an MDT task assigned to pharmacy to review and reconcile all medication. Within 24 hours contact is made with the patient's GP to check what has been prescribed. At discharge, medication prescription is included in the GP letter, and reviewed as part of the seven day follow up.
- Pharmacists are part of the MDT and are available to carry out education sessions with patients and families.

6.87 Housing

[64] *Channel is part of the Prevent strategy. The process is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism.* https://www.gov.uk/government/publications/channel-guidance

[65] *Prevent Strategy is about safeguarding people and communities from the threat of terrorism. Prevent is one of the four elements of CONTEST, the Government's counter-terrorism strategy.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf

- There are no longer any direct placements from the wards to the private housing provider which was previously used. A Local Authority housing officer attends the weekly MDT discharge planning meeting, and there is a weekly contact with the discharge coordinator and bed manager.
- Local authority housing processes are used to assess and make decisions about any housing needs, if a private provider is identified as appropriate, face to face assessment is arranged with the provider, patient and ward staff. This ensures that there is flexibility within the system to cater for vulnerability and complex needs, and patients' rights in terms of housing are looked after. There is a twice weekly clinic provided by the Citizens Advice Bureau which is available for patients.

6.88 We consider that the Trust can evidence that there is a system-wide focus on clinical leadership, which has demonstrated improvements in patient safety and experience in the Park Royal ward areas.

Medication regime

6.89 This section reflects concerns raised by Gary's family about aspects of his medication prescribing, including prescribing of methylphenidate, risk from being given both amisulpride and citalopram, and changes in dosage of antipsychotic medication. The Trust was unable to locate Gary's prescription charts to support this part of the investigation. We have therefore referenced what medication history there is in reports, and in the pharmacy summary prepared for the internal investigation.

6.90 In 2010, Gary was prescribed methylphenidate 20 mg three times daily for ADHD via his GP following assessment by Berkshire Mental Health Services. Gary was also prescribed citalopram for five months around this time at an unknown dose for low mood. He was referred by his GP to Brent Mental Health Services for an opinion as to whether methylphenidate should be continued since he had moved to London.

6.91 In March 2013, Gary was admitted to Shore ward, Park Royal. Aripiprazole was started for psychotic symptoms alongside his regular methylphenidate which was continued. Both medicines were taken for a few days then stopped as a plan to assess mental state without any medication. The working diagnosis at the time was psychosis secondary to methylphenidate. Methylphenidate was stopped after Gary's father expressed concerns.

6.92 Gary was thought to be experiencing a psychotic episode and so olanzapine was started on 5 April 2013 and titrated gradually up to 20 mg/day, the maximum dose. During the titration no adverse effects were reported and his psychotic experiences were reducing. Gary was also started on citalopram 10mg/day for low mood with symptoms of moderate depression on 2 May 2013. This was increased a week later to 20 mg/day, the minimum effective dose.

6.93 On the 13 May 2013, the MDT reported concerns around possible compliance problems at the point of discharge, and due to the risks to others which had presented when he was psychotic, a depot preparation was considered. A test dose of 100 mg zuclopenthixol decanoate was administered to check for

possible adverse effects, with a plan to switch from olanzapine to the zuclopenthixol decanoate gradually. There was no adverse reaction to the test dose after one week, so a regular depot treatment was started at 200 mg weekly. Olanzapine was continued as the dose of depot was titrated giving high dose antipsychotic therapy (combined doses of antipsychotics over 100% of the BNF maximum).

6.94 After two weeks, some tremor was noted on examination and Gary's father reported rigidity and drooling to the MDT, which are possible side effects of high dose antipsychotics. The plan for depot seems to have been stopped at this point without explanation and olanzapine monotherapy continued at 20 mg/day. Citalopram continued at 20 mg/day.

6.95 Gary's medication regimen remained unchanged during the remainder of his admission and he was discharged from the ward on 20 August 2013 on olanzapine 20 mg/day, citalopram 20 mg/day and nicotine patches for a smoking cessation attempt. No side effects were reported on discharge and Gary was reportedly happy to take medication.

6.96 From August 2013 to May 2014, Gary's medication remained as olanzapine 20 mg/day and citalopram 20 mg/day. His CCO asked about side effects and none were present other than a report of mild weight gain in January 2014. He also generally reported good compliance with his medicines at each appointment. He occasionally asked about having methylphenidate restarted to help with his focus and attention, but the EIS consultant after due consideration declined this request since it was thought this could exacerbate his psychosis.

6.97 At a CPA review on the 7 May 2014, Gary admitted to the doctor that he tried stopping medication in December 2013, although records at this time report than he was compliant. It was felt that he was mildly sedated and so olanzapine was reduced to 15 mg/day. Citalopram continued at 20 mg/day.

6.98 At a consultant review on 21 July 2014 olanzapine was reduced to 10mg/day and citalopram increased to 30 mg/day. This was because Gary reported feeling demotivated. The consultant reported fair compliance with his medicines with some mild weight gain.

6.99 Between this appointment and the next on 22 October 2014, Gary reported 'good concordance with no side-effects'. The MDT reported some muddled thoughts, but he seemed generally well.

6.100 On 22 October 2014 at a consultant appointment, Gary reported that he stopped his olanzapine in August, and he felt no better having stopped this. Amisulpride 100 mg twice daily was started at this point. However, in December 2014, Gary reported that he had not started taking the amisulpride since he feels he was not having any psychotic experiences at that time. It was explained that the amisulpride prescription was to help with problems of motivation, not to treat psychotic symptoms. We question this statement, as amisulpride is clearly prescribed to treat psychosis. However, he agreed a trial of amisulpride 100 mg twice daily for six weeks. Citalopram continued at 30 mg/day and Gary reported he was taking this.

6.101 In January 2015, there are reports from his father that Gary was not taking his medicines regularly, but Gary confirmed that he was taking amisulpride on the 16 January 2015. Gary informed the team that he would continue to take medication. There is no evidence that any efforts were made to consider any ways of objectively checking whether Gary was taking medication, for example checking if he was collecting his prescriptions.

6.102 In February 2015, Gary reported to the MDT that he was smoking cannabis more regularly and drinking alcohol but *'less than before'.*

6.103 On the 19 February 2015 Gary reported to CCO2 that he was admitted to hospital for two days following a bad reaction to amisulpride which was later found out to be an acute dystonia,[66] which gradually built up from jaw tension and teeth grinding. There is no further information in the clinical record about this episode. Gary's father reported to the internal investigation team that he had been treated with anticholinergic medication, he was kept in for four days and discharged with no antipsychotic medication.

6.104 On the 24 February 2015, Gary was advised to stop amisulpride due to this episode by CCO2, following a consultation with the consultant. CCO2 noted that advice was awaited about alternative medication from his consultant psychiatrist.

6.105 On the 4 March 2015, a medical review reported that Gary had stopped his amisulpride due to the adverse reaction. Citalopram 30 mg/day was still being prescribed but poor compliance was noted. An alternative to amisulpride was discussed, but Gary refused aripiprazole and was deemed to have capacity at this point although it was noted that this was *'only marginal'*. There was no medical review arranged to reconsider prescribing medication, or revisit Gary's capacity to consent or refuse medication.

Discussion

6.106 The responses to Gary's family's detailed queries have been prepared by Professor Taylor and are presented below as a table.

Family concern	Comment
The prescribing of methylphenidate caused psychosis.	This is conceivable but impossible to confirm or otherwise. The therapeutic use of methylphenidate does increase the risk of psychosis but only to a very small extent.[67] Misuse of high doses has a greater risk.[68]

[66] *Dystonia is a medical term for a range of movement disorders that cause muscle spasms and contractions. https://www.nhs.uk/conditions/dystonia/#:~:text=Symptoms%20of%20dystonia%20include%3A,shaking%20(tremors).*

[67] *Moran LV, Ongur D, Hsu J, Castro VM, Perlis RH, Schneeweiss S. Psychosis with Methylphenidate or Amphetamine in Patients with ADHD. N Engl J Med 2019; 380(12): 1128-38.*

[68] *Spensley J, Rockwell DA. Psychosis during methylphenidate abuse. N Engl J Med 1972; 286(16): 880-1.*

Family concern	Comment
There is no clear explanation for the co-prescription of methylphenidate and aripiprazole.	This combination defies explanation although I have seen it on occasion. Methylphenidate should probably have been stopped immediately, although it is unlikely that any harm was caused by the combination.
There is no explanation for the use of depot zuclopenthixol* which caused "tardive dyskinesia". *May have been flupenthixol although the dose suggests to me that it was zuclopenthixol.	This does seem odd but there were concerns about adherence. Adverse effects were unlikely to be tardive phenomena. The co-prescription of olanzapine meant high total doses were being used. Zuclopenthixol would not often be used now.
An abrupt switch from olanzapine to amisulpride may have precipitated a psychotic episode.	This is more likely than not: abrupt cessation of antipsychotics often leads to relapse.[69] [70]
Amisulpride caused acute dystonia.	This is more likely than not. (Note that this was not tardive dystonia, but acute dystonia.)
The co-prescribing of amisulpride and citalopram put the life of Gary at risk.	Any increase in risk would have been miniscule but perhaps only aripiprazole could have been safely used in this respect and even this drug is now known to have problems. Citalopram does not seem to increase the risk of sudden death.[71] Amisulpride seems to be dangerous only in overdose.[72]
Gary was given dangerous and unpredictable polypharmacy.	It was probably not dangerous and was (and is) normal practice.
The olanzapine dosing regimen was dangerous.	The dose was normal. The explanation for the danger presented is not entirely correct.

[69] *Winton-Brown TT, Elanjithara T, Power P, Coentre R, Blanco-Polaina P, McGuire P. Five-fold increased risk of relapse following breaks in antipsychotic treatment of first episode psychosis. Schizophr Res 2017; 179: 50-6.*

[70] *Viguera AC, Baldessarini RJ, Hegarty JD, van Kammen DP, Tohen M. Clinical risk following abrupt and gradual withdrawal of maintenance neuroleptic treatment. Arch Gen Psychiatry 1997; 54(1): 49-55.*

[71] *Ray WA, Chung CP, Murray KT, Hall K, Stein CM. High-Dose Citalopram and Escitalopram and the Risk of Out-of-Hospital Death. J Clin Psychiatry 2017; 78(2): 190-5.*

[72] *Lynch MJ, Woods J, George N, Gerostamoulos D. Fatality due to amisulpride toxicity: a case report. Med Sci Law 2008; 48(2): 173-7.*

6.107 Gary requested to stop olanzapine, and the initiation of amisulpride seemed to be indicated for treating the negative symptoms of his schizophrenia.

6.108 Amisulpride can cause dystonia although this is reported as occurring at a low incidence, so the acute dystonia is unusual, but did respond to appropriate treatment at the acute hospital. The symptoms Gary described of jaw tension and grinding teeth could all be manifestations of dystonia, part of extrapyramidal side effects more commonly seen with older antipsychotics, such as amisulpride.

6.109 The alternative antipsychotic that was suggested after the adverse reaction to amisulpride was aripiprazole which has a low propensity for extrapyramidal side effects and sedation. This appears to be a suitable choice. Alternatively, restarting olanzapine at a lower dose of 10 mg/day could have been a suggestion since Gary had previously tolerated this and also had a good response to the medicine. Olanzapine also has a low propensity to cause extrapyramidal side effects, but sedation is reported with it.

6.110 Gary had disclosed to the EIS several times that he had not taken medication as prescribed or had stopped it once it had been prescribed. In our view it is clear that Gary did not accept, or possibly understand, the need for him to take regular antipsychotic medication. There was insufficient effort made by services to provide the appropriate psychoeducation to support him with this aspect.

6.111 We also consider that there was a lack of an evidence-based approach to prescription, both for methylphenidate and antipsychotics. See our recommendations 1 and 6.

6.112 When he was noted to be at risk of relapse in March 2015, there was no formal assessment of capacity recorded, and no plan made to revisit his apparent capacity to consent. All adults are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise.[73] Gary 's capacity was described as *'marginal'* and should have been subject to formal review.

Recommendation 7
Where there is a question of capacity to consent to treatment, CNWL must ensure there is a structured process used to assess and record capacity, with action plans as appropriate.

[73] *Assessing capacity-consent to treatment* https://www.nhs.uk/conditions/consent-to-treatment/capacity/

7 CNWL Internal investigation and action plan

7.1 The terms of reference require us to:

- *Review the Trust's internal investigation and assess the adequacy of its findings, recommendations, and action plan.*
- *Review the progress that the Trust has made in implementing the action plan.*
- *Review any other serious incidents at the temporary accommodation.*

7.2 The internal report is termed 'Panel of Inquiry Internal Investigation Report', which was convened by the Executive Director of Nursing, on behalf of CNWL Trust Board, as a 'comprehensive internal investigation'. The report was completed on 1 April 2016 and signed off on 4 April 2016 by the Executive Director of Nursing. This was well outside the expected timeframe of 60 days, and the extension to the timeframe was agreed by NHS Harrow Clinical Commissioning CCG at the time (now part of NWL CCGs).

7.3 The investigation panel was comprised of a:

- Non-Executive Director (Chair).
- Divisional Director of Nursing.
- Divisional Medical Director.
- Service Manager (from another service).
- Serious Incidents Manager.

7.4 The report reviewed all the care and treatment provided to Gary and Nigel and focussed in detail on the six months before Nigel's death.

7.5 The action plan was signed off by the Jameson Director of Nursing in August 2018.

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

7.6 The report is a well-constructed and detailed report, which evidences the use of root cause analysis techniques. It contains a frank analysis of care and service delivery problems, and contributory factors. 16 recommendations were made to address these, which were accepted by the Trust. The internal investigation has reviewed the care and treatment for both Nigel and Gary in considerable detail, incorporating both family's comments and concerns.

7.7 The report identifies several care delivery problems, three for Nigel and seven for Gary. The report identifies four significant contributory factors – safeguarding, housing, resources, and communication, but has not identified these as part of service delivery problems.

7.8 There were two fixed recommendations and 16 specific recommendations.

7.9 We consider that the internal recommendations were met in full, and additional questions tabled by both families were incorporated and answered comprehensively.

7.10 We have applied our standard approach to assessing the quality of RCA investigation reports, which evaluated the guidance available and constructed 25 standards for assessing the quality of serious incident reports based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice.

7.11 We have graded this report as 23 out of 25, the detail of which is provided in full at Appendix C. The two standards not met were:

- completed in 60 days; and
- recommendations are measurable and outcome focussed.

7.12 The reasons for the extension to time have not been properly explained in the report. The panel did not meet until June 2015, and this delay to starting is not explained.

7.13 As is usual Trust practice, a Serious Incident Investigator was allocated, with a Non Executive Director panel chair, and subject matter experts from another directorate were appointed to assist. These were a Medical Director, Director of Nursing and a Service Manager, none of whom worked in the geographical area.

7.14 The report is described as a comprehensive internal investigation, which is a 'Level 2' investigation according to the expectations of the NHS England serious incident framework (SiF 2015). A Level 2 investigation is expected where there are '*complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable'*.

7.15 We agree that this is the appropriate level for this internal investigation. The NHSE SiF describes three levels of investigation, while within the CNWL Incidents and Serious Incidents policy (2016)[74] there are in fact four levels of investigation. The policy describes an internal investigation termed a 'panel of inquiry', which should be chaired by a Non-Executive Director, and cover incidents such as homicides, serious case reviews and high-level serious incidents. This appears to be a very sensible approach, indicating the extra degree of internal scrutiny required for the most serious incidents.

7.16 The internal investigation was carried out with the following objectives:

- To evaluate the care and treatment of patients [Gary] and [Nigel].
- To assess the adequacy of that care and treatment.
- To complete an investigation report for presentation to Central & North West London (CNWL) NHS Foundation Trust Board within agreed timeframes.

[74] *CNWL INCIDENTS AND SERIOUS INCIDENTS POLICY, TW/00009/16-18f, 2016.*

7.17 This was to be achieved through:

- Involving the families of both patients and as fully as is considered appropriate and involving [Gary] as is considered appropriate.
- A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident.
- An examination of the mental health services (including provision under the Care Programme Approach and review of assessments and care planning) provided to patients [Gary] and [Nigel] including review of the relevant documents.
- Examination of the extent to which both patients' care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies.
- Examination of the appropriateness and quality the mental health services.
- Consideration of the effectiveness of interagency working, with particular reference to the sharing of information between mental health services and other agencies, including the police, relevant local authority, and voluntary/private sector.
- Consideration of the risk that was posed to others and management of that risk.
- Consideration of other such matters as the public interest may require.
- Consideration of learning from previous incidents which may be applicable to this investigation.

7.18 The panel met for the first time in June 2015, two months after the homicide. At the end of June, the police informed CNWL that any investigation was not permitted until completion of the criminal investigation. In September 2015, once the criminal trial was concluded, the police indicated that the CNWL investigation could proceed without restrictions.

7.19 According to the SiF, 'there is no automatic bar on investigating incidents where criminal proceedings are underway. Wherever possible, serious incident investigations should continue alongside criminal proceedings. This should be considered in discussion with the police. Following a formal request by the police, a coroner or a judge, the investigation may be put on hold, as it may potentially prejudice a criminal investigation and subsequent proceedings (if any). Where this is the case, commissioners should review/agree the date for completion once the investigation can recommence'. While it may be possible to negotiate with the police in these cases, the decision was made with NHS NWL CCG to await the outcome of the criminal process, and the timeframe adjusted accordingly, which is acceptable practice.

7.20 Gary's father told the Trust that he would be unhappy for the investigation to be concluded without the panel viewing transcripts of the trial. The transcripts were sought and received in January 2016. Gary's father also provided written information for the investigation which the panel received in February 2016.

7.21 There is a comprehensive list of documents reviewed by the panel. Staff interviews and statements taken are provided as an appendix to the report, and these cover the Community Recovery Team (CRT/CMHT) and EIS, but

there does not appear to have been interviews conducted with inpatient staff. The report focusses in detail on the six months before Nigel's death, so it appears reasonable that the previous periods of psychiatric inpatient care some months before this were not included. Court transcripts were reviewed, and pharmacist was requested to carry out a medication review.

7.22 A list of other communications carried out is provided, which includes the property management company, police, both families, Hundred Families,[75] the probation officer for Gary.

7.23 A medicines review for both patients was undertaken by a pharmacist.

7.24 Information was sought from both patients' GP's; this request was followed up several times although no information was received.

7.25 Contributory factors have been identified in the recommendations; however, the underlying issues are not examined. For instance, the inability of the Brent EIS to provide a service that meets national guidance was identified as an 'ongoing issue', however there is no exploration of why this is the case. There were further detailed care delivery problems identified for each service user:

Nigel: *Risk and safety* *Housing* *Medication*
Gary: *Risk assessment* *Forensic assessment* *Safeguarding* *Housing* *EIS service provision and communication* *Handover* *Access to CBT*

7.26 Each of these is examined using the heading of contributory factors, but again these are listed rather than analysed.

7.27 Care delivery problems are where an incorrect/inappropriate act or omission has occurred during the process of direct care delivery, for example if a nurse does not give prescribed medication. A service delivery problem is where the way that a service is designed or delivered has resulted in an incorrect act or omission that is not direct care delivery, for example if a policy excludes a patient from accessing a service.[76]

7.28 We consider that there were a mixture of care and service delivery problems identified, however despite this, for those which we would consider service

[75] *Hundred families are a national charity offering specialist help, support, and advocacy to those affected by homicides committed by people with serious mental illness.* http://www.hundredfamilies.org/

[76] https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

delivery problems, recommendations have been appropriately made to address systems.

7.29 Recommendations were made following each individual service user's identified contributory factors, making the report easy to follow in a logical sequence.

7.30 The report is clearly written, and links recommendations to findings which are in turn linked to a thorough analysis of Gary and Nigel's care and chronology. The timeline does however begin in 2014, six months before the homicide, although the report states that all of their care and treatment was reviewed.

7.31 The action plan supplied contains very short timescales for completion, the longest being December 2016, eight months after the report was finalised. We question whether significant service changes, and changes to practice can be embedded in this timescale; this raises a question about whether actions are focussed on 'doing something specific' rather than changing practice, e.g. recommendation 10 is to 'review the current use and implementation of zoning systems', for this to be achieved the system needs to be reviewed, but there is no expectation of changing practice.

7.32 There are several recommendations that expect areas to be 'reviewed', 'reminded', or 'updated', making the effects on practice change very difficult to measure.

7.33 The distress and anxiety that serious incidents can cause for staff is acknowledged in the CNWL Incidents and Serious Incidents policy, implemented April 2015. The policy notes that the Trust has 'a duty of care to its staff' which includes the provision of support to staff involved in incidents. Such support often takes the form of a meeting (often referred to as a 'debrief') which is an opportunity to reflect on the incident and maybe facilitated by a psychologist or psychotherapist from outside the team. The policy also states that following a serious incident the '*Consultant or most senior clinician in the team should arrange for a clinical review of the case, which should give members of the MDT the opportunity to discuss the case in detail and identify any opportunities for improvement'*.

7.34 The Brent CRT who provided care to Nigel did not meet as a team for a debrief/clinical review, the CCO and support worker who worked with Nigel were both on leave when the team heard of his death and both were offered support individually.

7.35 The Brent EIT who provided care to Gary arranged to meet informally as a team to reflect on what had happened. However, it is not clear that a clinical review (as described above) took place. At interview for the internal report EIS team members said they had requested an externally facilitated session in which to discuss what had happened and that this had not taken place. The Team Manager noted that staff had felt overwhelmed by the incident.

7.36 Both teams expressed their shock and sadness about what happened and wished for their condolences to be offered to both families.

7.37 At the time of this independent report in 2018/2019 there were very few staff remaining in post who had provided care and treatment to Nigel or Gary; therefore, we were unable to ascertain staff views on the support received at the time.

7.38 The internal report did not identify events or omissions in the care provided that would certainly have prevented Nigel's death and were therefore unable to identify a root cause. The panel determined that the combination of the lack of suitable housing, the apparent absence of an overview of the safeguarding issues related to drug use in the Borough and the pressure experienced by the Brent EIS were the most important of the issues, and that there was significant learning to be gained from these. In particular the pressure experienced within the Brent EIS was found to be a significant contributory factor in all the care delivery problems identified in Gary's care and treatment. The internal panel concluded that it was not possible for the Brent EIS to work to the specific model of care with the numbers on the team caseload and the staffing level.

7.39 We agree with these findings and with the absence of a clear root cause.

Internal recommendations

7.40 We have listed the recommendations made and have analysed the implementation of them around the key areas of 'operational delivery' and 'embeddedness' of recommendations. To review the plan, we have used our 'Niche Assurance Review Framework' (NARF). Using the NARF, we will test out whether the Trust has completed the action plan and achieved improvements that address the original recommendations.

7.41 We have graded our findings using the following criteria:

Grade	Niche Criteria
A	Evidence of completeness, embeddedness, and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

7.42 As part of our review we had discussions with:

CNWL

- Head of Serious Incidents.
- Service Manager, Brent Mental Health Service.
- Deputy Borough Director, Brent Mental Health Service.
- Safeguarding Lead, Park Royal.
- Consultant Psychiatrist, Jameson division.
- Clinical Director, Jameson division.
- Director of Nursing, Jameson division.

- Lead Pharmacist, Jameson division.
- Ward Manager, Pine ward.
- Modern Matron, Shore and Caspian wards.
- Care Coordinator, CRT.

NHS NWL CCG

- Assistant Director of Quality and Safety (NHS Harrow CCG).

7.43 There are two standard (fixed) recommendations made by the Trust following a serious incident, and these were followed by 16 specific recommendations:

- Investigation findings are to be shared with the service user (as appropriate) and the patient's family.

- Investigation findings and action plan are to be shared with all those involved in the care and treatment of the service user and with other teams/services as applicable for the purposes of learning.

1. Brent Mental Health Service to agree a communication and reporting framework that covers the communication and reporting of concerns about illegal activity (including concerns about drug dealing) in consultation with the local police liaison officer.

2. The Community Mental Health Team (formerly the Community Recovery Team) to create a system to ensure that any change to medication is reflected in a patient's current prescription chart at the time the change is agreed or within one working day.

3. The Community Mental Health Team to implement local induction for temporary staff including briefing about CNWL's expectations of record keeping and other expectations relevant to their role.

4. That an audit is undertaken of whether depot clinic staff and care coordinators are following the Did Not Attend (DNA) protocol. It is suggested that three consecutive audit results (a suggested sample size of 15%) showing 100% compliance with the protocol demonstrates a change in practice.

5. CNWL staff to ensure they seek key risk information, including the most recent risk management plan, before or within a clinical review when the patient is not well known to them. And to use that information directly with the patient as appropriate.

6. Brent Mental Health Service to devise a system to ensure that any action recorded in a risk assessment or a core assessment is transferred to the care plan and clear steps for achievement of that action are recorded.

7. The EIS to ensure that there are systems in place within the team to ensure safeguarding concerns are managed and recorded in line with policy.

8. The EIS to ensure they meet compliance with mandatory adult safeguarding training.

9. Brent Mental Health Service to review support provided to service users to attain suitable accommodation, both alternative temporary accommodation (when a problem has been identified) and more permanent accommodation.

10. EIS to review the structure of multidisciplinary meetings and use of the zoning system, to ensure there is opportunity for discussion about people who are classified as 'amber' and whose condition is changing, as well as those in the 'red' zone.

11. EIS to review systems for annual leave handover and to ensure the agreed process is taking place.

12. A review and benchmarking exercise of the Brent EIS to be undertaken against demand, national guidelines, skill mix and other CNWL EIS teams with conclusions of the review to be presented to divisional management.

13. The Brent EIS Operational policy is to be updated in line with the exercise above and to meet National Guidance and commissioner contract standards.

14. Brent Mental Health Service to consider triggers for communication between teams about individual service users and how and where broader issues that may affect a number of service users could be discussed.

15. Brent Mental Health Service to consider whether and how communication between CNWL, [housing provider], the police and Brent Adult Safeguarding Team may be improved in order that any similar issues can be identified in future and appropriate responses made.

16. Communication and guidance regarding the new Trust Incidents and Serious Incidents policy is to include the specific expectations of communicating with patients and families following a serious incident and of the expectations regarding clinical reviews and debrief meetings for staff. And that monitoring arrangements for these key areas are in place.

Review and action plan implementation

7.44 We were supplied with a copy of the action plan dated 4 April 2016, which had been signed off by the Borough Director and Divisional Nurse Director (in August 2018). The headings of the action plan are: '*what action is needed to achieve the recommendation, what will be relied on as evidence of implementation, who by, when, and action taken to implement the recommendation, with the evidence embedded, and the date'.*

7.45 The copy provided has many dates apparently outstanding (dating back to 2016) and where the action is noted as completed, there are no completion dates provided.

7.46 There has been significant restructure and transformation of CNWL community mental health services in Brent and across London through 2015, 2016 and ongoing in 2017. There is a monthly Brent Transformation Board in place, and these meetings have worked through a series of sections of the care pathway. CNWL has adopted a quality improvement (QI) methodology in partnership with the Institute for Healthcare Improvement and has developed a resource and initiatives website[77] for staff. Each division has an improvement advisor available to support QI projects, and staff resources that can be utilised to support the division with projects.

7.47 Brent Mental Health Services (BMHS) has utilised this support to address areas of improvement that are key to this action plan, such as assessments, maintaining contacts with patients, risk assessments, psychology waiting lists, Recovery College resources and physical health monitoring.

7.48 There is a service action plan in place to address improvements requested by the CQC at their most recent visit, which also covers many of these areas.

7.49 A revised BMHS standard operating protocol[78] has been developed, which provides clear guidance for staff in managing issues relevant to this action plan, such as safeguarding, housing, depot administration and communication between teams. These will be referenced where they relate to particular actions. Standing agenda items at monthly Business and Care Quality meetings include:

- Staffing.
- Performance/KPIs.
- Health and Safety.
- MAPPA & MARAC feedback.
- Safeguarding.
- Learning from SIs and complaints.

7.50 The Trust now has clear key performance indicators (KPIs) in place, which was not the case in 2015. These provide a dashboard of data to be used by service managers and team leaders to check and maintain quality standards, and we will reference recent data where appropriate.

7.51 In terms of 'Fixed 1' the fixed action to share the investigation findings with the patient (as appropriate) and the patient's family this is noted as completed, but with no date.

No.	Original Report Recommendation	Niche Grading
Fixed 1	To share the investigation findings with the patient (as appropriate) and the patient's family.	B

[77] https://www.qi.cnwl.nhs.uk/

[78] *Brent Standard Operational Protocol, adult community mental health, August 2018.*

7.52 The Trust action was to share the investigation findings with the patient (as appropriate) and the patient's family.

7.53 We noted that the Care Quality Commission (CQC)[79] inspection report of August 2017 found that staff understood their responsibilities in relation to Duty of Candour and identified that staff were open and transparent with service users when something went wrong.

7.54 We reviewed the Trust policy on Learning and Responding from Deaths (approved September 2017, review August 2020) and found this to contain a section on involvement of families and carers explaining the principles of Being Open and the Duty of Candour requirements. There has been an additional standard operating procedure developed for Jameson Division, which provided a flowchart for staff involved.

7.55 The feedback from the SI about sign off for each the SI reports also contains reminders about Duty of Candour, and to share the findings with families.

7.56 We were informed that contact with the family during the course of an internal investigation was not, at the time, recorded on the Trust electronic serious incident system (Datix) at the end of the investigation process. We were therefore unable to see a record of the family contact for this internal investigation. The Divisional Governance Team now play a proactive role in identifying two teams where Duty of Candour is required. The Trust has developed a templated letter to assist staff in order to show how to formally write and notify families and loved ones regarding Duty of Candour and are the main conduit in relation to any clinical discussions that are required or queries in relation to the requirements to contact family in adhering to the Duty of Candour principles. Whilst the Trust does not have a formal family liaison officer within the policy, formal family liaison officer is identified as part of the SI process. Performance in relation to Duty of Candour is now reported to both Board and Divisions and monitored through the Divisional Boards through the Head of Governance and Divisional Directors of Nursing.

7.57 The report itself however provides a detailed summary of the contact made with both families during and after the investigation, and the action plan for the investigation contains evidence of emails, meetings and telephone calls over the time of the investigation. Both families provided written questions and queries to the internal panel, and there is a section focussed on answering both of the families' questions.

7.58 There is no mention of the application of the Duty of Candour prior to or during the investigation. The incidents and serious incidents policy (2016) states that:

'*Divisional Governance Leads are responsible for leading on the local management of serious incidents and implementation of this policy, including but not limited to, making arrangements to fulfil Duty of Candour and*

[79] *Central and North West London NHS Foundation Trust Community-based mental health services for adults of working age Quality Report 2017.* https://www.cqc.org.uk/sites/default/files/new_reports/AAAG5297.pdf

monitoring on open investigations and ensuring the monitoring and implementation of recommendations once completed'.

7.59 The Trust also has an Openness (Duty of Candour) policy[80] which has the expectation of contact and documentation.

7.60 These policies were not adhered to in this case, while we acknowledge that the families were communicated with during and after the investigation, we have not seen evidence that the Duty of Candour was enacted.

7.61 The report describes how the Trust did not communicate with Nigel's family directly after his death. CNWL was informed of Nigel's death on 17 March 2015 and received instruction from the police not to contact Nigel's family until formal identification of his body had taken place.

7.62 That morning, Nigel's father telephoned the Brent CRT and spoke to a social worker. His father said that he had heard something had happened to his son. The social worker sought advice from his manager, who advised that the team were not able to disclose any information at that time and Nigel's father was advised that a manager would contact him later that day.

7.63 A Service Manager was identified to maintain contact with Nigel's family, but contact was not made until 24 March 2015 because of leave.

7.64 On 6 July 2015, the Director of Hundred Families wrote to the CNWL Chief Executive, expressing the family's concern about the contact from the Trust. The CNWL Chief Executive replied on 13 July 2015 communicating how very sorry she was that the family felt unsupported by the Trust. The CNWL Chief Executive noted that the mobile phone number recorded in Nigel's care plan had a Portuguese dialling code prefix, which caused some doubt and was not tried. The CNWL Chief Executive noted that the Trust completely accepted that someone should have tried this number and she apologised for this.

7.65 Nigel's family stated at interview as part of this investigation that they had never received an apology from CNWL following Nigel's death, and would appreciate if this could be done.

7.66 Initial contact with Gary's parents was made by a service manager on 17 March 2015. A member of the panel wrote to Gary's mother and father on 3 July 2015 providing information about the investigation and explaining that following instruction from the police, it was not possible to proceed with the CNWL investigation at that point.

7.67 There was a telephone conversation with Gary's father in October 2015 and subsequent email contact. Gary's father provided written information for the investigation which the panel received in February 2016. The panel reviewed the information; some questions related to Gary's care and treatment in 2010 and 2013 which was outside the scope of the panel's detailed review. The Brent Clinical Director sought information in response to these questions and

[80] *CNWL Openness Policy (Duty of Candour) 2016 TW00143/16-19a.*

the information was forwarded to Gary's father in advance of this report being completed.

7.68 The report notes that panel members visited Gary in his current care environment and asked his views and opinions on his care. There is evidence that he was sent a copy of the report, and we have seen evidence that the findings of the report have been shared with Gary for feedback.

7.69 We have graded this at B, as there is clear evidence that the learning has been shared with families, so the action is completed. The Trust has now implemented two fixed standard actions in all action plans, the first being the requirement to share and finalise the report and action plan with patient families and secondly the expectations and need to exercise Duty of Candour.

7.70 This process was discussed at the Jameson Divisional Board in October 2019, and within individual Borough Management Teams. These will be tracked through Datix and monitored via the quarterly divisional governance reports.

7.71 In terms of Fixed 2 the fixed action that the investigation findings and action plan are to be shared with all those involved in the care and treatment of the service user and with other teams/services as applicable for the purposes of learning, we noted that this is marked as completed, but with no date.

7.72 The Trust action was that the investigation findings and action plan are to be

No.	Original Report Recommendation	Niche Grading
Fixed 2	That the investigation findings and action plan are to be shared with all those involved in the care and treatment of the service user and with other teams/services as applicable for the purposes of learning.	C

shared with all those involved in the care and treatment of the service user and with other teams/services as applicable for the purposes of learning.

7.73 The internal report stated that there was some support for staff in the teams involved in both patients' care and treatment, however it is not clear that a clinical review took place in either team. Members of the EIS noted they had requested an externally facilitated meeting for support and reflection which did not happen.

7.74 We noted that the internal investigation report stated that the draft report was sent out to staff who contributed to the investigation to check factual accuracy. Because there were very few staff still in post who had worked with either patient, we were unable to gather any information about this aspect from staff directly.

7.75 The final report was to be sent to the teams involved, Borough and Divisional Directors, the Divisional Governance Lead, Jameson Division, the CNWL Trust Board, NHS NWL CCG and NHS England. We have been informed that this would be through the Local Care Quality Management Team meeting, Borough Senior Management Team meeting and fed through team business meetings. We have seen the Brent Community Services Care Quality Management Team meeting for 16 June 2016, the panel of inquiry report was noted as discussed, and notes were made about actions to be taken within the teams to meet the recommendations. We have not been provided with evidence of other arenas where the report has been discussed or disseminated.

7.76 The action plan updates record that sessions were held on lessons learnt for all Brent Mental Health Community Team to focus on sharing of key clinical information involving senior practitioners and team managers. A number of workshops and learning events were facilitated over a period of months, about this and other serious incidents and events in the teams. Detail of dates and attendees were not provided.

7.77 The Divisional Governance Team maintains a central tracking log of action plans, and there are periodic updates requested from the Boroughs where actions are outstanding.

7.78 Jameson Division is developing a rolling learning log, which picks up themes from serious incidents and ensures they are shared across teams.

7.79 We have seen a presentation on *'Brent RCA themes - lessons learned'* which is an example of sharing of themes and actions taken after a cluster of incidents.

7.80 We have graded this at C, as there is some evidence that the learning has been shared, so the action is completed, but there is no objective evidence that the learning has been embedded.

7.81 We were informed that as part of an overall drive to improve standards, there has been a focus on ensuring care coordinators have the appropriate systems knowledge and are applying standards. 'Bitesize' training sessions have been carried out with care coordinators, covering the housing panel process, community treatment orders, care coordinator contacts and recording, depot administration, linked to the action plan. The focus of future 'bitesize' session is planned as the quality of care coordinator contacts, safe discharge to primary care, and medication management.

No.	Original Report Recommendation	Niche Grading
1	Brent Mental Health Service to agree a communication and reporting framework that covers the communication and reporting of concerns about illegal activity (including	A

	concerns about drug dealing) in consultation with the local police liaison officer.	

7.82 Attendance at these has not been formally recorded but addressed in supervision with individuals.

7.83 The Trust action was:

- A protocol to be drawn up, and the protocol is shared with the local police liaison group and made available to all BMHS staff.
- Brent local authority commissioners, Brent Senior Management Team and [housing provider]. This would cover process and expectations for communicating and reporting of concerns about illegal activity.
- The protocol is shared and available to all BMHS staff.

7.84 This was due to be completed by 6 May 2016, by the Service Manager. It is marked as 'complete' but there is no completion date, so it is not possible to determine whether it was completed within the expected timeframe.

7.85 The evidence provided was:

- Information Sharing Protocol, Brent sharing agreement for high risk mental health service users for Brent CNWL - Community Mental Health Team (October 2017).
- Housing and Mental Health - principles of practice (updated May 2018).
- Information sharing procedure (ISP) [81] (November 2017).
- Guidance on the funding of Bed & Breakfast within Brent MHS (September 2017).
- Police Brent Liaison meeting agenda 4 December 2018.

7.86 We also discussed these aspects with the Clinical Director, Service Manager, and CMHT and EIS team leaders.

7.87 The aim of the protocol is 'to establish comprehensive and consistent guidance for the exchange of personalised information between partners and stakeholders'.

7.88 This is supported by an information sharing procedure which includes a 'how to' guide and templates for information sharing.

7.89 The parties signed up to the ISP are those that have signed the Declaration of Acceptance & Participation and are listed below:

- Central North West London NHS Foundation Trust (CNWL).
- Brent Council ASC Mental Health, Support Planning, Safeguarding.
- Brent Council Housing Services.
- Brent Metropolitan Police.

[81] *CNWL INFORMATION SHARING PROCEDURE 2017 TW/00229/15-17a*

- MAPPA.
- Community MARAC.
- Housing associations, as and when required.

7.90 Examples of communication routes that have developed as a result of this ISP were given as:

- Monthly police meeting attended by the Deputy Borough Director, which includes a police link for mental health. An example was given about discussions regarding challenging behaviour at the team base in Brondesbury Road, which were addressed by a joint focus with local police.
- 'Channel' panel[82] attended by the BMHS Service Manager, which would include sharing information about vulnerable individuals, and safeguarding information.
- Housing and mental health principles of practice agreed, which provide clear responsibilities, routes and pathways for housing referrals if required.
- Link with West London Forensic services to discuss risk issues in the community where patients have a social supervisor.

7.91 There was evidence of a radical change in practice with regard to housing issues, where patients may become homeless as a result of challenging behaviour, or an inpatient stay. In 2015 supported housing was commissioned by CNWL, and this was decommissioned in 2016. It was recognised as a result of the internal report that the housing provider concerned had become a readily available option for discharge from inpatient services, where the person was of no fixed abode. This was the case with both Nigel and Gary, for different reasons.

7.92 This was funded by the local authority, and ultimately paid for through housing benefit. This 'pathway' was stopped completely in 2017, after meetings between the BMHS Service Manager, local authority housing and the accommodation provider.

7.93 The present system is that housing officers from the local authority:

- attend each inpatient ward weekly, identifying people of no fixed abode;
- arrange to move someone immediately if they are at risk; and
- escalate to CNWL where mental health input is needed.

7.94 Equally if CNWL find someone in accommodation who is relapsing and at risk, Trust staff will share this with the local authority.

7.95 A weekly local authority funding panel will prioritise and agree what kind of accommodation is appropriate, and if necessary, agree a funded support package provided by a tertiary provider.

[82] *Channel is part of the Prevent strategy. The process is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism.* https://www.gov.uk/government/publications/channel-guidance

7.96 We have seen the system in action at Park Royal centre for mental health where a housing officer attends weekly. The process of accessing housing for CNWL patients has been transformed. This has been supported by a local authority project on reducing homelessness in the Borough.

7.97 The standing agenda of the Brent police liaison meetings covered information sharing about service developments, and concerns arising in any of the teams or inpatient areas, support for Section 136 assessments.

7.98 Changes have been made which greatly reduce any likelihood a recurrence of the situation in which Nigel and Gary found themselves with regard to housing. This action has been marked as completed (but with no date). We have graded this as A, as there is evidence of completion, embeddedness, and impact.

No.	Original Report Recommendation	Niche Grading
2	The Community Mental Health Team (formerly the Community Recovery Team) to create a system to ensure that any change to medication is reflected in a patients current prescription chart at the time the change is agreed or within 1 working day.	C

7.99 The Trust action was:

- Brent Lead Nurse to communicate to all BMHS staff of expectation in medication management policy that prescription charts are to be brought to CPA/medical reviews to ensure changes to medication are recorded at the point of decision being made.
- Lead Nurse with senior practitioners for CMHT to audit 10 CPA reviews per month for three months to check that changes to medication is reflected in prescription charts on date identified in Jade/on CPA documentation.

7.100 The communication was due to be completed by 6 May 2016 by the Service Manager, and the audit was to be completed by the Lead Nurse and senior practitioners by 31 July 2016. The first action has been superseded by electronic prescribing, hence there are no requirements to bring paper copies to CPA meetings/medical reviews. The second action is marked as 'complete' but there is no completion date, so it is not possible to determine whether it was completed within the expected timeframe.

7.101 The evidence provided was:

- electronic prescription and administration chart; and
- CPA/medication audit information.

7.102 The electronic prescription and administration process has clear sections for detailed recording, and can be used to note medicines due, and non-attendances. This has been supported by written procedures for clozapine management, depot administration and management of missed depots.

7.103 The audit was intended to check that changes to medication are reflected in prescription charts on the date identified in Jade or on CPA documentation. A list of 30 patients' information is provided, with each result described, e.g. '*Medication review 12/5/16, reflected in progress notes and GP letter'*. There is no description of the process, no narrative that analyses or discusses the results, and no actions recommended. It was however clear the standards had not been met in 11 out of 30 case. One was recorded as '*also noted on the depot chart*', which had either not been measured in the other 29, or none of the others had a depot chart record.

7.104 The recommendation was that 'the Community Mental Health Team (formerly the Community Recovery Team) to create a system to ensure that any change to medication is reflected in a patients current prescription chart at the time the change is agreed or within 1 working day'.

7.105 In our view the actions listed would not produce this outcome and should have been more focussed on changing practice than completing an audit.

7.106 This action has been completed, that is the audit was done, however we have graded this as C, because there is no evidence that action was taken to address practice as a result of this audit.

No.	Original Report Recommendation	Niche Grading
3	The Community Mental Health Team to implement local induction for temporary staff including briefing about CNWL's expectations of record keeping and other expectations relevant to their role.	C

7.107 The Trust action was:

- Update local CMHTs induction file with added requirement for signature by agency staff when read and follow up in supervision with senior practitioners.
- This was due to be completed by 30 May 2016, by operational managers. It is marked as 'completed', but there is no completion date, so it is not possible to determine whether it was completed within the expected timeframe.

7.108 The evidence provided was:

- Example agency staff signatures that confirm they have read and understood the BMHS Operational policy.
- BMHS staff supervision template revised.

7.109 We have graded this as C, as there is evidence that the actions have been completed.

No.	Original Report Recommendation	Niche Grading
4	That an audit is undertaken of whether depot clinic staff and care coordinators are following the Did Not Attend (DNA) protocol. It is suggested that 3 consecutive audit results (a suggested sample size of 15%) showing 100% compliance with the protocol demonstrates a change in practice.	E

7.110 The Trust action was:

- Audit of the Did Not Attend (DNA) protocol for 3 monthly consecutive audit results (a suggested sample size of 15%).

7.111 This was due to be completed by 31 July 2016, by the Lead Nurse. It is marked as 'complete' but there is no completion date, so it is not possible to determine whether it was completed within the expected timeframe.

7.112 The evidence provided was:

- Brent CMHT disengagement (DNA) protocol.
- DNA audit.

7.113 It is noted that the Brent CMHT disengagement protocol should be read in conjunction with the DNA policy and Zoning protocol.

7.114 The document entitled 'DNA audit' is in fact a snapshot of a zoning discussion which dates from January 2018. It is not an audit of DNAs.

7.115 We have graded this as E, not enough evidence to say complete.

No.	Original Report Recommendation	Niche Grading
5	CNWL staff to ensure they seek key risk information, including the most recent risk management plan, before or within a clinical review when the patient is not well known to them. And to use that information directly with the patient as appropriate.	C

7.116 The Trust action was:

- Communication to all BMHS staff reminding them of expectation that they have access to electronic clinical notes or printed copies, to hand at time of assessment, of most recent risk assessment form when patient is not well known to the assessing staff.

7.117 This was due to be completed by 30 May 2016, by the Clinical Director. It is marked as 'complete' but there is no completion date, so it is not possible to determine whether it was completed within the expected timeframe.

7.118 The evidence provided was:

- An undated document which notes that a memo was sent regarding communication to all BMHS staff reminding them of expectation that they have access to electronic clinical notes or printed copies, to hand at time of assessment, of most recent risk assessment form when patient is not well known to the assessing staff.
- Brent Community Services Care Quality Management Team Meeting Thursday 16 June 2016.

7.119 There is some narrative with the first document which described how systems have changed and been updated since this incident:

'*At the time of this incident the organisational and IT arrangements were different to how they currently are. Since this incident, the teams have been restructured and there is now a dedicated group of staff who are a sub-team of the CMHTs whose primary role is to undertake assessments. Therefore, they are fully conversant with the need to be well prepared having accessed the person being assessed clinical records and having to hand the most recent information about the person being assessed.*

IT arrangements have also changed. At the time of the incident IT was available in the interview rooms used for assessments or outside of the building, i.e. in people's homes. Now, following a significant upgrading of IT all staff have laptops that are capable of connecting to CNWL's clinical systems wherever a 4G connection is available, therefore staff ordinarily take laptops into assessments so as they have complete access to a person's clinical records at the time of the assessment.

The current SOP states 'At all stages of the service user's engagement with mental health services, all staff must ensure that they seek key risk information, including the most recent risk management plan, before or within any clinical review when the patient is not well known to them, and to use that information directly with the patient as appropriate'.

7.120 We have graded this as C because there is evidence that the communication was sent. In our view a more useful action would have been to focus on developing practice in risk assessment, which could then be measured.

No.	Original Report Recommendation	Niche Grading
6	Brent Mental Health Service to devise a system to ensure that any action recorded in a risk assessment or a core assessment is transferred to the care plan and clear steps for achievement of that action are recorded.	E

7.121 The Trust action was:

- Seek audit data from the CNWL Divisional Clinical Governance Lead regarding Brent's compliance with recording risks to care plans in this key performance requirement.
- Lessons learnt shared and discussed at Brent Care Quality meeting and cascaded via email communication to all BMHS staff.

7.122 These were due to be completed by the Clinical Director by 30 May 2016 and 31 July 2016, respectively. Both are marked as 'complete' but there is no completion date, so it is not possible to determine whether they were both completed within the expected timeframe.

7.123 The evidence provided was:

- Risk assessment quarterly audit dated October 2017.
- Brent Community Services Care Quality Management Team Meeting Thursday 16 June 2016.

7.124 The document entitled 'risk assessment quarterly audit, dated October 2017' appears to have been an agenda item for discussion at the Jameson governance meeting on 12 October 2017, the minutes of this meeting were not available. The document shows results of seven quarterly audits from 2015 to 2018, carried out across the three teams in Brent: Brent EIS, Brent North, and Brent South.

7.125 The document notes that the teams should complete quarterly indicator audits which audit a range of standards, including whether risk assessments are complete and reflected in care plans. The target was 95% concordance.

7.126 The results show that only one audit was carried out in quarters three and four in 2015/2106, which was in Brent EIS, scoring 90%. Of the seven possible audits:

- Brent EIS showed four results - 90%, 75%, 50% and 100% (in quarter 1 2017/18).
- Brent CMHT North showed three results, three at 100% and the most recent (quarter 4 2016/17) at 60%.
- Brent South CMHT showed results for four of the seven possible audits, ranging between 80%, 100%, 70% and the most recent in quarter 1 2017/18 as 100%. There is no analysis of the results or discussion about implementation of findings.

7.127 It is not possible to comment further, as this appears to be an isolated snapshot of concordance with the expectation of the standard under review. The original recommendation was '*Brent Mental Health Service to devise a system to ensure that any action recorded in a risk assessment or a core assessment is transferred to the care plan and clear steps for achievement of that action are recorded*'.

7.128 The actions listed would not in our view result in the development of a system but are merely the results of an incomplete audit.

7.129 The minutes of the Brent Community Services Care Quality Management Team Meeting Thursday 16 June 2016 show that the findings of the internal report were discussed, and actions agreed. The relevant point for this action was for the quarterly audit data to be sent to the Business and Transformation Manager.

7.130 We have graded this as E, not enough evidence to assess.

No.	Original Report Recommendation	Niche Grading
7	The EIS to ensure that there are systems in place within the team to ensure safeguarding concerns are managed and recorded in line with policy.	B

7.131 The Trust action was:

- BMHS now have a Safeguarding Lead in each team.
- There is a Borough-wide monthly safeguarding group with the local authority. Lessons learnt are shared and discussed.
- Safeguarding group to undertake six monthly review of themes/patterns from safeguarding to share with teams.

7.132 This was due to be completed by:

- Deputy Director, date not specified but marked complete.
- Borough Director, date not specified but marked complete.
- Borough Director 31 October 2016, marked as 'complete' but there is no completion date, so it is not possible to determine whether it was completed within the expected timeframe.

7.133 The evidence provided was:

- Brent safeguarding group list of attendees.
- Terms of reference for the monthly Safeguarding Meeting between CNWL, the CCG and the local authority.
- Brent Borough Safeguarding Meeting minutes 6 July 2017 and 7 September 2017.
- A presentation on Brent serious incident reports and lessons learnt.

7.134 We met the Safeguarding Lead for inpatient units at Park Royal, who described the systemic changes which have resulted in there being safeguarding advice readily available in services, regular safeguarding meetings to review issues, and an increased awareness in staff. Safeguarding professionals attend morning ward meetings and clinical reviews where needed.

7.135 There is now a section to log safeguarding concerns on Datix, making this easy to track. We saw evidence of work focussed on sexual safety for inpatients, which can include capacity assessments.

7.136 A good relationship with the local authority safeguarding structures was cited, and CNWL staff attend the Tri-borough[83] safeguarding meeting alongside police and NHS NWL CCG representatives.

[83] *Brent, Harrow, Barnet.*

7.137 Work on particular projects was outlined, including with police on 'county lines', radicalisation, human trafficking and modern slavery.

7.138 We have graded this as B, as there is evidence of completeness and embeddedness. We have not seen objective evidence of impact.

No.	Original Report Recommendation	Niche Grading
8	The EIS to ensure they meet compliance with mandatory adult safeguarding training.	B

7.139 The Trust action was:

- Monthly compliance data provided from CNWL learning and development service (LDS) currently reviewed by operational managers.
- Staff out of compliance to undertake training within one week and to be routinely checked up in supervision.

7.140 This was due to be completed by operational managers by 31 July 2016 and is shown as not complete.

7.141 The evidence provided was:

- EIS staff mandatory training and appraisals.
- Staff supervision template July 2017.
- CQC provider information request for staff supervision 9 November 2018.

7.142 We have seen a spreadsheet which shows EIS compliance with mandatory training and appraisals in 2017, showing 95% compliance. This now forms part of KPIs for team leaders and is reviewed monthly. We did not have access to the most recent compliance levels.

7.143 The staff supervision template includes a section on mandatory training compliance.

7.144 We have graded this as B, as the actions have resulted in a system to ensure compliance is recorded and monitored, but we did not see objective evidence that practice had changed over time.

No.	Original Report Recommendation	Niche Grading
9	Brent Mental Health Service to review support provided to service users to attain suitable accommodation, both alternative temporary accommodation (when a problem has been identified) and more permanent accommodation.	A

7.145 The Trust action was:

- The temporary accommodation protocol to be amended to include pathway for when a person needs to move to alternative accommodation (temporary/permanent) and emailed to all BMHS staff.
- Ongoing working with local authority commissioners to meet gap in housing provision.

7.146 This was due to be completed by:

- the Service Manager by 30 May 2016, which is not marked as completed.
- the Service Manager and Borough Director, by 30 December 2016, which is not marked as completed.

7.147 The evidence provided was:

- Guidance on funding bed & breakfast, circulated to team leaders on 29 December 2016.
- Agreement by the local authority and NHS NWL CCG on the new housing principles.

7.148 Although these are not marked as completed on the most recent action plan, we consider that they have been completed, referencing the evidence for recommendation 1. We have graded this as A accordingly.

No.	Original Report Recommendation	Niche Grading
10	EIS to review the structure of multidisciplinary meetings and use of the zoning system, to ensure there is opportunity for discussion about people who are classified as 'amber' and whose condition is changing, as well as those in the 'red' zone.	A

7.149 The Trust action was:

- EIS team to undertake a review of current use and implementation of the zoning system.

7.150 This was due to be completed by 20 June 2016, by the Service Manager and EIS Operational Manager. It is not marked as ‘complete’.

7.151 The evidence provided was:

- EIS in Psychosis Operational policy - draft April 2017.
- Clinical Risk Management (CRM) excel spreadsheet 27 September 2017.
- Audit of multidisciplinary team actions August to October 2018.
- Early Intervention in Psychosis Network (EIPN) Royal College of Psychiatrists' Centre for Quality Improvement Assessment report Brent EIS, April 2018.

7.152 The CNWL EIS service is provided across three teams:

- Westminster, Kensington, and Chelsea.

- Brent and Harrow.
- Hillingdon.

7.153 These teams now share a common overarching Operational policy, while working out detailed local procedure according to local context.

7.154 Within the new Operational policy, caseloads are described within recommended limits, and the acceptance criteria, length of treatment and therapies offered are described in detail.

7.155 Complex data collection to enable proper audit of activity and outcome was intended to be collected across the EIS and will be monitored in the Clinical Governance Committee. This would follow the guidance from the London EIS research group, in order to facilitate London wide audit and research in EIS services but may add further measures agreed within the service.

7.156 The EIS has undergone a complete review of the service and has joined the Royal College of Psychiatrists' Centre for Quality Improvement 'Early intervention in Psychosis' Network. The April 2018 audit report has assessed the service against national guidance and standards.

7.157 The overall score for Brent EIS was '*Level 2: Needs improvement'.*

7.158 The scores for 2017/18 are contrasted with the 2016/17 scores, and the national averages, so that improvements can be easily seen. For instance, in 2016/17 the score for 'timely access' that is, percentage of people in this CCG referred with suspected First Episode Psychosis who commenced treatment within two weeks of referral, was 85%. The national average is 72%, and the Brent score for 2017/18 was 91%, which puts the service in 'Level 4: Top performing' for this element.

7.159 There is an action plan in place as part of service improvement plans to address the results of the audit.

7.160 The 'CRM excel spreadsheet' is the rolling log (at August and September 2017) of the changes in zoning for EIS patients. This shows the RAG rating (zoning) over time, and the daily team meetings are structured to allow time for those on red and amber to be discussed, and agreed actions logged.

7.161 The 'audit of MDT actions' August to October 2018 is part of a quality improvement project. This project has focussed on logging and tracking all cases discussed in MDT meetings, which are held on a tracker and updated weekly. Quality checks are completed based on cases selected at random from the tracker, MDT notes and actions identified, and completion of actions are checked. The current MDT is being reviewed as part of a new QI project in EIS starting November 2018.

7.162 There are other QI projects focussing on outcomes and caseloads. The intention is to reduce caseloads to 19, standards[84] state that full-time care coordinators have a caseload of no more than 15 (reduced pro-rata for part-time staff). In contrast to this, CCO2 for Gary had a caseload of 35. There was no psychologist at the time in 2015, there is now 1.5 WTE psychology resource. Staff vacancies have reduced from 50% to 10%, and band 5 (newly qualified) nurses have their caseload capped at 20.

7.163 We have graded this as A, as we consider there is objective evidence that changes have been implemented and embedded.

No.	Original Report Recommendation	Niche Grading
11	EIS to review systems for annual leave handover and to ensure the agreed process is taking place.	C

7.164 The Trust action was:

- EIS buddy system in place to provide cross cover at times of leave.
- Email communication to Brent EIS staff regarding buddy system.

7.165 This was due to be completed by 30 June 2016, by the Service Manager and EIS Operational Manager. It is not marked as 'complete'.

7.166 The evidence provided was:

- Buddy system protocol.
- Four months examples of allocated leave 'buddies' within the EIS team.

7.167 There was clear evidence that this process is in place, hence we have graded it as C, as no evidence of impact was received.

No.	Original Report Recommendation	Niche Grading
12	A review and benchmarking exercise of the Brent EIS to be undertaken against demand, national guidelines, skill mix and other CNWL EIS teams with conclusions of the review to be presented to divisional management.	B

7.168 The Trust action was:

- Exercise has been undertaken – evidence.
- Recruitment underway of additional clinical staff.

[84] *Standards for Early Intervention in Psychosis Services. RCPsych 2018.* https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/early-intervention-in-psychosis-teams-(eipn)/epin-standards-first-edition.pdf?sfvrsn=fd9b4a0f_2

7.169 This was marked as completed by the Governance Team with no date, and the recruitment of additional clinical staff by 31 July 2016, by the Service Manager and EIS Operational Manager. This item is not marked as complete.

7.170 The evidence provided was:

- EIPN Royal College of Psychiatrists' Centre for Quality Improvement assessment report Brent EIS, April 2018.
- Brent EIS staffing spreadsheet July 2017

7.171 The EIPN audit has been discussed above in the evidence for recommendation 10.

7.172 The Brent EIS staffing sheet shows that all three medical posts were recruited to substantively, and there were three substantive psychologists, all working part time, providing 1.2 WTE. The only 'locum' posts were four of the six nursing posts, and one locum of three social workers. Plans were in place to recruit to further posts, a specialist CBT/family intervention practitioner, a full-time psychologist, and an assistant psychologist.

7.173 There is evidence of substantial investment in the service, referencing the evidence for recommendation 10 also.

7.174 We have graded this at B, in the absence of measurable outcomes for the EIS service.

No.	Original Report Recommendation	Niche Grading
13	The Brent EIS Operational Policy is to be updated in line with the exercise above and to meet National Guidance and commissioner contract standards.	A

7.175 The Trust action was:

- Update Brent EIS Operational Policy in line with National Guidance and local expectation.

7.176 This was due to be completed by 30 June 2016, by the Service Manager. It is not marked as 'complete'.

7.177 The evidence provided was:

- EIS Operational policy.
- Evidence as provided for recommendation 10/11/12.

7.178 We have also been able to discuss the EIS service with the Service Manager, EIS Operational Manager and the Brent Clinical Director. Development plans were discussed, such as recruiting a family therapist, and developing the interventions to include families.

7.179 We have graded this as A, as there is evidence already discussed which shows that the service has been transformed, and there are measures that are being used to monitor quality.

No.	Original Report Recommendation	Niche Grading
14	Brent Mental Health Service to consider triggers for communication between teams about individual service users and how and where broader issues that may affect a number of service users could be discussed.	C

7.180 The Trust action was:

- Session on lessons learnt for all BMHS community team to focus on sharing of key clinical information involving senior practitioners and team managers.

7.181 This was due to be completed by 31 July 2016 by the service managers. It is not marked as 'complete'.

7.182 The evidence provided was:

- An undated document which notes that a memo was sent regarding communication to all BMHS staff reminding them of expectation that they have access to electronic clinical notes or printed copies, to hand at time of assessment, of most recent Risk Assessment form when patient is not well known to the assessing staff.

7.183 The action plan notes that a register of attendees and learning notes should also be kept, but these were not provided.

7.184 We have graded this as C, it is clear that some sharing of learning has taken place, but the detail of which teams and who attended for what presentations is not available.

No.	Original Report Recommendation	Niche Grading
15	Brent Mental Health Service to consider whether and how communication between CNWL, [accommodation provider], the Police and Brent Adult Safeguarding Team may be improved in order that any similar issues can be identified in future and appropriate responses made.	B

7.185 The Trust action was:

- Stakeholders, police, CMHT, EIS, Brent local authority and housing – meeting with all parties to share highlights of the learning and agree systems for sharing need to know information.

7.186 This was due to be completed by 30 June 2016, by Brent local authority Head of Service and CNWL Borough Director. It is not marked as 'complete'.

7.187 The evidence provided was:

- Minutes of a joint agency meeting.
- Brent information sharing protocol.

7.188 We were able to discuss this aspect with the Service Manager, Brent Clinical Director and a CMHT Care Coordinator. Examples were provided about actions taken jointly with the local authority and police to reduce risk in particular cases.

7.189 We have graded this as B, as has already been discussed for recommendation 1 and 9.

No.	Original Report Recommendation	Niche Grading
16	Communication and guidance regarding the new Trust Incidents and Serious Incidents policy is to include the specific expectations of communicating with patients and families following a serious incident and of the expectations regarding Clinical Reviews and debrief.	C

7.190 The Trust action was:

- The Trust will review the Incidents and Serious Incidents (I&SI) policy to ensure that it reflects these requirements and incorporate appropriate monitoring arrangements to provide assurance that the systems are in place.
- The Datix system will be used to monitor compliance with reporting via the Divisions Quarterly Governance Reports.

7.191 This was due to be completed by a) Head of Safety by 30 June 2016, and b) by Heads of Governance by 30 August 2016. It is not marked as 'complete' but there is no completion date, so it is not possible to determine whether it was completed within the expected timeframe.

7.192 The evidence provided was:

- Jameson Senior Management Team report July 2017.
- Incidents and serious incidents policy[85] revised August 2016.

7.193 The SMT report in July 2017 was intended to provide an update on progress on embedding learning following serious incidents within Jameson services. Details of outstanding serious incident action plans were provided.

7.194 An internal audit was completed looking at Serious Incidents and Learning within Jameson Division. It was identified that there had been a small number of incidents where the Trust was unable to source the documentary evidence

[85] *CNWL INCIDENTS AND SERIOUS INCIDENTS POLICY 2016. TW/00009/16-18f*

which demonstrates that final reports have been shared with either the patient or their family. In all of these cases the service were satisfied that the action was completed, but that as a result of staff moving on it was not possible to secure a copy of the correspondence as evidence of completion.

7.195 Services were asked by the Head of Safety to review their systems to ensure that:

- Local care quality meetings or equivalent must monitor all SI action plans.
- Particular attention should be given to the fixed action to share the report with the patient/carer.
- Upon completion of an action the evidence must be embedded within the action plan.
- Where there is slippage on a completion date, this should be noted and a revised date for completion included, best practice would be to include a note within the action plan around the revised date and rationale.
- Once all actions have been completed, this should be signed off by the service and the completed action plan with embedded evidence forwarded for the Divisional Management Team for final approval.

7.196 The SMT report listed all the action plans for incidents still outstanding, suggested a template to be used to identify and share lessons learned. From 2017 action plan evidence would be maintained centrally by the Governance Team, when it has been gathered and embedded by provided services.

7.197 The policy has been updated to include emphasis on reporting and feedback to families.

7.198 We have not seen any follow up action or reporting back for assurance; therefore, we have graded this at C.

Trust oversight

7.199 We noted that the Care Quality Commission (CQC) inspection report of August 2017 found that staff understood their responsibilities in relation to Duty of Candour and identified that staff were open and transparent with service users when something went wrong. In February 2015, the CQC had recommended that staff be supported to learn about incidents from other services within the Trust. At the 2017 inspection it was found this had improved and learning from incidents in other services took place.

7.200 The CQC also noted that there was an effective incident reporting system in place and staff knew how to report incidents. All incidents were reviewed and discussed within the teams so that learning was shared, and improvements made.

7.201 We have seen the Brent Community Services Care Quality Management Team Meeting for 16 June 2016, the panel of inquiry report was noted as discussed, and notes were made about actions to be taken within the teams to meet the recommendations.

7.202 The Trust produced a 'Learning and Improvement' guide in 2015 which was accepted by the Trust Operations Board in July 2015. This document provides a summary of the Trust structures for learning from incidents, and the divisional and corporate roles that are in place to provide information and support.

7.203 In terms of Trust wide systems for learning, we understand that the clinical message of the week aims to spread current learning across the Trust through a short two to three-line message that is quick to read. Messages are drawn from current incident themes, serious incidents, policy updates and risk alerts. Learning is supplemented by providing feedback through emails, internal audit, meetings, and learning walks. However, we were informed that there is no current electronic facility for Trust divisions to review other divisions completed internal investigation reports for the purposes of shared learning.

7.204 We were told that the quarterly Trust wide learning event aims to deliver a minimum of four learning events every year, supported by local divisional learning events. The regular learning events provide a forum for staff to collaborate and discuss changes to improve quality in the services.

7.205 We saw that the Trust had delivered previous learning events on putting patients and carers at the centre of their care, working to reduce harm across community and mental health services specifically on suicide prevention, and pressure ulcer prevention and management.

7.206 An email was sent in August 2018 by the Brent Service Manager asking that the report be discussed in team meetings again, with notes of the relevant findings.

7.207 The completed report was signed off by the Executive Director of Nursing in April 2016. The subsequent action plans were signed off by the Jameson Director of Nursing in August 2018.

7.208 Action plans are tracked, and timelines monitored by the Central Governance Team, who provide regular reports and updates on progress. Contact is made with Borough directors if actions are not completed.

7.209 There is a weekly conference call between the Jameson Director of Nursing and the Central Governance Team to monitor progress.

7.210 When submitted by the Division as complete, the final version is scrutinised by the Jameson Director of Nursing, and each piece of evidence is reviewed.

7.211 We found that some of the actions lacked robust evidence of implementation, and two audits were particularly lacking in detail or outcomes. Several actions appear to have been completed, but not all of these had been marked as complete. We have however been provided with recent Trust information which shows that there is more overt version control of action plans, with detailed scrutiny before sign-off.

7.212 There is a central SI team who support divisions with the process of SI investigations. The central team would be part of a panel for serious incidents such as death of an inpatient or a homicide, arranging coordination and communications. The tracking of serious incidents has been a focus of work for the Trust both in terms of version control and Borough/investigator feedback about the investigations.

7.213 There is a dedicated SI investigator in the Division, with an SI investigator from the central resource aligned to the Division.

7.214 There is a weekly teleconference with the Jameson Deputy Director of Nursing, Governance and Central and Divisional SI leads to track progress with Boroughs getting weekly emails related to their ongoing serious incidents and outstanding serious incident action plans. A report is produced two monthly which tracks timeliness of SIs and the outstanding action plans.

7.215 The number of ongoing action plans and closed in month are reported to the quality and performance committee on a monthly basis, to the Board on a bi-monthly basis and we have also started to report this in the quarterly reports.

7.216 There are bimonthly and quarterly safety meetings, where SIs are discussed, and the 'clinical message of the week' may be a learning point distilled from an SI report.

CCG oversight

7.217 The CCG oversight is provided by NHS Harrow CCG, on behalf of North West London Collaboration of Clinical Commissioning Groups.

7.218 The CCG link to CNWL in 2018/19 is currently the Assistant Director of Quality and Safety, NHS Harrow CCG. A change of systems is in progress, while the North West London Collaboration of Clinical Commissioning Groups is developing structures.

7.219 The standard operating procedure for serious incidents is still in draft[86]. This includes a flow chart the overarching process for the management of serious incidents within the CCG, and a more detailed flow of the responsibilities of the CCG Patient Safety Team, and the CCG SI approval process.

7.220 Because of these structural changes, the detailed audit trail of approval and decision making in the case of this incident are not accessible.

7.221 We have however had positive feedback from the CCG about the improvements in quality of CNWL serious incident reports, the robustness of their action plans and improvements in timeliness.

7.222 There is a weekly SI group at the CCG which is attended by CNWL senior staff, to discuss reports and action plans. The Trust hold a bimonthly Clinical Quality Group workshop/seminar. Topics chosen are primarily based on some

[86] *NWL CCG Standard Operating Procedure (SOP) for the internal management of Serious Incidents utilising "Datix" v1 WR 24.8.18*

of the themes that are noted in the SI reports. These are attended by commissioners and appropriate service leads from the Trust.

7.223 The CCG make regular quality oversight visits to CNWL services and utilise action plans and learning from SIs to inform and guide these visits.

7.224 No concerns were expressed about this report or the completion of the action plan.

Any other related serious incidents at the temporary accommodation location

7.225 The internal investigation panel reviewed the learning from investigations following three homicides relevant to this investigation.

7.226 A homicide in 2010 was particularly relevant and information was sought regarding the implementation of the two pertinent recommendations. This independent investigation was concerning two men who lived in 'supported accommodation.'

7.227 The panel reported that they found evidence that the recommendations had been carried out.

7.228 One recommendation was 'the Serious Incidents policy should be amended to ensure that staff receive adequate and appropriate support following a serious incident'. The Incidents and Serious Incidents policy, implemented June 2012 and the more recent policy implemented in April 2015 clearly detail measures to be taken to ensure staff are supported, however it was not evident that the policy had been followed in this instance.

7.229 The other relevant recommendation identified was that a formal agreement between the housing provider and CNWL should be reached, covering information sharing responsibilities and feedback arrangements and that this should be shared with staff. It was noted that the agreement should describe the working relationship between the housing provider and operational services and outline the role of each, how concerns are raised with services and timescales for the response, overseen by team leaders. The panel viewed the document which had been completed in May 2012.

7.230 The panel understand the protocol was reviewed in March 2016 by Service Manager 1 (previously the Brent Community Rehabilitation Service Manager and who is now the Brent Community South and Early Intervention Service Manager) and will be circulated to staff and temporary accommodation providers for approval and was to be ratified at the Brent Care Quality Forum in early April 2016.

7.231 We found however that it was further recommended that the Trust reviews how it ensures that the person's history is adequately incorporated in the assessment of risk and that risk management is part of the subsequent care plan. Relapse indicators must be clearly identified and monitored by the care coordinator in conjunction with the individual's consultant. It was also recommended that the actions arising out of this review be included in the

audit programme in such a way that the Trust Board are able to satisfy themselves that these requirements are reflected in actual clinical practice.

7.232 In our view this aspect of practice directly impacted on Gary's care. At the most recent assessment of his mental state on 4 March 2015 the panel of inquiry report notes that the most recent risk assessment was not used to inform the assessment at the review meeting.

7.233 In Nigel's case it is clear from our investigation that the risk assessment should have been updated with the information about his overdose and suicidal thoughts, however the services did attempt to provide him with follow up and support by BHTT and the CCO, and we do not consider that this had any bearing on the homicide.

7.234 We have however made a recommendation (2) about the Trust providing assurance the Trust Clinical Risk Assessment and Management policy for Mental Health and Allied Specialties policy is implemented, which does raise the question of whether the action plan and assurances from the 2010 investigation were fully implemented.

8 Overall analysis and recommendations

8.1 The Trust's internal investigation identified a number of care and service delivery problems in relation to the care and treatment of Gary and Nigel and developed an action plan to address these. Although in our view this action plan is not complete, the Trust can evidence some positive changes that have been made.

8.2 The inappropriateness of the housing was of great concern to both families, and our investigation has shown that the Trust has recognised this and made wide-ranging changes to how housing is managed at discharge for vulnerable people.

8.3 It was recognised that there was insufficient support for both Gary and Nigel with regard to financial exploitation, and this has also been addressed by the Trust.

8.4 The safe administration and management of medication was of significant concern in both cases. Systems have been put in place to address the depot administration issues highlighted in Nigel's care.

8.5 The diagnosis and treatment of adult ADHD in BHFT and CNWL remains an outstanding issue. We consider that there was a lack of evidence-based treatment for the diagnosis of ADHD, and we have made a recommendation about this aspect (recommendation 6).

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

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

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

Priority Three: The recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Gaps or deficiencies in the care and treatment that both the service users received which could have avoided the homicide from happening

8.7 This element of the terms of reference require is to consider whether there were gaps or deficiencies which could have avoided the homicide from happening. In our view the private accommodation must be seen as a

contributory factor, affecting the daily lives of both young men, but there is no obvious causal link to the homicide.

8.8 The concerns about Nigel's care which have been identified certainly impacted on the quality of his care, but we cannot link these to an increase in his vulnerability to assault. It is clear that he had a care coordinator who knew him well and made great efforts to improve his quality of care, and that there was a therapeutic relationship in place. Nigel did not always agree with plans of care and was believed to have capacity to make choices.

8.9 The significant contributory factors in Gary's care were the lack of evidence-based treatment by the Early Intervention Service, associated with the lack of appropriate staffing resources. This meant that Gary did not receive appropriate care during his recovery from a significant psychotic episode. Gary was seen however in March 2015, when he showed signs of relapse and an increase in paranoia.

8.10 In our view the service response to his relapse indicators was insufficient to reduce his risk of relapse and did not address the potential increased risk of violence. He refused to take antipsychotic medication and was felt to be close to a full relapse. There was insufficient follow up after this review, which increased the possibility of violence.

Recommendations

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

Recommendation 1:
The commissioners of services and CNWL should ensure that the care and treatment of people with psychosis is delivered to meet the expectations of NICE guidance 'Psychosis and schizophrenia in adults: prevention and management' (CG178) CG178 in Brent community teams.

Recommendation 2
CNWL must ensure that there are clear standards for the accuracy, quality, and timeliness of discharge letters from Park Royal Centre for Mental Health, and that measures are in place to maintain these standards.

Recommendation 3
CNWL must demonstrate that the expectations of the Care Programme Approach policy with respect to regular timely documented CPA reviews are met, and there is a system in place to maintain these standards.

Recommendation 4
NHS NW London CCG and CNWL must demonstrate that the guidance in 'Coexisting severe mental illness and substance misuse: community health and social care services' (NICE 2016) is implemented in Brent EIS.

Recommendation 5

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

Recommendation 7
Where there is a question of capacity to consent to treatment, CNWL must ensure there is a structured process used to assess and record capacity, with action plans as appropriate.

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

Recommendation 6
Commissioners of services (NHS NW London CCG and NHS East Berkshire CCG) must ensure that there are clear pathways for the diagnosis, medication prescription and management of ADHD in adults.

Appendix A – Terms of reference

Terms of Reference for the Independent Investigation into the care and treatment of G and N

Purpose of Investigation

To identify whether there were any gaps or deficiencies in the care and treatment that both the service users received which could have avoided the homicide from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring. Specifically,

- Review the trust's internal investigations and assess the adequacy of the findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from both the service users first contact with services to the time of the offence, focusing on the period leading up to the homicide.
- Review and verify the trusts chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the appropriateness of the temporary accommodation, the time spent there and response from all partners to issues raised.
- Review any other related serious incidents at the temporary accommodation location to examine if any incidents had occurred previously, and what actions, if any, have been taken to address these.
- To understand and clarify actions taken following reports by G about his bank account being suspended due to fraudulent activity, being exploited by other residents and being targeted by drug dealers.
- To review the appropriateness and management of consistent requests from G for prescriptions of methylphenidate, which had been discontinued previously during his inpatient stay
- Review G's voluntary admission to Park Royal and whether a more restrictive regime was appropriate in light of his acts of violence
- Review G's drug regime and its potential contribution to the psychotic episodes and his risk from being given both amisulpride and citalopram

- Review the changes in dosage of G's antipsychotic medication, the timing of administration in light of olanzapine half-life and the appropriateness of his drug regime in light of best practice

- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.

- Examine the effectiveness of the service users care plans including the involvement of the service users and the families.

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

- Involve the families of both the victim and the perpetrator as fully as is considered appropriate.

- Provide a written report to NHS England that includes measurable and sustainable recommendations.

- Assist NHS England in undertaking a post investigation evaluation.

- Undertake an assurance follow up review 6/12 months after the report has been published to assure that the report's recommendations have been fully implemented

- Produce a short report that may be made public.

Appendix B – Documents reviewed

CNWL documents.
Nigel's CNWL clinical records.
Gary's CNWL clinical records.
Audit of EIS MDT actions November 2018.
Brent CMHT SOP short version August 2018.
Brent managerial supervision October 2018.
Brief interventions CMHT & EIS presentation.
Brent 'you made a difference' 14/11/18,17/10/18, 17/9/18.
Trust-wide Clinical Risk Assessment and Management Policy for all Mental Health and Allied Specialties (MHAS) clinical staff. TW/00022/14-17b December 2014.
Care Programme Approach Policy. TW/00070/15-17a January 2015.
Care Records Standards. TW/00005/16-18a April 2016.
Care Records Policy & Strategy. TW/00206/18-20a March 2018.
Copy of Brent HR dashboard.
CMHT compliance Brent v2.
CNWL Quality Account 2011/2012.
CNWL divisional structure November 2018.
CNWL Board papers March 2016, paper 5.
Guidance policy for adult safeguarding. TW/00196/17-20a January 2017.
Learning & improvement guide July 2015.
Mandatory Training & Appraisal Compliance Brent. CMHT Borough October 2018
Medicines Policy. TW/0039/14-17a February 2014.
Number of carer's assessment in Brent.
Incidents & serious incidents Policy. TW/00009/16-18f December 2018.
Responding to and Learning from Deaths Policy. TW/000362/17-20a September 2017.
Serious Incident review poster, January 2017.
Staff wellbeing CNWL poster.
Staff Appraisal and supervision pack, June 2018.
Staffing November 2018.
Substance Use in mental health Policy. TW/00351/18-23a. January 2018.
Thematic Review poster 2015- 2016.
Jameson Duty of Candour standard operating procedure (undated).
SI feedback letter.
Other documents.
G's GP records.
N's GP records.
NHS NWL CCG Draft SI SOP 24 August 2018.
CQC Brent 2017.
N's room video.

Appendix C – RCA standards

Standard		Present
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident.	Yes
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	Yes
1.3	The person leading the investigation has skills and training in investigations.	Yes
1.4	Investigations are completed within 60 working days.	No
1.5	The report is a description of the investigation, written in plain English (without any typographical errors).	Yes
1.6	Staff have been supported following the incident.	Yes
Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident.	Yes
2.2	The terms of reference for the investigation should be included.	Yes
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	Yes
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	Yes
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	Yes
2.6	A summary of the patient's relevant history and the process of care should be included.	Yes
2.7	A chronology or tabular timeline of the event is included.	Yes
2.8	The report describes how RCA tools have been used to arrive at the findings.	Yes
2.9	Care and service delivery problems are identified (including whether what were identified were actually CDPs or SDPs).	Yes
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	Yes
2.11	Root cause or root causes are described.	Yes
2.12	Lessons learned are described.	Yes
2.13	There should be no obvious areas of incongruence.	Yes
2.14	The way the terms of reference have been met is described, including any areas that have not been explored.	Yes
Theme 3: Lead to a change in practice - impact		
3.1	The terms of reference covered the right issues.	Yes
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	Yes
3.3	Recommendations relate to the findings and that led to a change in practice are set out.	Yes
3.4	Recommendations are written in full, so they can be read alone.	Yes
3.5	Recommendations are measurable and outcome focussed.	No
Total		**23/25**

Niche Health and Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

www.nicheconsult.co.uk