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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of a mental health service user (Mr N) in West London

February 2022

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Our report has been written in line with the terms of reference as set out in the proposal for an independent investigation into the care and treatment of Mr N. 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Events which may occur outside of the timescale of this review will render our report out-of-date.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. However, 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 & Social Care Consulting Ltd
4th Floor, Trafford House,
Chester Road
Manchester
M32 0RS

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

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Foreword

This report concerns the care and treatment of Mr N who killed 'L' on 16 August 2016 in West London. Although this report concerns the care and treatment of Mr N and does not tell the story of 'L', he too should be remembered as a young life tragically cut short.

We found in this investigation that the killing of 'L' was not predictable. However, we believe that it was preventable.

The services involved have developed action plans to implement the recommendations from this report. Because we believe that such similar events could arise in many other places, we urge all services involved in the care of young people with serious mental health problems and a history of substance misuse to take note of this report and its findings.

Services are now much more aware of the endemic problems of 'county lines' drug gangs and their exploitation of vulnerable young people, especially when they have mental health problems. But more work remains to be done to ensure that services work together to address this problem, so that young people with such a background are treated and supported in the community and not left vulnerable to exploitation, despite the risks they may initially present to others around them.

In July 2018, the Health Service Investigation Branch (HSIB) published a report into the care and treatment of a young person who committed suicide as they transitioned between CAMHS and adult mental health services. A recommendation was made about the responsibilities of NHS England and NHS Improvement to work with the commissioners of mental health services to ensure that the care of a young person before, during, and after transition is shared in line with best practice, including joint agency working.

We have identified further areas for improvement relevant to all wider health and social care systems involved with the care and treatment of young people with mental health problems, and we make an additional four recommendations to be taken forward nationally and for all services to consider:

Arrangements and decision-making regarding accommodation for 18+ care leavers after discharge from an inpatient mental health service.

We found a lack of effective interagency working between NHS mental health services and local authority 'Looked After Children' structures. This resulted in unstable accommodation, contributing to a lack of effective assessment and care planning. The unregistered accommodation was a 'last resort' solution, which in our view, was only necessary because of a lack of proactive assessment, care, and treatment.

Regional recommendation 1

The North West London Integrated Care System to seek assurance that all planning for care leavers discharged from mental health in-patient services formally involves the relevant local authority. Furthermore, to seek assurance that the application of

Section 117 Mental Health Act has been considered for patients who have been detained under Section 3 MHA.

Identification of and interventions for young people at risk from bullying and undue influence.

Despite system-wide programmes in place to identify and intervene in Child Criminal Exploitation, grooming and radicalisation, we found a lack of curiosity about the 'red flags' in this case. It was clearly possible for these issues to be 'hiding in plain sight' in 2016, but systems should be much more aware of the issues at hand, and the risks posed to vulnerable young people by these criminal gangs.

Regional recommendation 2

The North West London Integrated Care System should seek assurance that an understanding of the risks to vulnerable young people of 'county lines', and gang related threats is embedded in all services and systems dealing with the mental health of young people. This will help to ensure there are no opportunities for misperception and that vulnerable young people with serious mental health and substance misuse problems receive appropriate and timely services that meet their needs.

Antipsychotic depot prescription and administration to under 18s

As part of our background research, we have found that licensed medications for the treatment of psychosis for under 18s are very limited. Despite this it is clear they are widely prescribed as oral preparations, and less commonly as depot prescriptions. The safety and clinical data in this age group is also limited, and there are no depot medications licensed for the treatment of psychosis in under 18s. More research is needed to guide the use of antipsychotic depot medication in under 18s.

National recommendation 1

NHS England & NHS Improvement should work with NICE to consider including in existing guidance information about the prescribing of injectable anti-psychotics for the treatment of psychosis in under 18s.

Nick Moor,
Partner,
Investigations & Governance,
Niche Health & Social Care Consulting

1 Executive summary

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

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

1.5 Mr N killed L on 16 August 2016 following an altercation that started in the accommodation, where they both lived, and continued on the street outside. We would like to express our condolences to L's family. It is our sincere wish that this report does not add to their pain and distress and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr N.

Mental health history

1.6 Mr N was under the care of West London NHS Foundation Trust (the Trust) at the time he committed the homicide. He was initially under the care of South London and Maudsley NHS Foundation Trust (SLaM) Children and Adolescent Mental Health Services (CAMHS) prior to being admitted to the Wells Unit[3] in November 2015 under Section 2 of the Mental Health Act 1983 (MHA).[4]

1.7 It is reported that Mr N used cannabis from the age of 12. He tested positive for cannabis when he was admitted to the Wells Unit, when he returned to the unit having been absent without leave (AWOL) in April 2016 and was expelled from College in August 2016 because he smelt strongly of cannabis. His

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

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

[3] *The Wells unit is a secure unit for young people provided by West London NHS Foundation Trust.*

[4] *Section 2 MHA admission for assessment for up to 28 days. http://www.legislation.gov.uk/ukpga/1983/20/section/2*

offending history began at the age of 14 and by the time he was admitted to the Wells Unit he had convictions for a variety of criminal offences.

1.8 While detained in the Wells Unit Mr N was diagnosed with first episode psychosis and commenced on a depot injection.[5] After five months Mr N was discharged from the Wells Unit, this was six weeks before his 18th birthday. The Early Intervention in Psychosis team (EIP) in Ealing did not accept patients under the age of 18, so Mr N was discharged to the temporary care of Ealing CAMHS, with a plan to transfer him to EIP on his 18th birthday.

1.9 Mr N was under the care of Ealing Council (the local authority) as a Looked After Child and was accommodated under Section 20 of the Children Act (1989)[6] prior to his admission to the Wells Unit. He was discharged from the Wells Unit to his mother's address (address one) in April 2016. The views of Mr N and his mother about him returning to live with her were changeable while he was detained to the Wells Unit. It was noted that his mother found maintaining boundaries with Mr N a challenge.

1.10 Ealing CAMHS had limited success in engaging with Mr N. He did attend some appointments and they supported the provision of his depot once; the first depot post discharge was provided by the Recovery Team West. While under the care of CAMHS Mr N committed some criminal offences including shoplifting, taking a car without permission and criminal damage, and his mother reported being unable to manage him.

1.11 A professionals meeting was held on 29 June 2016, attended by EIP, CAMHS and the local authority social worker (SW1). SW1 thought that there were signs that Mr N's mental health was deteriorating, non-compliance with his medication, increasing criminality and bad behaviour towards mother. The plan from this meeting was for his care to be transferred to EIP.

1.12 The EIP care coordinator met with Mr N on 3 June 2016 to support the transfer of his care from CAMHS. This was the EIP care coordinators only face to face contact with Mr N in the community. Mr N did not engage with the team, attend planned medical reviews or receive his depot.

1.13 By the 18 July 2016, his mother was not willing to allow Mr N to live at her address. Following an appearance in court he was accommodated at a bail hostel (address three) at the direction of the court. At the time this placement was made the hostel was unaware of Mr N's mental health problems. The hostel became concerned about his behaviour and following a phone call with the EIP care coordinator they ended the tenancy on 4 August 2016.

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[5] A depot injection is a long-lasting injection of antipsychotic medication.

[6] Provision of accommodation for children: general.

(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of:

(a)there being no person who has parental responsibility for him;

(b)his being lost or having been abandoned; or

(c)the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care. http://www.legislation.gov.uk/ukpga/1989/41/section/20

1.14 Mr N was now homeless. His mother was prepared for him to return to live at her address in the short term in order to allow the local authority time to find him alternative accommodation.

1.15 The local authority then followed its own process to find accommodation for Mr N and only one provider was willing to provide accommodation with support for him (address four). This accommodation in Hayes was provided by an unregulated accommodation provider.

Relationship with the victim

1.16 L was already a resident at the accommodation in Hayes (address 4) when Mr N moved in, having been placed there by the local authority. This semi-independent accommodation was temporary and seen as a steppingstone for Mr N to independence. It provided accommodation for up to four young people at a time.

1.17 There is limited information available to the investigation about the relationship between the two boys. The Leaving Care team[7] were made aware of tensions between Mr N and L by the accommodation provider, but this information was shared after the homicide.

1.18 The day before the homicide an ambulance was called to address four and Mr N received medical treatment for a superficial wound to his mouth. It is unclear if this injury was sustained as the result of a fall or an assault. Information available after the homicide suggested that this incident may have involved L.

The homicide

1.19 At about 15.30 in the afternoon of 16 August 2016, L was sitting at a table in the office at the accommodation with an administrative assistant who was visiting the property. Mr N entered the room with a bag, he approached L and removed a large knife from the bag. He slashed/stabbed at L aiming for his upper back. To escape, L went out through the open office window. Mr N followed him onto the street, going out through the front door of the property. Mr N was heard to be shouting in a foreign language.

1.20 Mr N followed L down the street, L collapsed, and Mr N approached him and stabbed him repeatedly in the back. Mr N walked away and after a short distance he disposed of the knife over a high wall. He disposed of the jumper and jogging bottoms that he was wearing in a car park.

1.21 About 30 minutes after the incident Mr N walked into a local shop and requested a bottle of water, stating that he had no money to pay for it but would return with the money; the shopkeeper gave him his own bottle of water.

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[7] *Leaving Care Teams provide a service to those looked after children and young people who are preparing to leave care. The team works with young people from the ages 16 to 25.*
https://www.ealingfamiliesdirectory.org.uk/kb5/ealing/directory/service.page?id=2qQgso92q7c

1.22 The police were provided with Mr N's description by a witness to the attack and Mr N was arrested at 16.10 for attempted murder.

1.23 A local resident had attempted to provide L with first aid but by the time the paramedics arrived at the scene L was already in cardiac arrest. The helicopter emergency medical team arrived but were unable to revive L and he was declared dead at the scene at 16.37.

1.24 Mr N pleaded not guilty to the murder of L but guilty to manslaughter. He was detained on a Hospital Order under Section 37 MHA[8] with a restriction order under Section 41 MHA, without limit of time.

Internal investigation

1.25 The Trust carried out an internal investigation which was completed in April 2017.

1.26 The internal investigation made nine recommendations.

1. The Clinical Directors of the Wells Unit, CAMHS and EIP should meet to the review the report and consider ways to minimise the risk of multiple transitions in the future.

2. The service manager for CAMHS and EIP lead must develop a written protocol for the transition of patients from CAMHS to EIP.

3. The service manager of CAMHS must ensure that all aspects of care/treatment for a patient discharged into their care are adequately planned and the patient is fully aware of arrangements.

4. The EIP Lead must ensure that the 7- day risk plans are comprehensively documented with agreed timescales for escalation should the patient still not engage.

5. The Service Manager for CAMHS and EIP Lead must ensure that risk assessments are reviewed and updated in line with the Clinical Risk Policy.

6. The Service Manager for CAMHS and EIP Lead must ensure that management of dual diagnosis is included in relevant patient's care plans.

7. The EIP Lead must ensure that professionals meetings with all services involved with the patient are convened at key points to manage identified and escalating risks.

8. The EIP Lead must ensure that care co-ordinators arrange a regular update at agreed intervals with all agencies involved with the patient to facilitate effective collaborative working.

[8] *Powers of courts to order hospital admission or guardianship, with limits on discharge. http://www.legislation.gov.uk/ukpga/1983/20/section/37*

9. The Incident Review Facilitator must ensure that the report is shared with all agencies involved for shared learning.

1.27 The internal investigation report focused on Mr N's care and treatment in the community. No consideration was given to the quality of the discharge planning and discharge from the Wells Unit. The investigation report did not identify the implications for Mr N of being a Looked After Child (LAC) and the role the LAC team played in his care.

1.28 We have carried out a quality assurance review of the internal investigation and the Trust action plan. Our analysis of the internal investigation can be found at Section 6.

Independent investigation

1.29 This independent investigation has reviewed the internal investigation report and studied clinical information and policies. The team has also interviewed staff who had been responsible for Mr N's care and treatment and spoken to his current responsible clinician.

1.30 The investigation was carried out by Elizabeth Donovan, senior investigator for Niche, with expert advice provided by Dr Andrew Leahy, consultant child and adolescent psychiatrist. The investigation was supervised by Nick Moor, Partner and Dr Carol Rooney, Associate Director, Niche.

Conclusions

1.31 We have concluded that Mr N was not provided with an acceptable level of support by mental health services in the community after his discharge from the Wells Unit.

1.32 The plan put in place to allow him to access his depot while under the care of CAMHS was weak. In our view it was only because of the perseverance of the CAMHS junior doctor that Mr N received three depot injections between his discharge from the Wells Unit on the 25 April 2016 and his transfer of care to EIP on 29 June 2016.

1.33 EIP were not assertive in their approach to his care and support. They failed to see Mr N face to face, provide him with a medical review or administer his depot injection.

1.34 The Wells Unit did not give enough consideration to Mr N and his mother's support needs when considering his discharge to her address. His mother demonstrated an ambivalence about his mental health needs and need for medication.

1.35 The EIP care coordinator did not look for alternative accommodation for Mr N as they had agreed they would at the professionals meeting on 29 June 2016. They left responsibility for accommodating Mr N to the criminal justice service and local authority. The result was that when Mr N was no longer able to remain at his mother's he was moved to a bail hostel and then to address 4

without any further assessment of his mental health or consideration of his support needs by mental health services.

Findings and recommendations

1.36 This independent investigation has made findings and recommendations for the Trust to address in order to further improve learning from this event.

1.37 The Wells Unit was closed in September 2020 and the Trust no longer provides an inpatient forensic CAMHS service, patients requiring this type of placement is cared for in an out of area bed.

1.38 We have identified five recommendations made by this review relating directly to the Wells Unit. As a result of the closure of the Unit we consider two of the recommendations no longer applicable (Recommendation 11 and 15) and there is no expectation that the Trust will address these recommendations in their action plan. There is one recommendation no longer applicable to the Trust but applicable to the wider system, therefore Recommendation 12 has been removed, but has been included in the regional recommendations, for the North West London Integrated Care System.

Findings 1: Assessment and capacity
The Wells Unit completed a psychiatric assessment of Mr N that resulted in a revised diagnosis and medication regime. A thorough psychological assessment was undertaken while Mr N was on the Wells Unit, which drew together a number of other assessments that had been completed in the past together with assessments completed while he was on the Unit, including a speech and language therapy assessment. Mr N himself discussed the approach of his local community to mental health issues in a psychology appointment, but there is no evidence available that this was shared with the wider team. **Ealing CAMHS** made extensive efforts to engage him and to ensure his depot medication was administered. We have concluded that the Ealing CAMHS junior doctor developed a rapport with Mr N, and Mr N did attend some planned appointments. **EIP** accepted Mr N for an extended assessment of his mental health needs. However, in our view EIP staff spent a considerable amount of time looking for evidence that this was not Mr N's first episode of psychosis. A review of the notes indicates that psychosis was only considered a feature of Mr N's mental health issues immediately before his admission to the Wells Unit. **Capacity** There were no capacity assessments completed with regard to Mr N's mental capacity with regard to medication, finances, or substance misuse.
Findings 2: Clinical care and treatment
Wells Unit

Mr N was treated in line with NICE guidance, psychosis and schizophrenia in children and young people: recognition and management.

He was offered and accepted psychological therapy.

He was offered choice with regard to his medication and was supported in making his choice.

His family were offered and accepted family therapy.

He was provided with physical health care and treatment, and was offered advice about his illicit substance misuse, but did not accept it.

Mr N was provided with opportunities to leave the ward on escorted and unescorted leave. However, the plan for phased leave including home leave and overnight leave was not followed through.

Ealing CAMHS

The CAMHS team could be viewed as a 'holding' service until Mr N's care and treatment could be transferred to EIP on Mr N's 18th birthday.

EIP

Mr N had an identified care coordinator while under the care of EIP.

The Support Time and Recovery worker did not work with Mr N as agreed on 3 June 2016. This was a missed opportunity for a member of the EIP team to develop a relationship with Mr N.

The EIP team did not have face to face contact with Mr N in the following six weeks that he was under the care of the team. Although Mr N was in the red zone, this did result in a more assertive approach.

EIP did not negotiate with Mr N to provide his depot at a time and location that would have increased the chance of his compliance.

In our view the EIP team did not make sufficient efforts to engage with the police, courts and social workers in the face of a deteriorating situation, and no direct contact was made with Mr N.

Findings 3: Care Programme Approach

Ealing CAMHS did not complete a CPA review for Mr N when he was discharged to the care of the team. Had a CPA review been completed in line with the Trust policy it would have allowed for the team to articulate the challenges in providing Mr N with his depot, as an unmet need.

The CAMHS junior doctor did complete thorough mental health state assessments for Mr N on the occasions that he saw him, and these are clearly recorded in the clinical notes.

The CAMHS junior doctor completed a good transfer of care to EIP. Although this was completed over the phone, there was a professionals meeting prior to this with EIP and the social worker.

EIP did not complete an assessment or CPA review for Mr N. They saw him on one occasion when they attended a CAMHS appointment on 3 June 2016.

EIP accepted Mr N for an extended assessment of his mental health needs.

It is noted that EIP spent a considerable amount of time looking for evidence that this was not Mr N's first episode of psychosis. A review of the notes indicates that psychosis was only considered a feature of Mr N's mental health issues immediately before his admission to the Wells Unit.

Findings 4: Management of depot

The Wells Unit engaged Mr N in the discussions and decision making about his medication choices. Mr N recognised that when he was in the community there was a risk that his compliance with medication could be poor.

The Wells Unit did not recognise that a young person in receipt of depot medication was rare and that community services might not have been equipped to provide this for Mr N.

The Wells Unit should have sought to understand how the depot would have been provided in the community and ensure that a more robust plan was in place.

The **CAMHS** plan for the provision of Mr N's depot when he was discharged into the community was not robust. No named member of the CAMHS team took initial responsibility for managing the provision of the depot. CAMHS did not provide depot injections and the Recovery team provided the initial depot as a favour; there was no plan in place for future depot injections.

The CAMHS junior doctor endeavoured to provide Mr N with his depot in the face of a number of challenges, such as the CAMHS service not providing depots, not understanding the prescribing process etc.

EIP were not assertive in their approach to providing Mr N with his depot. They were reliant on Mr N attending the team base and would not provide a depot at home because Mr N was not known to them and this was identified as a risk.

EIP did not recognise that Mr N's non-compliance with his medication was a relapse indicator.

Findings 5: Alcohol and substance misuse management

Mr N declined offers of support from mental health services to manage his substance misuse. It is reported that he did attend a session with the local authority substance misuse worker, but he did not continue to engage with them.

Given Mr N's history of substance misuse mental health services did not consider Mr N to be a dual diagnosis patient and he was not offered an assessment, treatment and advice as such.

Findings 6: Discharge from the Wells Unit

The discharge was informed by Mr N's approaching 18th birthday and he became the victim of 'birthday services', i.e. services choosing to strictly impose age criteria to exclude a patient's access to the service.

The discharge from the Wells Unit did not consider the NICE guidance on transitions. This contains advice about the risk of transferring children and young people between services and warns against transitions between multiple services in a short period of time.

The discharge plan from the Wells Unit did not identify and address Mr N's support needs when he was in the community.

The plan to discharge Mr N to the care of CAMHS for six weeks and then to transfer his care to EIP was not robust. There was no clear care plan agreed with CAMHS about the care and treatment that they would provide beyond an ad hoc agreement for the team to support Mr N's depot.

There was no relapse plan in place with clear relapse indicators and a contingency plan other than to take Mr N to Accident and Emergency (A&E).

From the discussion at Mr N's discharge CPA meeting the Wells Unit and CAMHS believed that the EIP team had accepted Mr N for assessment/care and treatment on his 18th birthday.

We have concluded that this was not the case and that the EIP team accepted Mr N as a transfer from CAMHS after their assessment meeting with him on 3 June 2016.

Findings 7: Transition between services

The NICE guidance 'transition from children's to adult's service for young people using health or social care services should have informed Mr N's discharge from the Wells Unit, as he was six weeks short of this 18th birthday.

Had this been used to inform the process better consideration might have been given to:

- ensuring that Mr N received appropriate support with his psychosis.
- his social and personal circumstances, especially the appropriateness of him returning to live with his mother; and,
- address outcomes such as education, community inclusion, health and well-being, including his emotional health, his independent living and housing options.

The guidance is clear that 'the point of transfer should not be based on a rigid age threshold and take place at a time of relative stability for the young person.'

Mr N's rapid transfer through CAMHS to EIP was based on the application of a rigid age threshold and there was no period of stability for Mr N.

There was no agreed protocol to inform the transition between CAMHS and EIP.

There was a misunderstanding between the services about the CAMHS service offer. EIP described an understanding that CAMHS could provide an EIP service for a patient under the age of 18 and that this could be extended by three years. This would have been applicable to a young person who was on a clear pathway with CAMHS prior to their 18th birthday. However, EIP had agreed at the discharge planning meeting that Mr N would transfer to their care on his 18th birthday.

This series of rapid transfers between service is not in keeping with the NICE guidance that states young people should '*routinely receive care and treatment from one single multidisciplinary team (MDT); are not passed from*

team to team unnecessarily; do not undergo multiple assessments unnecessarily.'

Findings 8: Application of the Mental Health Act

The Mental Health Act was correctly applied to Mr N throughout his detention at the Wells Unit.

There is no justification given for admission to medium ~~security~~ mental health unit. We would have expected to see evidence of a discussion at the CAMHS national network meeting, however there was no record of such a discussion in the clinical notes. It appears that the decision to admit to the Wells Unit was made by the individual clinicians.

We have not been able to find any evidence of the proper application of Section 117 MHA in relation to the social care support available to Mr N following his discharge from the Wells Unit.

Findings 9: Risk assessment and management

The Wells Unit completed a SAVRY[9] for Mr N. We have not been able to establish how widely this was shared with community services. We were told by the Wells psychologist that this was shared with the CAMHS consultant along with the Wells Unit discharge summary. However, this assessment was not uploaded to RiO[10] until September 2016 so we are unclear if this assessment was available to EIP.

There was no obvious assessment or care planning in response to the risks presented by Mr N when he absconded from the ward area.

He was not assessed through the use of Section 17 leave prior to discharge.

CAMHS did not update the Trust risk assessment in line with the Clinical Risk Policy:

- when Mr N transitioned from the Wells Unit.
- when high risk incidents were reported by Mr N's, i.e. criminality; and
- when he missed his depot.

EIP did not update the Trust risk assessment:

- when Mr N transitioned from CAMHS.
- when Mr N was not engaging with EIP.
- when he missed his depot.
- increasing criminality; and
- when there were reports that Mr N had spat at his mother when she would not give him money.

EIP was not assertive in their approach to the care and treatment provided to Mr N. He was placed in the red zone for the whole of the time he was under the care of EIP. However:

[9] *SAVRY- Structured Assessment of Violence Risk in Youth. https://www.annarbor.co.uk/index.php?main_page=index&cPath=416_419_189*

[10] *The Trust electronic clinical record system*

- **the strategies and plans were not comprehensively documented.**
- **no timeframe was identified for escalation if Mr N did not engage with the team.**
- **the plan remained the same from week to week; and**

No risk assessments were completed for Mr N after he left the Wells Unit so there was no assessment made of his risk to others.

Findings 10: interagency communication

The Wells Unit worked collaboratively with all the agencies in the community who supported Mr N.

The **Ealing CAMHS** junior doctor worked collaboratively with the local authority social worker.

EIP was reliant on the Leaving Care Team contacting them.

EIP was not proactive in seeking communication with or information from the Leaving Care Team.

Findings 11: Safeguarding

Trust safeguarding policies were not followed when information about sexual, financial and physical vulnerability were reported involving Mr N.

Trust policies regarding carer support and risk assessment were not followed.

Findings 12: Gang involvement

Services did not demonstrate an awareness of Mr N's risk with regard to gang activity. They lacked professional curiosity and did not seek further assurances from the police when presented with further information that may have supported the idea that Mr N was involved in gang activity.

Findings 13: Family engagement, carers assessment, culture and community

Family engagement and carers assessment

The Wells Unit developed a good working relationship with Mr N's parents and provided them with family therapy.

The CAMHS junior doctor developed a good working relationship with Mr N's mother.

EIP did not develop a relationship with Mr N's mother.

Mental health services did not complete a carer's assessment for Mr N's mother to determine her care and support needs.

Culture and Community

The Wells Unit did not fully explore with Mr N and his family the impact that their cultural background had on their understanding of the mental illness that he was experiencing and his need for treatment.

Although the family therapy at the Wells Unit was of value, the ward did not fully identify the cultural factors that were at play within the family dynamic,

or the impact that cultural factors had on Mr N's mother's attitude to his mental health problems, care and treatment.

Findings 14: Mental health services and accommodation

We have concluded that his mother was not able to manage Mr N and the breakdown of this placement was inevitable.

At the professionals meeting on the 29 June 2016 the EIP care coordinator agreed to start to look for supported accommodation for Mr N, we have not been able to find any evidence that they did this.

The EIP care coordinator was aware that Mr N had been asked to leave the bail hostel and the local authority were seeking an alternative placement for him. The EIP care coordinator did not consider that Mr N might have required a placement to meet his specific mental health needs and agreed to look for accommodation for him. This was a missed opportunity.

Findings 15: Local authority process for placement at address 4

The local authority supported Mr N's return to live with his mother, completing home visits to monitor the situation and sharing concerns with mental health services.

The local authority completed a comprehensive referral for a placement through the Access to Resources Team (ART) at the end of July 2016. The placement at Hayes was the only provider to offer to accommodate Mr N.

We have been unable to conclude that the unregulated-status of this accommodation was a directly influencing factor in the homicide.

Findings 16: Internal investigation

The narrow scope of the Trust SI investigation did not allow for a full exploration of the care and treatment provided to Mr N prior to the incident. This narrow scope limited the findings of the investigation.

Mr N was supported by the Leaving Care Team, it would have been good practice to have invited the team to be part of the investigation. This would have helped the panel to develop a more rounded picture of the care and support available to Mr N.

The recommendations made are not, in our view, sufficiently focused on systemic issues, so are unlikely to prevent a reoccurrence.

Findings 17: CCG oversight

There was insufficient CCG oversight of the Trust action plan.

Recommendation 1

The Trust must ensure that there is a clear system for ensuring that capacity assessments are completed and recorded where indicated.

Recommendation 2

The Trust CAMHS service must ensure that all patients under its care that are subject to CPA have a named care coordinator.

Recommendation 3

The Trust must revise the EIP Zoning Policy to more clearly define the care and treatment that a patient in the red zone can expect, to support a more assertive approach.

Recommendation 4
The Trust should develop a performance matrix to monitor and improve compliance with the Trust CPA policy, and this matrix must identify patients who have transferred between services and if a CPA was completed.

Recommendation 5
The Trust must revise the current arrangements to ensure that missed depots are reported to the care coordinator within 48 hours and what plans need to be put in place to provide the missed depot.

Recommendation 6
The Trust must ensure that there is a clear and transparent process in place that will support all patients to be provided with a depot, irrespective of the team providing care and treatment. These arrangements must identify the criteria for providing a depot in a patient's home.

Recommendation 7
Trust medicine management policies for long acting antipsychotic injections should provide guidance for their use in young people.

Recommendation 8
The Trust to review the approach that it takes to young people with established substance misuse issues and to develop a dual diagnosis approach to these patients.

Recommendation 9
The Trust must provide assurance that all transitions between services for children and young people are completed in line with NICE guidance on the Transition of children and young people.

Recommendation 10
The Trust CAMHS to review its approach to transferring patients and to benchmark itself against the NICE guidance on the Transition of Children and Young People, to use the findings to develop a robust patient centred approach to transfer and discharge.

Recommendation 11
The Wells Unit operational policy should include the expectation that all admissions make reference to the clinical rationale for the level of security.

Recommendation 12
The Trust must ensure that the expectations of Section 117 MHA are applied when patients are discharged from out of area CAMHS forensic admissions.

Recommendation 13

The Trust should audit current risk assessments completed in CAMHS and EIP against the Clinical Risk Policy, and then develop a plan to improve performance and quality.

Recommendation 14
The Trust must review its CPA policy to ensure that where there are multiple agencies providing care and support to a patient the care plan identifies:

- The lead agency for communication between the agencies
- Information and reporting channels
- Reporting intervals
- How urgent information will be effectively shared
- Contingency plans for information sharing when staff are absent from work
- Consideration of the application of Section 117 MHA were applicable.

Recommendation 15
The Wells unit must ensure that all patient reported allegations of bullying are appropriately investigated, and safeguarding procedures instigated.

Recommendation 16
The Trust must ensure that the policy expectations regarding risks to family members are incorporated into risk assessment and care planning.

Recommendation 17
The Trust and Local Authority should complete a review of the current processes in place for identifying children and young people who may be vulnerable to child exploitation, county lines drug gangs or general involvement with gangs to ensure that these are in line with current national best practice and local expectations on exploitation.

Recommendation 18
The Trust must ensure that all families caring for young people in inpatient services are offered access to a carers assessment.

Recommendation 19
The Trust should assure itself that the perspective of families is included in care planning, and appropriate cultural awareness is applied when communicating with families.

Recommendation 20
The Trust must provide assurance that appropriate accommodation is addressed in all patients' care planning at the point of discharge from out of area CAMHS forensic admissions.

Recommendation 21
The Trust must ensure that there are effective processes in place for working with the local authority to meet the accommodation needs of young people with mental health problems.

Recommendation 22
The Trust to review its existing management of investigations against the requirements of the NHS England SIF, and develop and implement a methodology for the management of investigations that meets the requirements of the NHS England SIF.

Recommendation 23
The North West London Collaborative of CCGs should revise the CWHHE Serious Incident Operational Policy (November 2016) against the requirements of the NHS England SIF to ensure that it meets with national policy and guidance with regard to the monitoring of action plans. It should also be explicit about the criteria that must be met before an incident can be closed on StEIS.

Good practice

1.39 We would like to commend the work of the junior doctor in the Ealing CAMHS team for his work as de facto care coordinator. He was the only mental health professional in the community who developed a relationship with Mr N that resulted in Mr N attending appointments and accepting his depot.

1.40 He also navigated the prescribing and dispensing process to ensure that Mr N received his depot on two occasions while under the care of CAMHS, in addition to the depot provided by the adult community team as per the arrangements agreed at the discharge CPA meeting.

1.41 We also commend the Trust for putting together a serious incident investigation panel that included a psychiatrist from another Trust to provide an addition level of scrutiny and independence.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework (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. 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 overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.4 The investigation was carried out by Elizabeth Donovan, senior investigator for Niche, with expert advice provided by Dr Andrew Leahy, consultant child and adolescent psychiatrist. The investigation was supervised by Nick Moor, Partner and Dr Carol Rooney, Associate Director, Niche.

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

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

2.7 We used information from:

- South London and Maudsley NHS Foundation Trust.
- West London Mental Health Trust.
- Ealing Council.
- London Ambulance Service.
- Hillingdon Hospitals NHS Foundation Trust.
- NHSE England Specialised Commissioners.
- Ealing Safeguarding Adults Board.

2.8 As part of our investigation we interviewed:

- Consultant psychiatrist – the Wells Unit.
- Psychologist – the Wells Unit.

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

- CAMHS junior doctor.
- EIP care coordinator.
- EIP team leader.
- Leaving Care team leader – Ealing Council.
- Lead investigator – Trust internal review.
- Clinical adviser – Trust internal review.

2.9 A full list of all documents we referenced is at appendix B.

2.10 The draft report was shared with NHS England, West London NHS Trust, Ealing Council and NHS England North West London Collaborative of Clinical Commissioning Group. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with the victim's family

2.11 We met with L's mother at the beginning of the investigation, and she talked to us about L. She told us that he had spent some of his childhood under the care of his Aunt, but prior to the incident he was being accommodated under the care of his local authority. She told us that L had been placed in the accommodation where the incident happened because it was close to the College that he wanted to attend to complete his education. We had shared the terms of reference for this review with L's mother and in the meeting, she told us that she had no further questions that she wanted the investigation to address.

2.12 NHS England contacted L's aunt and girlfriend and offered them the opportunity to meet with the lead investigator. Whilst they expressed an interest in meeting with us and contact was made, they were unable to make arrangements to meet.

2.13 We offered L's mother the opportunity to meet with us prior to publication of the report and we will make contact with his aunt and girlfriend and offer to meet with them.

2.14 Feedback about the draft report was provided to L's mother and Aunt on 22 June 2021 by video call. This was supported by the solicitor representing them. Following this call the solicitor provided written comments on the draft report on behalf of the family. We have responded to the comments made on behalf of the family and where appropriate revised the draft report. Where we have not been able to revise the report, we have shared the rationale for this with the family.

Contact with the perpetrator's family

2.15 We met with Mr N's mother at the beginning of the investigation, and she shared Mr N's history with us. She did not have any specific questions that

she wanted the investigation to answer beyond the terms of reference that we shared with her.

2.16 We provided Mr N's mother with initial feedback about the draft report in a phone call with her on 20 May 2021. This was followed up with a face-to-face meeting with her on 22 June 2021. His mother provided us with some feedback on the draft report and where appropriate we revised the draft report. Where we have not been able to revise the report, we have shared the rationale for this with her.

Contact with the perpetrator

2.17 We wrote to Mr N at the start of the investigation and explained the purpose of the investigation.

2.18 We met with Mr N in June 2019 and gave him the opportunity to share his story with us. Mr N did not share any concerns about his care and treatment with us at this meeting.

2.19 We met with Mr N on 22 June 2021. His engagement in this meeting was better than the meeting we held with him in 2019. We talked to him about the findings of the report and shared a copy of the report with him and his care team. Mr N did not have any comments to make about the draft report and did not request any revisions.

Structure of the report

2.20 Section 3 describes Mr N's background.

2.21 Section 4 sets out a detailed chronology of the care and treatment provided to Mr N.

2.22 Section 5 examines the issues arising from the care and treatment provided to Mr N and includes comment and analysis.

2.23 Section 6 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.24 Section 7 sets out our overall analysis and recommendations.

3 Background of Mr N

Childhood and family background

3.1 Mr N was born in London on 7 June 1998, he is the only child of his parents, Ms N and Mr I. Mr N's mother came the UK from Africa before he was born, and his father followed her in 1999. When Mr N was five the family moved to Northolt.

3.2 Ms N reported to mental health services that Mr N was born weighing less than 2kg, but he grew normally and was an appropriate weight by the age of one. However, by the time he was at primary school he was experiencing bullying because he was overweight. The issue with his weight was exacerbated when he was prescribed anti-psychotic medication in 2016.

3.3 It is reported that his parents divorced in 2013/14. Mr N continued to be cared for by his mother while his father-maintained contact with him, although he did spend periods of time abroad. It is reported that from an early age Mr N's mother experienced difficulty maintaining boundaries with him.

3.4 Mr N began to use cannabis from the age of 12 and his challenging behaviour began at about this time. It was not long after this that his father queried him being involved with a gang and that he was being manipulated/exploited.

3.5 Mr N became involved with the criminal justice system and this resulted in him being remanded into custody at Oakhill Secure Training Centre[12] in April 2014. On 15 August 2014 he was sentenced to a Youth Referral Order (YRO).

3.6 Following this his mother requested that he be accommodated by the local authority because she was unable to cope with him.

3.7 Whilst at primary school Mr N made an allegation of sexual abuse against a teacher and aged 17 accused a close family member of abusing him sexually when he was four years old.

Looked After Child/Care of the local authority

3.8 Mr N was referred to the Ealing Children's Integrated Response Service (ECIRS)[13] in February 2014 following an argument with his mother, this referral was closed and the Youth Offending Team[14] (YOT) continued to provide him with support.

3.9 In April 2014 Mr N was reported as missing and a further referral was made to ECIRS. Mr N had gone missing from his home with a knife because he believed himself to be in danger. He had been told not to go onto the housing

[12] *Oakhill Secure Training Centre is a young offenders centre.*

[13] *Ealing Children's Integrated Response Service (ECIRS) is the Ealing Council single point of entry for all referrals where there is a need for support, or where there are specific concerns about the welfare of a child or young person. https://www.ealing.gov.uk/info/201183/information_for_professionals/1301/ealing_childrens_integrated_response_service/1*

[14] *https://www.gov.uk/guidance/youth-offending-teams-london*

estate where he lived by an Elder from the Mosque. Following his return home, he was arrested for the possession of a bladed weapon and was given a 12-month custodial sentence to Oakhill Secure Training Centre.

3.10 In August 2014, the court discharged Mr N to the care of the local authority. He was accommodated under Section 20 Children Act 1989[15] at address 1. He repeatedly went missing from this accommodation. In October 2014 it was reported that he went missing a total of 18 times.

3.11 In May 2015, the local authority moved Mr N to another address (address 2), it was from this address that he was admitted to the Wells Unit.[16]

3.12 Whilst under the care of the local authority Mr N received support from a LAC social worker (SW1). They continued to provide support to Mr N while he was in the Wells Unit, played an active part in the discharge planning and continued to provide support to Mr N and his mother following discharge.

3.13 The local authority was responsible for accommodating Mr N at address 4. This was following the breakdown of the court directed placement at the bail hostel (address 3).

Schooling

3.14 Mr N attended primary school in Northolt. Whilst at primary school he presented with behavioural problems. He was disruptive in a school environment and he made an allegation of sexual abuse against a teacher. In December 2004 Mr N told the school nurse that he found school difficult.

3.15 As a result of the reported behavioural problems Mr N was assessed by an educational psychologist. No significant concerns were identified and when he left at the end of year 6, he had achieved average scores in his SATS.[17]

3.16 Following primary school Mr N was registered at Northolt High School (year 7), however, he did not engage with secondary school and he was permanently excluded in 2012, in year 9. This was following an incident when he brought a BB gun[18] into school (it was noted that the gun was broken).

3.17 Mr N then attended off-site specialist provision, but his attendance was poor. In October 2012 he was excluded from this specialist educational provision following a search of his clothing when he was found to have a fishing knife. He was placed on an on-line educational programme that required him to log

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[15] *Provision of accommodation for children: general.*

(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of:

(a)there being no person who has parental responsibility for him;

(b)his being lost or having been abandoned; or

(c)the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care. http://www.legislation.gov.uk/ukpga/1989/41/section/20

[16] *The Wells unit is a secure unit for young people provided by West London NHS Foundation Trust*

[17] *Statutory Assessment Tests carried out in UK schools by the Standards & Testing Agency. SATs are tests which help to measure the success schools have had teaching their children.*

[18] *BB guns are air guns designed to shoot metallic ball projectiles called BBs.*

onto the education website between 9.00 am and 3.00pm each school day. In June 2013, his learning mentor noted that Mr N had not been logging on consistently and had not completed much of his work.

3.18 In September 2014 Mr N was enrolled at Lewisham College but was taken off the roll in October 2014 for poor attendance. He was then accepted for an adult course at Lewisham College but failed to attend for the interview. He enrolled for a similar course at Sutton College but again did not attend regularly.

3.19 In October 2015 Mr N enrolled at City Gateway College to study business administration but this was suspended due to concerns about his state of mind.

3.20 Mr N briefly attended Skills Training UK following his discharge from the Wells Unit but was asked to leave. This was because he attended smelling of cannabis, urinated outside the building, and made inappropriate comments to female learners.

Relationships

3.21 Mr N and his mother were reported to have a difficult relationship. She found it a challenge to maintain boundaries with him. She reported that he would bully her to provide him with money and if she tried to deny his requests, he would cause damage to her home. She was concerned about what the local community said about Mr N and his involvement with the police and mental health services. This combined with her cultural background (while at the Wells Unit Mr N spoke to the psychologist about his community not sharing the modern western view of mental health issues), resulted in her being at best ambivalent towards Mr N's mental health problems and his need for medication. However, his mother was supportive, visited him in hospital and attended family therapy sessions.

3.22 During the period covered by this report his mother was also the main carer for her own mother with whom she shared her home.

3.23 Mr N had a more distant relationship with his father, who had another family and was often abroad. However, his father was supportive, visited him in hospital and attended some of the family therapy sessions.

3.24 Mr N disclosed no friendships with young people of his own age to any of the professionals who worked with him. He would not disclose who he was with when he went missing from his home, the local authority placement where he lived, or the Wells Unit when he was detained there. He did report to staff while on the Wells Unit that he was being bullied by other young people on the unit, although this was not always witnessed by the staff and his reports of the bullying were inconsistent.

3.25 The consultant psychiatrist states in the report she prepared for the Mental Health Tribunal in February 2016 that '*[Mr N] has consistently said that he has acquaintances rather than friends. It is noted that professionals have very little*

information about who he associates with.' She went onto say that '*since his admission to the Wells Unit. [Mr N] has not wanted to discuss his peer relationships. He has not asked to be in contact with any friends in the community*.'

Contact with criminal justice system

3.26 Mr N first came into contact with the criminal justice system in May 2011 when he was accused of the theft of two phones while at school. This first offence resulted in the charge being dismissed/dropped. Later that month he was arrested for arson, again this charge was dismissed/dropped.

3.27 Between October 2012 and September 2015 Mr N committed a number of offences including possession of an offensive weapon, theft, having an article with a blade, assault by beating and criminal damage.

3.28 Details of the offences and their disposal can be seen in the table below.

Date of offence	Offence	Date of Disposal	Disposal
12/05/2011	Theft of two phones at school	27/09/2011	Charge dismissed/dropped
30/05/2011	With a youth and one of them pushed hot coals through a letter box. Arrested for arson with intent but does not appear to have been charged.		Charge dismissed/dropped
12/10/2012	Having an article with a blade in a public place	unclear	Youth Referral order
07/05/2013	Possession of offensive weapon with intent to do grievous bodily harm (GBH)	12/12/2013	Youth Referral Order 2 years and remanded to Oakhill
03/07/2013	Theft (from Selfridges)	31/08/2013	Fine
14/04/2014	Phone and knife recovered from him following a search at the pupil referral unit		No charge was brought at this time
22/04/2014	Having an article with a blade in public	15/08/2014	Youth Referral Order 2 years and remanded to Oakhill
30/06/2015	Assault by beating, criminal damage	07/09/2015	Youth Referral Order 1 year

22/09/2015	Broke shower panel in supported accommodation		Unclear from records if he went to court to answer charge - was due in Bromley Court 29/09 or 29/10

3.29 Mr N also had a number of contacts with the police for reasons other than criminal behaviour. In August 2010, he told the police that he had run away from home because he had been chastised by his parents. There were also further times when Mr N was reported missing by his parents and these are detailed below.

Date of contact	Issue	Outcome
09/08/2010	Reported to police by a member of the public who was concerned about this behaviour. Had bought food and eaten it in a toilet, said he had run away from home. He told police he had been told off by his father for downloading inappropriate material from Facebook.	Police returned Mr N home. Parents confirmed Mr N's story about inappropriate material. Parents were unaware that Mr N had run away and reported that they thought he was at a home of a friend nearby.
22/03/2011	His mother reported that Mr N had not returned home from school.	Police attended the family home; Mr N had returned home just before they arrived. His mother said the school had contacted her and said that he had not arrived in school that morning. The school had also told her that Mr N had been caught shoplifting in Harrow but had been allowed to put the items back and leave the store. Mr N said that he had attended school and that they had confused him with a child with the same name. After school he had gone to an arcade with a friend, they had been chased by other children and he had hidden from them until 22.30. Mr N was unable to say why he had not contacted the police or his family.

		Police outcome – no cause for concern.
27/03/2011	His mother reported Mr N missing.	Mr N returned before the police arrived at his home. He said he had been playing football and lost track of the time. His mother said that she thought that he was mixing with the wrong crowd and he was misbehaving. Police gave '*strong words of advice.*'
22/06/2012	Involved in fight with another youth at Study Centre and required treatment at hospital.	It was reported that there may have been ongoing issues of bullying between Mr N and the other pupil. Mr N denied this.
19/07/2012	Mr N called police using his mother's phone and said he was going to be kidnapped. Police attended Mr N's home, only father was there. Called mother, Mr N was with her and expressed concerns about *'classmates'* who had said '*people were gonna (sic) knock on his door at home and do something.*' Mr N would not answer any further questions and the phone was turned off when the police tried to make further contact.	His father told the police that Mr N was regularly saying things like this and that they were liaising with the school. Police had concerns about what was happening at the school but were satisfied that this was being dealt with by the school. This was discussed with an Inspector before the incident was closed.
06/08/2012	Mr N reported that he had been threatened at school. His father expressed concerns that a gang was trying to recruit him, but Mr N is saying no, and this is causing problems.	A referral to SAFE[19] was made and they started to work with the family on 08/01/2013

[19] *Supportive Action for Families in Ealing. SAFE is an area-based, multi-disciplinary service bringing together professionals from social work, domestic violence, education, parenting and mental health backgrounds. The service offers a range of preventative interventions to ensure better long-term outcomes for families https://www.ealing.gov.uk/info/201023/children_and_families_social_care/1187/safe_-supportive_action_for_families_in_ealing*

	Parents willing to work with SAFE, Mr N is not.	

Substance Misuse

3.30 Mr N was reported to be using cannabis from the age of 12. While an inpatient at the Wells Unit he periodically said that he was going to stop using cannabis but there was no evidence that he did. Once he was back in the community there is strong evidence that he was continuing to use cannabis, and he was expelled from college for smelling strongly of cannabis.

3.31 He would also misuse alcohol and following his detention to a police station in July 2016 he told the assessing mental health team that he had drank two bottles of wine prior to his arrest. The referral for supported accommodation made in August 2016 identified that there were empty alcohol bottles in his room and outside his bedroom window when he was living at the bail hostel.

3.32 There is no evidence available to suggest that Mr N used any other illicit substances.

3.33 Mr N accessed support with his substance misuse provided by the YOT, but he declined offers of support from mental health services and did not engage with the support available from the local authority.

4 Care and treatment of Mr N

Contact with mental health services prior to the Wells Unit

4.1 The first recorded contact with mental health services was when Mr N was referred to SLaM CAMHS in July 2013. On initial assessment his family told the service that there had been a change in Mr N's behaviour over the previous two years and that they attributed this to his use of cannabis. Mr N refused to attend his GP's surgery for a physical examination and drug test.

4.2 In December 2013 Mr N was to be sentenced for wounding with intent and possession of an offensive weapon. SLaM CAMHS completed a psychology assessment at the request of the court. The YOT worker was concerned that Mr N was presenting as sad and demotivated and not accepting responsibility for his actions. They queried if there was an underlying emotional or behavioural issue that might shed some light on his offending.

4.3 The assessment concluded that Mr N was depressed, isolated and confused. He was described as an intellectually vulnerable person with some difficulties communicating, who struggled to organise and orientate himself in some circumstances.

4.4 In May 2015, the YOT made a further referral to SLaM CAMHS. This referral identified that Mr N smoked cannabis (he had completed some sessions with a substance misuse worker) and included concerns about his emotional/mental health and details of his criminal offences. An assessment summary sent to his GP in September 2015 suggested a working diagnosis of mental and behavioural disorder due to cannabinoids; unspecified mental and behavioural disorder.[20]

4.5 On 22 September 2015 Mr N broke a shower screen at address 2 and was arrested. Whilst at the police station he told his key worker that he had been sexually assaulted by a close family member when he was young. He was due in Bromley Court on the 30 October 2015 to answer a charge of criminal damage.

4.6 On 24 September 2015 Mr N did not attend a planned appointment with SLaM CAMHS. The housing support worker provided details of his recent behaviour. Mr N was reported to be fearful of people, not leaving his room or wanting to go out. He described feeling paranoid and hearing voices.

4.7 SLaM CAMHS applied for a Section 135[21] MHA warrant on 25 September 2015 so that an assessment could be completed for Mr N. The application identified that in the last two months Mr N's behaviour had become unmanageable, noticeably more depressed than usual and appeared to be displaying psychotic symptoms. A mental health assessment was completed that day by the SLaM CAMHS psychiatrist at address 2. The support workers

[20] *(ICDC10 code F12.90) Substance use disorder, also known as drug use disorder, is a condition in which the use of one or more substances leads to a clinically significant impairment or distress. https://icd.codes/icd10cm/F1290*

[21] *Section 135 Mental Health Act 1983 Warrant to search for and remove persons suspected to be in need of care and treatment. http://www.legislation.gov.uk/ukpga/1983/20/section/135*

at the property provided details of Mr N's recent behaviour. This included him being fearful of people, not wanting to leave his room, him feeling paranoid and hearing voices. The assessment concluded that he was not detainable. He was prescribed risperidone[22] 0.5mg, although he did not collect the prescription for this medication.

4.8 After the assessment Mr N went to stay with his mother. On 28 September 2015, his mother said that she did not feel safe with him and she was advised by support staff from address 2 to take him to A&E. His mother reported that Mr N had been staring into space for long periods of time; she had heard him scream while in the bathroom and he had hit the toilet. He had also thrown a computer monitor through a window and smashed a television.

4.9 Mr N's mother and SW1 took him to A&E. They confirmed that Mr N was living at the local authority placement (address 2) during the week and with his mother at the weekend. During the mental health assessment Mr N was thought disordered and displaying anger towards his parents (he had recently disclosed alleged abuse by a close family member when he was four years old and he was angry about this). Mr N self-reported using cannabis since the age of 12. He had been using it daily but was now only using it occasionally. He tested positive for cannabis while in A&E. Mr N disclosed that he has been hearing voices since the age of 14 but no hallucinations or delusions were identified during the assessment.

4.10 The plan from this assessment was to discharge Mr N from A&E to his mother's address, for him to take the previously prescribed risperidone and for SLaM CAMHS to bring forward his next planned appointment to the following week. Information about the assessment was faxed to SLaM CAMHS and a telephone call was also made to make the team aware of Mr N's attendance at A&E. A referral was to be made to psychology to help Mr N deal with the sexual abuse he was reporting, and Mr N was advised to self-refer to drug and alcohol services.

4.11 At this time SLaM CAMHS were concerned that his mother was not equipped to manage Mr N and that she would not seek support for him. It was noted that she had been heard suggesting that Mr N not make any further disclosures.

4.12 On 4 October 2015 Mr N threw milk at the staff at address 2 and attempted to push them over. The police were called, they told Mr N he would be arrested if he continued to abuse staff and they encouraged him to take his medication.

4.13 Later in the day Mr N broke into the office at address 2, kicking the door and bending the lock. He was arrested for criminal damage.

4.14 On 6 October 2015 SLaM CAMHS began to plan for an MHA assessment of Mr N because of the concerns about his behaviour. There had been three incidents involving Mr N since the beginning of the month. On 12 October

[22] *Risperidone is an antipsychotic medication.* https://bnf.nice.org.uk/drug/risperidone.html

2015, an application was made for additional funding for day staff at the unit in the event of further incidents involving Mr N.

4.15 SLaM CAMHS recorded Mr N's diagnosis as 'cannabis induced psychosis' on 6 October 2015.

4.16 Mr N was seen by the SLaM CAMHS consultant on 13 November 2015 and prescribed fluoxetine[23] 20mg and risperidone 1mg.

4.17 On 20 November 2015 SLaM CAMHS made a request to the police to support an MHA assessment on 23 November 2015; a Section 135 MHA warrant was to be obtained in advance of the assessment. This was because there was a concern about the risk of violence.

4.18 On 25 November 2015, a recommendation for detention under Section 2 MHA was completed. The police were not able to remove Mr N from the property because he was not posing a threat to others. Mr N was reported to be intoxicated on 'skunk'.[24]

4.19 The assessment concluded that Mr N required detaining to a CAMHS psychiatric intensive care (PICU) bed.

4.20 In 2015/16 there was a national shortage of CAMHS PICU beds so it was agreed that he would be detained to the Wells Unit, a secure forensic unit for young people with mental health problems. This was because the nearest potential CAMHS PICU was in Manchester and it was considered to be in Mr N and his family's best interest to treat him close to home.

Wells Unit

4.21 Mr N was detained to the Wells Unit from 26 November 2015 to 25 April 2016, initially under Section 2 MHA.[25] Mr N's detention was reviewed on 15 December 2015 and a further assessment under the MHA was completed. The outcome was to detain Mr N under Section 3 MHA.[26] This was because he continued to show signs of psychosis and disturbed behaviour while he was on the ward. Mr N was not willing to engage in community-based treatment.

4.22 During his admission to the Wells Unit he was regularly reviewed by the consultant psychiatrist and the MDT. These reviews included CPA meetings which were attended by the social worker, SLaM care coordinator, YOT, Ealing CAMHS and Ealing EIP.

4.23 Mr N was prescribed risperidone 1mg daily to be increased to 2 mg if he tolerated it. This was to be given in liquid form to monitor compliance. On 7

[23] *Fluoxetine is a type of antidepressant known as an SSRI (selective serotonin reuptake inhibitor). https://www.nhs.uk/medicines/fluoxetine-prozac/*

[24] *https://www.urbandictionary.com/define.php?term=skunk -skunk drugs cross breed of Cannabis sativa and Cannabis.*

[25] *Section 2 Mental Health Act provides for someone to be detained in hospital for assessment and/or treatment of their mental disorder for up to 28 days. http://www.legislation.gov.uk/ukpga/1983/20/section/2*

[26] *Section 3 Mental Health Act, admissions for assessment and treatment for up to 6 months. http://www.legislation.gov.uk/ukpga/1983/20/section/3*

December Mr N was prescribed 3mg risperidone, although he complained that it was making his thinking cloudy and he felt out of touch with the world. Mr N did not want to comply with his medication and would spit it out or run away from staff to avoid being given it.

4.24 By the beginning of February 2016, it was noted that Mr N accepted that he was unwell and agreed to take medication. It was explained to him that he would need to take medication for at least a year. On 7 March 2016, the consultant psychiatrist completed an assessment of Mr N's capacity to consent to treatment and there was a decision about his medication being provided as a depot. This was discussed with Mr N and after giving it some thought he agreed to this. He told the team that he did not think that he would remember to take medication in the community.

4.25 Mr N was prescribed 37.5 mg risperidone depot[27] and was given his first depot on 17 March 2016. He was given further depots on 2 and 17 April 2016.

4.26 While he was on the ward there were a number of incidents, these included:

Date	Issue	Outcome
02/12/2015	Grabbed keys from a nurse.	Taken to seclusion.
12/12/2015	Knocked a tissue dispenser off the wall in the shower.	De-escalation room.
16/12/2015	Knocking on bedroom doors and refused to stop.	Placed in holds and taken to seclusion.
30/01/2016	Threatening and challenging to the staff who collected him from reception after unescorted leave.	Returned to unit.
01/02/2016	Pushed boundaries when returned to ward after leave. Brought two cigarettes onto the ward.	Leave suspended for three days, then to be given one escorted leave and review.
09/02/2016	Verbally aggressive to staff when returning from leave, ran away from ward staff in reception.	Leave suspended.
13/02/2016	Returned to the ward smelling of alcohol, breathalysed, just over UK drink driving limit.	Leave suspended.
22/02/2016	Threw a bottle of baby oil at a member of staff.	Not allowed escorted leave because staff did not think they could manage him.
24/02/2016	Returned from unescorted leave with chewing gum hidden in waist band.	Escorted leave.
28/02/2016	Racially abusive to a member of staff and attempted to throw a hot drink over them.	Leave suspended.

[27] *Risperdal Consta is a long-acting injection used to treat schizophrenia and symptoms of bipolar disorder, indicated for the maintenance treatment of schizophrenia in patients currently stabilised with oral antipsychotics. https://www.drugs.com/risperdal_consta.html*

20/03/2016	Altercation with another patient.	Given 1:1 time to explore his feelings about this. Leave suspended.
21/03/2016	Altercation with another patient on the ward. Mr N said they were play fighting, but staff did not believe this account.	Given 1:1 time.
26/03/2016	Punched a member of staff on the shoulder and demanded to be taken to seclusion. Tried to grab the staff's keys. When returned to the ward was charged at and threatened by another young person.	De-escalation room. Returned to de-escalation room.
27/03/2016	Asked to be nursed 1:1, said he was afraid of another patient.	Advised not to open his bedroom door and staff would be available on the corridor and communal areas.
01/04/2016	Complained to staff that he had been threatened by other patients.	As above.
03/04/2016	Altercation on ward with other patients. Mr N pushed emergency alarm.	Drug screen completed, tested positive for cannabis.
07/04/2016	Found in possession of a lit cigarette and matches.	De-escalation room.
08/04/2016	Assaulted by another patient on the ward. Thought to be related to an issue in the community between the two patients.	Requested to be nursed 1:1 but was told that this was not needed.
09/04/2020	Verbally harassed by another patient.	Ward staff managed the incident.
10/04/2016	Further altercation between Mr N and another patient.	Ward staff managed the incident.
11/04/2016	Did not engage in psychology session and refused to return to the ward.	Returned to the ward by staff.
19/04/ 2016	Punched by another patient.	Ward staff managed the incident.
20/04/2016	Verbally abused by another patient.	Ward staff managed the incident.
20/04/2016	Would not engage in psychology session.	Removed from the appointment by ward staff.
25/04/2016	Reported he had been assaulted by other patients.	Ward staff managed the incident.

4.27 While on leave from the ward Mr N tried to abscond twice and did abscond from the ward while on leave three times.

Date	Issue	Outcome
07/01/2016	Tried to abscond while on escorted leave.	Told the consultant psychiatrist that this was a joke, and he would not do it again.
15/01/2016	Requested a takeaway while on escorted leave, when this was declined pushed past staff to go towards the takeaway.	Returned to ward with staff when he was told police would be called to return him to the ward.
15/03/2016	AWOL	Found at mother's address and returned to the ward. Put into seclusion on adult ward, did not want to leave or return to the ward.
30/03/2016	AWOL	31 Mar 2016, his mother notified ward Mr N was at her address. She would not allow access to the property and the police were needed to return him to the ward. Mr N would not say where he had been while he was absent. He said he had used cannabis while he was off the ward.
12/04/2016	AWOL when visiting college.	Returned to ward 15 Apr 2016. Said he had been riding round on a bus, had been at mother's the previous evening, had been drunk and told the police that he had had a 'spliff'.

Plans for accommodation on discharge

4.28 Before Mr N was admitted to the Wells Unit he was accommodated by the local authority in supported accommodation. The issue of where he would live on discharge from the Wells Unit was discussed with both Mr N and his mother because he was approaching his 18th birthday.

4.29 In January 2016, the option of Mr N returning to live with his mother was discussed in the ward round. SW1 was sceptical about this option because his mother found it difficult to maintain boundaries. The plan was for SW1 to talk to Mr N's mother about the support that would be needed if Mr N returned home, and for them to report back to the ward round.

4.30 In the ward round on 3 February 2016 Mr N said that he wanted to return to live with his mother. She wanted to move to a new area because she was concerned that Mr N would be vulnerable to local gangs. The police identified that there was no immediate risk from gangs although it was acknowledged that there was always the potential.

4.31 On 12 February 2016 SW1 sent an email to the Wells Unit consultant psychiatrist to explain that Mr N's mother did not want him to return to the care of the local authority on discharge from the Wells Unit. They also stated that

the housing association was working with his mother to find her alternative accommodation, but that this was without success.

4.32 On 15 February SW1 discussed with Mr N the option of returning to live with his mother. Mr N expressed concerns about the risks he might be exposed to if he returned to live at his mother's address. He said that he had argued with his mother a lot in the past and that she used to give him money for drugs. He said that he wanted to live in semi-supported accommodation on discharge.

4.33 By 1 March 2016 both of his parents had written to the local authority asking for him to be discharged to his mother's address and for the Section 20 to be discharged.

4.34 On 21 March 2016 SW1 told the Wells Unit consultant psychiatrist that Mr N's mother had been offered and declined three properties because she did not think that they were good enough for Mr N. She did not think that the risks to Mr N's safety were high should he return to her current address. Mr N again told SW1 that he did not want to return to his mother's address and requested semi-supported accommodation.

4.35 On 7 April 2016 it was agreed that Mr N would have some home leave to prepare him for discharge. This would include a 7.00 pm curfew and a requirement that Mr N did not use cannabis. It is to be noted that he did not access any home leave before his discharge, the only times he visited home were when he absconded from the ward.

4.36 Mr N asked for semi-supported accommodation again on 20 April 2016, he was told that this would delay his discharge, so he agreed to be discharged to his mother's address.

Discharge from the Wells Unit

4.37 Mr N was approaching his 18th birthday, and this influenced the plans made for his discharge.

4.38 The Wells Unit consultant psychiatrist had concluded that Mr N was experiencing a 'first episode' psychosis and was looking to discharge him to the care of Ealing EIP Team. However, this team did not provide care to patients under the age of 18. As a result, it was agreed that Mr N would be discharged to the care of Ealing CAMHS[28] for six weeks, and on his 18th birthday he would be transferred to the care of EIP.

4.39 To support this discharge, staff from both Ealing CAMHS and EIP attended the discharge CPA meeting and agreed to the plan. The discharge CPA meeting was also attended by SW1.

4.40 We were told by staff from the Wells Unit and CAMHS that it is unusual for a young person to be prescribed a depot. CAMHS were not able to provide him

[28] *Provided by WLHT*

with a depot and arrangements were made for Mr N to be given the first depot following his discharge by the adult community team.

4.41 The Wells Unit consultant psychiatrist completed a discharge summary for Mr N on 25 April 2016, this is a detailed summary of their contact with him, the psychology input, family therapy and education.

4.42 The 'Opinion and Discharge Plan' section is a narrative summary that does not reference the plans agreed at the discharge CPA meeting.

Ealing CAMHS

4.43 On 27 April 2016 Ealing CAMHS asked the Ealing Recovery Team West (RTW) to provide Mr N with his fortnightly depot and Ealing CAMHS were to allocate a new CPA care coordinator.

4.44 Mr N attended the RTW for his depot supported by his mother on 29 April 2016, which was given at the appropriate time. His mood and mental state were reported to appear stable.

4.45 The Ealing CAMHS consultant psychiatrist received the Wells Unit psychology report and risk assessment for Mr N on 5 May 2016; however, this was not uploaded to RIO until 26 June 2016.

4.46 Mr N cancelled an appointment with Ealing CAMHS on 6 May 2016.

4.47 On 10 May 2016, to complete the seven day follow up, the Ealing CAMHS junior doctor attempted to contact Mr N using the phone numbers that were available for him. The telephone numbers in the clinical record were incorrect, a key worker from the team was asked to find the correct number and arrange a seven day follow up.

4.48 Mr N attended the RTW for his depot on Friday 13 May 2016. The RTW contacted Ealing CAMHS and said that they were unaware that they were to do it, they provided the last depot as a courtesy to Ealing CAMHS. They had not planned to administer another depot. The plan was for Ealing CAMHS to discuss this and make alternative arrangements. Ealing CAMHS spoke to Mr N over the phone, another appointment was suggested for the Monday, but Mr N said that he was not available on that day. Another appointment was to be made for as soon as possible. This plan was then discussed with the Ealing CAMHS consultant and it was agreed that a review would be completed by the Ealing CAMHS junior doctor.

4.49 Later that day in a telephone call with his mother it was agreed that Mr N would attend for an appointment with the junior doctor on the Monday. Following the appointment, he was to be taken to the RTW base for his depot. His mother was unable to provide the team with a phone number for Mr N.

4.50 The junior doctor had a discussion with the local pharmacy about Mr N's depot. He was unable to locate the prescription chart, and the RTW team said that they had seen it but were unable to find it. The junior doctor agreed to

write a new prescription. RTW stated that an Ealing CAMHS member of staff would need to administer the depot.

4.51 Mr N did not attend for the appointment with the Ealing CAMHS junior doctor on Monday 16 May 2016. His mother was contacted, and she said that he had not attended because he wanted to go to college. Mr N refused to come to the phone to speak to the Ealing CAMHS junior doctor, his mother reported that he was fine although he was smoking cannabis. She agreed to an appointment the following day at 11.00 am.

4.52 Mr N was supported by his mother to attend an appointment with the Ealing CAMHS junior doctor on 17 May 2016. The Ealing CAMHS junior doctor took a history and completed mental health and risk assessments. Mr N was argumentative about his depot, he was requesting that it be provided after 4.30 pm but this was not possible while he was under the care of Ealing CAMHS. It was agreed that he would receive his depot the following day at a time yet to be confirmed. Mr N and his mother were reminded that if Mr N had any concerns about his mental health they could go to A&E.

4.53 Mr N's mother was informed that the depot could be given at 3.30 pm on 18 May 2016 by a senior practitioner from Ealing CAMHS. She said that this time was not convenient for Mr N because he was at college until 4.30 pm.

4.54 On 18 May 2016, the Ealing CAMHS junior doctor contacted SW1 to impress on her the importance of Mr N receiving his depot. She informed the junior doctor that there had been an incident at college when Mr N urinated into a cigarette bucket and during the subsequent interview with his tutor Mr N smelt strongly of cannabis. He had been asked to go home and told that any further incidents would result in him being withdrawn from the course. The junior doctor was to discuss with the Ealing CAMHS team manager how Mr N was to receive his depot as it was now five days late.

4.55 Mr N was expelled from college on 19 May 2016 for persistent lateness and inappropriate sexual comments to vulnerable learners.

4.56 He was discussed at the Ealing CAMHS team meeting on 23 May 2016. It was agreed that family therapy could wait until Mr N was transferred to EIP; the main priority was to complete the transfer of care. The plan from the meeting was to arrange a transfer CPA, ensure that a depot was delivered to the RTW before 1 June 2016 and for an appointment with the junior doctor the following week.

4.57 Following the meeting CAMHS contacted EIP to arrange the transfer of care. The conversation was with the EIP practitioner who attended Mr N's discharge meeting from the Wells Unit. He said that a referral needed to be made to the EIP team manager for Mr N and that EIP would review him in two weeks' time.

4.58 On 25 May 2016 SW1 sent an email to the Ealing CAMHS advanced practitioner. She believed that Mr N's mental health was poor, and she wanted a named member of staff from Ealing CAMHS to work with. She was told that EIP was to attend a medical review for Mr N at Ealing CAMHS on 3

June 2016 and if it were established that he was experiencing a first episode of psychosis EIP would take over responsibility for his care. SW1 requested feedback following the appointment.

4.59 On 26 May 2016 Ealing CAMHS contacted the RTW to confirm the arrangements for the depot. RTW informed them that the medication chart was there but that the depot had not been ordered.

4.60 On 26 May 2016 SW1 also sent an email to the junior doctor and the Wells Unit consultant psychiatrist requesting the name of the care coordinator and a copy of Mr N's care plan. They wanted to know what his identified mental health needs were and how these were to be addressed in the community. She said that she was aware that EIP were to start their assessment of Mr N on 3 June 2016. She told them that Mr N's mother did not accept that he had mental health needs and that his mother's main concern was his education.

4.61 On 27 May 2016, the EIP team manager sent an email to the Ealing CAMHS junior doctor and CAMHS duty manager, confirming that Mr N was open to EIP from this date. The email confirmed that the EIP practitioner would attend the outpatient appointment on 3 June 2016 accompanied by the STR worker who would start to work with Mr N immediately. The plan was to arrange the transfer CPA in an outpatient meeting. EIP would not be able to provide the next depot but they would provide the following one.

4.62 On 27 May 2016, the Ealing CAMHS junior doctor made the arrangements for Mr N to be given a depot on 1 June 2016. He provided a new drugs chart and asked the RTW to cancel the drug chart that they had. He made a telephone call to Mr N's mother confirming the date, time and location for the depot. The depot was to be provided by the Ealing assessment team not the RTW, this was a change of location. His mother said that Mr N was okay, he was 'out and about' but she did not know what he was doing. She denied that he had any psychotic features, signs of deliberate self-harm or any aggression/risk to others.

4.63 On 27 May 2016 SW1 was informed of the arrangements for the depot on 1 June 2016 and the medical review on 3 June 2016. In this phone call with the CAMHS junior doctor SW1 identified a need for support for Mr N's mother because she was caring for both him and her own mother.

4.64 In a phone call with the junior doctor on 31 May 2016 the manager for the Ealing Leaving Care Team expressed concerns about Mr N having been discharged too early from the Wells Unit, the delays in providing Mr N with his depot because of poor coordination and that, despite her significant anxieties about Mr N, his mother found it difficult to understand the need to carefully manage his care.

4.65 The junior doctor explained the plan for the joint appointment with EIP on 3 June 2016 and the difficulties in providing the depot because Mr N was under 18. He told the Leaving Care Team manager that the team had been in regular contact with SW1 and that Ealing CAMHS would be responsible for the next two depots and then EIP would take over. The CAMHS junior doctor

explained that an EIP STR worker would start to work with him following the appointment on the 3 June 2016 and that there was a commitment to family intervention work following the transfer to EIP.

4.66 On 1 June 2016 Mr N attended the Ealing assessment team for his depot, it was noted that his next depot was due in two weeks' time but because he was being transferred to EIP no arrangements were made for this. Following this appointment Mr N went into a shop and took a mini shisha pipe.[29] He returned it when asked and went into another shop, swung a dustbin at a woman and was then arrested.

4.67 In a phone call to SW1 on 1 June 2016 his mother said that Mr N kept asking her for money and was spending about £40 a week on cannabis. He had lost two bank cards in that week and was waiting for a replacement. His mother said that she thought that someone had taken the cards off him.

4.68 A review was held at CAMHS on 3 June 2016. This was attended by the CAMHS junior doctor, EIP care coordinator, EIP STR worker and SW1. Mr N was supported at the appointment by his mother. The meeting noted that he had been arrested and bailed for the offence (common assault) on 1 June 2016. Mr N was using cannabis daily and alcohol a couple of times a week. He was selling items to get money and demanding money from his mother. Mr N thought that his mother was embarrassed by him because of his hospital admission for mental health issues.

4.69 Mr N's mother was seen on her own and expressed concerns about his weight gain. She said that she was unaware that she needed to update services about any changes in Mr N's circumstances, e.g. when he was arrested.

4.70 A mental state assessment was completed with Mr N. He was unkempt in appearance, was easily distracted but did not appear to be reacting to stimuli. The Ealing CAMHS junior doctor concluded that Mr N's insight had worsened since the last time he saw him.

4.71 A full risk assessment was not completed but it was noted that Mr N had been carrying a pen knife (which had been confiscated by his mother). An issue of financial vulnerability was identified but the meeting was not able to explore this with Mr N because he would not answer any questions about this topic. Mr N denied any thoughts of self-harm. It was noted that he was not in education at this time.

4.72 EIP were to make a decision about the service accepting the referral for Mr N on 9 June 2016. A further appointment was made with Ealing CAMHS for 23 June 2016 in the event that Mr N was not accepted by EIP. Mr N's next depot was to be arranged with RTW for 16 June 2016. The Ealing CAMHS junior doctor was to discuss Mr N's capacity to manage his finances with the Ealing CAMHS consultant psychiatrist and he was to review SLaM CAMHS notes for

[29] *Shisha usually contains tobacco which is sometimes mixed with fruit or molasses sugar. Popular flavours include apple, strawberry, mint and cola. Wood, coal or charcoal is burned in the shisha pipe to heat the tobacco and create the smoke.*

Mr N from 2013-15. SW1 was to explore education options for Mr N. He and his mother were aware of and agreed to the crisis plan, i.e. for Mr N to go to A&E if there were concerns about his mental health or thoughts of deliberate self-harm or suicide.

4.73 While the Ealing CAMHS medical review was taking place Mr N was seen driving his mother's car around the CAMHS site, and he hit a tree. The building manager informed the police about the incident. It is thought that this happened while his mother was being seen on her own. The CAMHS junior doctor did not become aware of this incident until sometime after the event and he sent an email with details of the incident to the EIP team manager, EIP care coordinator and SW1 on 20 June 2016.

4.74 Following the appointment, the EIP care coordinator wrote to Mr N's GP and shared the following information:

- history of violence and threatening behaviour;
- history of possessing weapons;
- history of theft and damage to property;
- there had been an incident of arson for which he was not charged;
- his risk of deliberate self-harm was low;
- inadequate work completed around his drug use;
- inadequate work completed around relapse prevention;
- Insight into his mental health was limited;
- concordance with medication had been a problem in the past;
- risk of harm from others and need to explore disclosure about abuse by close family member further;
- risk of financial inappropriateness and/or vulnerability. Reports from his mother that he might be being exploited by his peers.

4.75 The EIP care coordinator did not include details of a risk management plan in the letter to the GP.

4.76 Mr N became 18 years of age on 7 June 2016.

4.77 On 7 June 2016 SW1 sent an email to the EIP care coordinator. Mr N was due in court that day to answer the common assault charge. It is noted that he was now 18 years old and any offences he committed would now be dealt with through the adult criminal justice system. His mother did not attend court with Mr N, and SW1 was not able to attend either but asked the YOT duty worker for feedback. The YOT duty worker told the EIP care coordinator that Mr N was regularly smoking cannabis, asking his mother for money and selling items. Mr N was encouraged to attend an appointment with the substance misuse worker. SW1 thought that Mr N's mother needed support to develop strategies to manage him.

4.78 On 9 June 2016 EIP accepted Mr N for an extended assessment of 6 -12 months. The EIP care coordinator contacted SW1 by phone on 10 June 2016 to inform them that Mr N had been accepted by EIP and suggested a meeting (to include the Leaving Care Team manager). Mr N's allegation of sexual abuse as a child was discussed. SW1 had made the decision not to pursue a safeguarding referral because there was limited information available from Mr N and he would not consent to the matter being pursued through a formal safeguarding process. The concerns about Mr N's financial vulnerability were also discussed with an expectation that the Ealing CAMHS junior doctor was completing a capacity assessment with regard to this.

4.79 The EIP care coordinator explained that they needed to establish if Mr N was experiencing psychosis or if this was a continuation of behavioural issues that had been ongoing since childhood. They confirmed that EIP would provide him with his depot on 16 June 2016.

4.80 The plan from this phone call was to wait for the transfer of care from Ealing CAMHS to EIP until it was established that Mr N was experiencing first episode psychosis. A meeting was to be arranged for Ealing CAMHS, EIP, SW1, the EIP team manager and the manager for the Leaving Care Team (to include the EIP consultant) to plan Mr N's care.

4.81 The EIP team manager sent an email to SW1 on 15 June 2016 explaining that the service needed two years of missing clinical notes to establish if Mr N was experiencing a first episode of psychosis. She provided the details for the EIP care coordinator, confirmed that Mr N would be supported by an STR worker initially for three months and he would be given an appointment with the EIP consultant psychiatrist. The EIP team manager wanted to understand what action had been taken regarding Mr N's disclosure of sexual abuse by the close family member. She said that a formal telephone handover was needed with CAMHS and that EIP would provide Mr N's next depot.

4.82 Mr N did not attend EIP for his depot on 16 June 2016. The EIP care coordinator contacted Mr N over the phone, he agreed to attend on the 17 June 2016 and his mother agreed to bring him. His mother also disclosed that he had broken a window in the family home, and she was waiting for it to be repaired.

4.83 On 16 June 2016 the EIP care coordinator sent an email to the Ealing CAMHS care coordinator requesting clinical notes, details of the follow up on the disclosure of sexual abuse and details of the capacity assessment completed with regard to Mr N's capacity to manage his finances.

4.84 The Ealing CAMHS junior doctor replied to this email on the day it was received by Ealing CAMHS. He told EIP that the MHA Tribunal reports identify the services that had been involved with Mr N prior to his admission to the Wells Unit (the local authority, YOT and SLaM CAMHS). CAMHS and the local authority were to take no further action about the allegation of sexual abuse. The decision was taken following a discussion between SW1 and Mr N in which Mr N declined to give his permission for the further investigation into

the incident. The Ealing CAMHS junior doctor had been unable to complete a capacity assessed with regard to Mr N and financial management.

4.85 The EIP care coordinator sent an email to the CAMHS junior doctor on 17 June 2016 informing him that he was taking annual leave until 27 June 2016 and would not be able to attend the CAMHS medical review on 24 June 2016.

4.86 Mr N did not attend for his depot on 17 June 2016. This was rescheduled for the 20 June 2016 with EIP.

4.87 On 20 June 2016, the CAMHS junior doctor emailed the EIP team manager and EIP care coordinator to cancel the CAMHS medical review planned for 24 June 2016 (they noted that there was an EIP medical review planned for this date). They offered to complete a telephone call to formalise the handover of Mr N to EIP with the EIP care coordinator after 27 June 2016, or to speak to the EIP team manager. They were to write to Mr N to inform him of the cancelled medical review.

4.88 Mr N did not attend the EIP team base for his depot on 20 June 2016. The EIP care coordinator made a phone call to his mother but was not able to speak to her. The EIP care coordinator was able to speak to her on 21 June 2016, she said that Mr N was out, and she did not know when he would be returning but she would ask him to contact EIP on his return. Mr N did not attend the medical review with the EIP consultant psychiatrist on 24 June 2016.

4.89 An email to the EIP care coordinator from SW1 was entered in Mr N's clinical record on 27 June 2016. In this they shared details of recent events. His mother reported that he had been staying out late and returning home intoxicated. He was refusing to attend appointments including for his depot, an appointment with the National Probation Service to complete a pre-sentencing report and an appointment with the substance misuse worker. His mother was requesting the EIP provide Mr N with his depot at home.

4.90 SW1 wanted to know when the STR worker would be starting to work with Mr N. They provided their availability for a professionals meeting (Wednesday 29 June 2016 at 3.00 pm) and said that their team manager would attend with them.

4.91 The EIP care coordinator made a telephone call to Mr N's mother on 28 June 2016.Mr N's mother did not answer the call and they left a message for her. They told her that EIP was not able to provide Mr N's depot at home because he was new to the team and there was a risk of harm to others, in line with the team risk management strategy. The EIP plan was to wait to hear from Mr N's mother and to try and make contact the next day about the depot.

4.92 On 28 June 2016, the EIP care coordinator emailed SW1 to provide an update on Mr N's care. They told SW1 that the transfer from Ealing CAMHS to EIP had not been completed but there was a plan to complete it over the phone. Mr N had not attended for his depot or medical review with EIP. The EIP care coordinator said that they would not provide Mr N with a depot at

home because he was new to the team and that this was in line with the team risk management strategy. The STR worker was to start work with Mr N once an EIP care plan had been formulated. The EIP care coordinator confirmed that they would attend the professionals meeting planned for the 29 June 2016 and that the EIP team manager would also attend the meeting.

4.93 The transfer of care between Ealing CAMHS and EIP was completed in a phone call between the CAMHS junior doctor and the EIP care coordinator on 29 June 2016. The CAMHS junior doctor confirmed that Mr N had been known to mental health services since 2013 (there were no further clinical notes available in Ealing, the notes would be with SLaM). The management of Mr N's disclosure of historic sexual abuse was discussed. The plan was for the CAMHS junior doctor to complete the transfer CPA and for the EIP care coordinator to follow up the safeguarding concerns with social services.

4.94 Following the professionals meeting the EIP team manager obtained some further information about Mr N. This was that he had been prescribed risperidone prior to his admission to the Wells Unit. On 25 April 2015 he had been prescribed an anti-psychotic and anti-depressant. The EIP team manager thought that it was important to determine if Mr N had been prescribed an anti-psychotic before 2015.

4.95 EIP planned to take advice from the safeguarding team with regard to historic abuse allegations because they were unclear what conclusion had been reached about this.

4.96 On 29 June 2016, the EIP care coordinator had a telephone call with the Ealing CAMHS junior doctor. They had been unable to find any clinical notes for 2013/14 and suggested that EIP approach SLaM CAMHS.

4.97 The EIP care coordinator asked Ealing CAMHS to complete a CPA transfer form on RiO, CAMHS informed EIP that this did not need to be done because Mr N was being transferred on his 18th birthday.

4.98 Mr N did not attend for his depot on the 30 June 2016, his depot was now two weeks late.

Contact with EIP July and August 2016

4.99 SW1 sent an email to the EIP care coordinator on 4 July 2016. They had completed a home visit; Mr N was not at home, but his mother was. His mother said that she was unable to care for Mr N and requested that the option of supported accommodation be considered. His mother said that she did not trust him and was putting cash and her mobile phone in a locked place. She was of the opinion that Mr N did not need his depot injection as it did not make any difference to how he behaved.

4.100 In this meeting his mother had made a number of disclosures:

- Mr N had travelled to Southampton on the train, without a ticket. His mother was unsure why he had done this but thought that he had gone with a friend;

- he had spat in her face the previous day;
- he had lost his passport;
- on 30 June 2016 Mr N had been granted police bail on condition he did not return to Uxbridge shopping centre;
- he was due to return to Harrow police station on 5 August 2016;
- he had failed to attend the probation appointment to allow probation to complete a pre-sentencing report for the common assault charge;
- he was due to attend Ealing Magistrates Court on 6 July 2016 to answer the charge of common assault. His mother said that she would not be supporting him to attend Court; and
- his mother said that Mr N was capable of cleaning his room but that he was refusing to do it.

4.101 Mr N's mother was requesting a home visit from the EIP care coordinator. The Leaving Care Team duty worker's contact details were provided in case the EIP care coordinator needed support from the team when SW1 was not available.

4.102 The EIP care coordinator replied to this email on 5 July 2016 stating that they would follow up the information about SLaM CAMHS and that they had been experiencing difficulties getting through to his mother to arrange a home visit. They intended to write to Mr N and invite him into the EIP team base for an appointment.

4.103 SW1 suggested that the EIP care coordinator should send Mr N's mother a text rather than calling, as she kept her phone on silent and did not answer calls.

4.104 On 5 July 2016, the EIP care coordinator tried to call Mr N and invite him in for his depot on 6 July 2016, Mr N did not answer the call. The EIP care coordinator was to write to Mr N and invite him to come for his depot.

4.105 The EIP MDT team meeting discussed Mr N on 5 July 2016. They applied the service zoning criteria and Mr N was placed in the red zone.[30] It was noted that he maybe relapsing and had not received his depot. The EIP care coordinator was to continue to try and engage with Mr N and provide him with his depot, a medical review was to be booked for as soon as possible and Mr N was to be invited to attend an appointment to discuss his accommodation needs. The EIP care coordinator wrote to Mr N later that day inviting him to attend a medical appointment. The letter provided the date and venue for the appointment but not the time.

4.106 On 6 July 2016, the EIP team manager contacted the Trust safeguarding lead to ask for advice about Mr N's safeguarding issues. They wanted to know if another safeguarding referral should be made with regard to the sexual abuse allegation given that Mr N would not provide any further information about this

[30] *WLMHT Adult EIP Traffic/ Light Zoning System*

matter. The reply was that a safeguarding adult referral could be made if Mr N would cooperate with this.

4.107 Mr N was seen at Acton Police station on 7 July 2016 by a practitioner from the Court Diversion team. A mental state examination was completed while Mr N was waiting for an appropriate adult to support him during a police interview. Mr N disclosed that he had taken cannabis and drank two bottles of wine before he was detained by the police. He was asked about his overdue depot, but he was unable to explain why it was overdue. Mr N denied any plans of self-harm or suicide. The practitioner concluded that there were no apparent signs of psychosis and noted that he was a '*guarded young man who did not want to say much'.*

4.108 The Court Diversion practitioner contacted EIP. The care coordinator was not available, but they returned the call later that day and were provided with details of Mr N's detention at the police station. The EIP care coordinator contacted the police station, the police told them that no decision had been made about Mr N's disposal.

4.109 The EIP MDT team meeting discussed Mr N again on 7 July 2016. They applied the service zoning criteria and Mr N remained in the red zone. There were ongoing concerns about relapse of psychosis, his forensic risk and a risk of vulnerability (his mother had expressed concerns about Mr N being involved with a gang). Mr N had not engaged with his care coordinator, he had last had a depot on 1 June 2016. Mr N had been sent a letter inviting him to an appointment with the EIP consultant psychiatrist on 15 July 2016. The care coordinator was to arrange a home visit with mother.

4.110 The EIP care coordinator spoke to Mr N's mother on the phone on 8 July 2016. She confirmed that he was back at her address and she was unsure about the outcome of his attendance at the police station. A home visit was planned for 13 July 2016, this was later cancelled by the EIP care coordinator by text and they confirmed the medical review for 15 July 2016.

4.111 The EIP MDT team meeting discussed Mr N on 14 July 2016. They applied the service zoning criteria and Mr N remained in the red zone. The care coordinator was not present at the meeting. Mr N had now missed two depot appointments with EIP. A medical review was planned for 15 July 2016, but he did not attend this appointment. The care coordinator was to follow up when they returned to work.

4.112 The Magistrates Court contacted the EIP care coordinator on 18 July 2016. Mr N had been charged with criminal damage; his mother was not willing for him to return to her address. He had been bailed to a bail hostel in Norwood (address 3). The care coordinator told the magistrate's office that while he was in custody on 7 July 2016 a forensic assessment had been completed; this had concluded that Mr N was not presenting as psychotic and was not detainable under the MHA. The assessment was not a forensic psychiatry assessment, we believe that they were referring to the assessment completed by the Court Diversion worker on 7 July 2016. Mr N had been bailed to appear in court again on 27 July 2016. The care coordinator did not think that Mr N

would attend court and that interim care plans would need to be put in place. Mr N had another medical review planned for 26 July 2016. The EIP care coordinator was to wait to hear from the court about the progress of the criminal proceedings.

4.113 Mr N did not attend the EIP medical review on 26 July 2016.

4.114 On 27 July 2016, the EIP care coordinator spoke to his mother on the phone. She said that she had reminded Mr N about the outpatient appointment the previous day. She also said that she felt that 'there was something wrong with Mr N' but she was not able to say what exactly what she meant by this.

4.115 The care coordinator attended Ealing Magistrates Court on 27 July 2016 with the intention of seeing Mr N. He failed to attend court to answer charges of shoplifting and criminal damage. These charges were carried forward to the next day when he was due in court to answer another charge of aggravated vehicle theft. If he did not attend court the next day the plan was to issue a warrant for his arrest.

4.116 The EIP care coordinator made arrangements for a medical review on 16 August 2016.

4.117 The EIP MDT team meeting discussed Mr N on 28 July 2016. They applied the service zoning criteria and Mr N was placed in the red zone. He had not attended court that day. The EIP plan was to complete a medical review on 16 August 2016 and for the EIP care coordinator to liaise with Ealing Magistrates Court.

4.118 The Together Team[31] sent an email to the bail hostel manager on 28 July 2016. Mr N had not attended court and the hearing had been held in his absence and adjourned until 4 August 2016. The team asked the bail hostel to support Mr N to attend court and also the EIP medical review on 16 August 2016. They also provided the contact details for SW1 and asked the bail hostel manager to contact them. The EIP care coordinator was copied into this message.

4.119 On 3 August 2016, the EIP care coordinator received a phone call from the bail hostel manager. They were requesting details of Mr N's mental health problems and reported that there had been some issues with Mr N's behaviour at the hostel. They said that they would not have accepted Mr N had they been aware of his mental health problems and that they might revoke his tenancy.

4.120 On 4 August 2016, the EIP care coordinator received a second phone call from the bail hostel manager who expressed concerns about Mr N's mental health. Mr N's tenancy had been revoked and it was believed that he had returned to live with his mother.

[31] https://ealingtogether.org - *Ealing Together is a collaboration between local community and voluntary groups.*

4.121 The EIP care coordinator received a phone call from the LAC social worker (SW2). They had gone to the bail hostel to take Mr N to court. He had lost his place at the bail hostel because he was being disruptive. His mother had agreed for him to return to her address, but it was agreed that this might not be a good plan due to the relationship issues. Mr N's solicitor had expressed concerns about his mental health, and the EIP care coordinator said they were unable to comment because they had not completed a recent assessment of Mr N. They suggested that it might be in Mr N's best interest for a forensic assessment to be completed. This was in the light of him not engaging with mental health services and a growing forensic history. The EIP care coordinator suggested that the best option might be for SW2 to contact the local crisis team. However, it was noted that when mental state assessments had been completed following his recent arrests, an MHA assessment had not been considered appropriate.

4.122 The EIP care coordinator then made a phone call to Mr N's mother, she had been reluctant to allow Mr N to return to her home.

4.123 The EIP MDT team meeting discussed Mr N on 4 August 2016. They applied the service zoning criteria and Mr N was again placed in the red zone. Mr N had lost his place at the bail hostel and was potentially homeless. It was noted that if he did not attend court, a warrant would be issued for his arrest.

4.124 The EIP care coordinator received a further phone call from SW2 on 9 August 2016. The Magistrates had adjourned the hearing until 25 August 2016, and he was also due to appear in Uxbridge on 5 September 2016 on a charge of theft.

4.125 The local authority moved Mr N to address 4 in Hayes and the plan was for him to remain there until 5 September 2016. The EIP care coordinator did not think it would be appropriate for EIP to complete a report for the court as Mr N had not attended an initial appointment with the service, one was planned for 16 August 2016. They said that if the court was requesting a mental health report for Mr N a forensic assessment and report might be more appropriate. SW2 was to contact Mr N's solicitor about this and ask them to request a forensic assessment. A professionals meeting was planned for 17 August 2016.

4.126 The EIP MDT team meeting discussed Mr N on 11 August 2016. They applied the service zoning criteria and he remained in the red zone. The EIP plan was for a medical review on 16 August 2016 and a professionals meeting at Mr N's solicitors on 17 August 2016.

4.127 On 11 August 2016, the EIP care coordinator made a phone call to Mr N to remind him about the medical review on 16 August 2016. There was no reply to the call, so they sent a text.

4.128 On 15 August 2016 (Monday) the EIP care coordinator received an email from SW2 to inform them that on Friday 12 August Mr N had allegedly fallen at the supported accommodation and sustained an injury to his mouth. An

ambulance was called, and he attended Hillingdon A&E but refused any treatment.

4.129 On 15 August 2016, the EIP STR worker received an email from the staff at address four reporting that Mr N had been making comments about ISIS to himself and other people.

4.130 On 16 August 2016 Mr N attacked L with a knife.

4.131 In summary, Mr N was seen once by EIP while he was in the community. This was at the CAMHS appointment on 3 June 2016.

5 Arising issues, comments and analysis

5.1 In this section we will review the care and treatment provided to Mr N by services against the detailed terms of reference (see appendix A).

5.2 Between May 2015 and November 2015 Mr N was in contact with SLaM CAMHS prior to his admission to the Wells Unit. Mr N was an inpatient at the Wells Unit from November 2015 to 26 April 2016 when he was discharged to the care of Ealing CAMHS.

5.3 He was in contact with Ealing CAMHS between 26 April 2016 and 29 June 2016 when he was transferred to Ealing EIP. Ealing EIP were then responsible for the care and treatment of Mr N up to the date of the incident.

Diagnosis

5.4 Mr H had been given an initial diagnosis of '*mental and behavioural disorder due to cannabinoids; unspecific mental and behavioural disorder'* in 2015 by SLaM CAMHS.

5.5 The CAMHS team revised this diagnosis on 6 October 2015 to '*cannabis induced psychosis'*.[32] The correct definition is '*cannabis abuse with psychotic disorder'*, which implies that the psychosis is secondary to, and caused by, the use of cannabis.

5.6 He was discharged from the Wells Unit in April 2016 and the discharge summary identified '*first episode psychosis, conduct disorder and cannabis misuse'*. The later diagnosis of first episode psychosis was then questioned by the EIP in Ealing, and they made considerable efforts to track down previous clinical records.

5.7 Despite cannabis misuse being identified as an issue, and his lack of insight into the impact of his substance misuse on his mental health; no consideration was given to a dual diagnosis. Mr N was provided with support about his substance misuse by the YOT worker in 2015 and was offered support by mental health services and the local authority, but we have seen no evidence that Mr N accessed specialist substance misuse support in 2016.

Assessment, clinical care and treatment

Wells Unit

5.8 Mr N was admitted to the Wells Unit in November 2015 from supported accommodation commissioned by Ealing local authority and was discharged to his mother's address and the care of Ealing CAMHS on 25 April 2016.

5.9 Mr N was detained to the Wells Unit for assessment under Section 2 MHA on 26 November 2015. The application for his detention identifies that he was not

[32] *Cannabis abuse with psychotic disorder: https://www.icd10data.com/ICD10CM/Codes/F01-F99/F10-F19/F12-*

willing to agree to a voluntary admission. He was showing signs of psychosis to the degree that he required a hospital admission for further assessment, and this may possibly need to be followed by treatment. The risks to himself were identified as a deterioration in his mental health, retributive violence, and the loss of his housing placement. Risks to others were identified as aggression and damage to property. It was also identified that Mr N might benefit from a period of assessment while he was free from cannabis to allow effective medication and psychological treatment of any mental disorder.

5.10 Another MHA assessment was completed in December 2015 and Mr N was detained for treatment under Section 3 MHA. Mr N had an appeal hearing in February 2016 that confirmed his detention under Section 3 MHA.

5.11 In line with the expectations of the NICE Guidance: 'psychosis and schizophrenia in children and young people: recognition and management',[33] Mr N was assessed and treated by a multi-disciplinary team including a consultant psychiatrist, psychologist and nursing staff. He was also able to access support from speech and language therapy and dietetic advice. Mr N was seen regularly by the Wells Unit consultant psychiatrist in one to one sessions, ward rounds and CPA meetings. The Wells Unit consultant psychiatrist was responsive to requests from Mr N to be seen on an ad hoc basis alongside planned appointments. Mr N was also assessed and treated by junior doctors on the Unit and reviewed weekly in ward rounds attended by the multidisciplinary team.

5.12 In addition, Mr N had access to a wide range of educational opportunities and groups while he was detained to the Wells Unit. These included drama therapy, sport, music, mindfulness and communication groups. Between November and March Mr N's average weekly attendance at education was 80%, although this dipped in the April to 50%. Mr N was not a regular attender at groups, although he could and did access them from time to time. This is in line with the NICE Guidance expectations for the care and treatment of children and young people with psychosis.

5.13 Whilst detained in the Wells Unit Mr N was initially prescribed oral anti-psychotic medication, risperidone, provided in liquid form. In line with NICE Guidance the Wells team discussed medication options with Mr N and his family. He acknowledged that he might not take medication when he was living in the community and accepted that a depot might be the best approach. When discussing medication with him the Wells Unit were clear that he would need to continue to take medication for at least 12 months after his discharge from hospital.

5.14 The discharge summary from the Wells Unit completed by the consultant psychiatrist provides a detailed chronology of all the events while Mr N was detained to the Wells Unit. There is a section in the discharge report titled 'Opinion and Discharge Plans'; this is a narrative summary and does not

[33] *NICE: Psychosis and schizophrenia in children and young people: recognition and management. Clinical guideline [CG155] Published date: 23 January 2013 Last updated: 26 October 2016. https://www.nice.org.uk/guidance/cg155*

reference any of the plans agreed at the discharge CPA meeting held prior to his discharge from the Wells Unit.

Psychology

5.15 Mr N was offered ten individual psychology sessions while at the Wells Unit and he attended all of these. However, his level of engagement in the sessions fluctuated. It is reported that at times he found it difficult talking about his previous experience of mental health problems, and at these times he would deny or minimise the extent of his mental health problems. In one of the sessions Mr N discussed the attitude to mental health issues in the African culture and how this differed to the view of the Western world.

5.16 Mr N was administered the Personality Assessment Inventory for Adolescents.[34] This noted that Mr N's interest in and motivation for treatment was substantially lower than is typical of individuals seen in treatment settings. His responses to the inventory suggested that he was satisfied with himself as he was, was not experiencing any marked distress, and as a result saw little need for change.

5.17 The report identified that when making treatment decisions Mr N's reluctance to participate or cooperate in treatment should be explored with him. For example, he was provided with a depot because he acknowledged that he might find taking oral medication difficult when living in the community. It went on to identify that Mr N might have initial difficulties placing trust in a treating professional as part of his more general problems with close relationships.

5.18 The Conner's Rating Scale[35] was administered to Mr N and his mother. His mother rated Mr N as markedly atypical for oppositional behaviour and cognitive problems/inattention. Mr N rated himself as elevated for cognitive problems/inattention.

5.19 A cognitive assessment of Mr N had been completed in December 2013. He completed a Wechsler Intelligence Scale for Children.[36] Mr N's scores ranged from borderline to average. His borderline scores were in the area of verbal reasoning and processing speed. His average performances were in the area of perceptual reasoning (non-verbal problem solving and reasoning) and working memory (holding information in his short-term memory and then retrieving it; with or without first performing a mental operation on that information). The test identified that Mr N might experience difficulties with activities that make high demands on attention and also those which involve speed of mental problem-solving and eye-hand coordination.

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[34] Personality Assessment Inventory – Adolescent (PAI-A) is designed for the clinical assessment of adolescents ages 12 to 18 years. https://psycentre.apps01.yorku.ca/wp/personality-assessment-inventory-adolescent-pai-a/

[35] Conners 3rd Edition (Conners3) is an assessment for Attention Deficit Hyperactivity Disorder. https://www.pearsonclinical.co.uk/Psychology/ChildMentalHealth/ChildADDADHDBehaviour/Conners3rdEdition(Conners3)/Conners3rdEdition(Conners3).aspx

[36] The Wechsler Intelligence Scale for Children (WISC), is an individually administered intelligence test for children between the ages of 6 and 16. https://www.pearsonclinical.co.uk/Psychology/ChildCognitionNeuropsychologyandLanguage/ChildGeneralAbilities/WechslerIntelligenceScaleforChildren-FourthUKEdition(WISC-IVUK)/WechslerIntelligenceScaleforChildren-FourthUKEdition(WISC-IVUK).aspx

5.20 One of Mr N's head teachers and his mother completed a High Functioning Spectrum Screening Questionnaire[37] for him. The head teacher rated Mr N above the 'head teacher cut-off'. The highlighted behaviours were deviant style of gaze, failing to make relationships with peers, questions about common sense and bullied by others. His mother's rating was considerably lower and below the cut-off, but she did highlight a deviant style of gaze and his failure to make relationships with peers.

5.21 The psychologist completed a Structured Assessment of Violence Risk in Youth[38] (SAVRY), the details of which can be found in paragraph 5.26. In the discharge summary the psychologist recommended he would need support to develop:

- insight into his mental health difficulties;
- an awareness of the relationship between his cannabis use and his psychosis;
- strategies to promote abstinence from substance use;
- a relapse prevention plan; and
- coping strategies for managing distressing emotions.

5.22 The summary also identified that Mr N would need further assessment to rule out the diagnostic areas highlighted in his personality test, and that a further assessment might be useful in the area of social-communication difficulties.

Capacity

5.23 The Mental Capacity Act 2005 (MCA)[39] is designed to protect and empower people over the age of 16 who may lack the mental capacity to make their own decisions about their care and treatment. It can also be applied to day-to-day decisions.

5.24 The MCA assumes that the person has the capacity to make decisions unless proved otherwise, is decision specific and it accepts that capacity to make a decision can fluctuate over time. It also acknowledges that people can and do make unwise decisions.

5.25 The NICE guidance: 'Transition from children to adults' services for young people using health or social care services'[40] expects that, '*Health and social care professionals ensure that they can: assess capacity and competence, including 'Gillick competence' [41] in children and young people of all ages; and*

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[37] The Autism Spectrum Screening Questionnaire (ASSQ) was developed to assess the prevalence of Asperger Syndrome and high-functioning Autism Spectrum Disorder.https://psychology-tools.com/test/autism-spectrum-screening-questionnaire

[38] The SAVRY is composed of 24 items in three risk domains (Historical Risk Factors, Social/Contextual Risk Factors, and Individual/Clinical Factors), drawn from existing research and the professional literature on adolescent development as well as on violence and aggression in youth.

[39] Mental Capacity Act 2005. https://www.legislation.gov.uk/ukpga/2005/9/contents

[40]Transition from children to adults' services for young people using health or social care services. This guideline covers the period before, during and after a young person moves from children to adults' services. NICE guideline [NG43] Published date: 24 February 2016. https://www.nice.org.uk/guidance/ng43

[41] Gillick competence test and Fraser Guidelines are used to establish whether a particular child is capable of giving consent for a particular action. Gillick v West Norfolk & Wisbech Area Health Authority [1986] AC 112 House of Lords.

understand how to apply legislation, including the Children Act, the Mental Health Act and Mental Capacity Act, in the care and treatment of children and young people.'

5.26 There is no evidence available that an assessment of Mr N's capacity with regard to his substance misuse was completed while he was detained to the Wells Unit.

5.27 EIP asked Ealing CAMHS to complete an assessment of Mr N's capacity to manage his finances. This was not done and EIP did not complete one following his transfer of care. This was a missed opportunity to explore with Mr N how he was spending his money and the loss of his bank cards.

5.28 Furthermore no consideration was given to completing a capacity assessment with Mr N with regard to his drug use, his friendship choices or the decisions that he made around the safeguarding issues he raised with the teams about alleged abuse by a close family member.

5.29 Capacity assessments may have supported wider conversation about Mr N's lifestyle choices and led to a better understanding of his motivations and risks.

Ealing CAMHS

5.30 While Mr N was under the care of Ealing CAMHS, he did not have an identified care coordinator, despite a member of the team attending the Wells Unit discharge CPA meeting. This resulted in the CAMHS junior doctor acting as 'de facto' care coordinator. The CAMHS junior doctor accepted responsibility for arranging to meet with Mr N and his mother, along with the arrangements for the provision of the depot. The CAMHS junior doctor was the main point of contact for SW1 following Mr N's discharge from hospital. They developed a good working relationship with SW1, sharing information and responding to their concerns. The CAMHS junior doctor was also the main point of contact for EIP and they attempted to source the additional information requested by EIP about Mr N. They made the arrangements for the CAMHS medical review on 3 June 2016 attended by SW1 and EIP, and the professionals meeting on 29 June 2016.

5.31 When interviewed the CAMHS junior doctor told us that it was not unusual for him to act as care coordinator and that he was well supported in this role by the CAMHS consultant.

5.32 The CAMHS junior doctor took an assertive approach to providing Mr N with care and treatment. When they were unable to contact Mr N because the phone numbers in his record were not correct, they were proactive in finding alternative numbers. Despite Mr N's reluctance to be seen by services he attended two appointments with the CAMHS junior doctor.

5.33 The CAMHS junior doctor sought to resolve the problems associated with providing Mr N's depot, liaising with the Mr N's mother, the adult teams and pharmacy to agree a 'work around' solution. RTW provided Mr N with his depot on 29 April 2016 but declined to give it on 13 May 2016 because they were not aware of the plan to provide it. CAMHS supported the provision of Mr

N's depot on 1 June 2016. EIP accepted responsibility for the provision of Mr N's depots at the meeting on 3 June 2016.

5.34 The CAMHS junior doctor spent time with Mr N's mother and tried to understand her view of Mr N's mental health and issues.

Ealing EIP

5.35 Mr N was referred to community mental health services in Ealing while he was an inpatient at the Wells Unit, this was because there was plan for him to return to live with his mother on discharge.

5.36 EIP declined to accept Mr N for the service when he was discharged from the Wells Unit in April 2016 because he was six weeks short of his 18th birthday. At the discharge CPA meeting they did agree that his care could be transferred to the team once he was 18.

5.37 EIP treated the referral of Mr N to the service as a referral from Ealing CAMHS because he had reached the age of 18, as opposed to being in the spirit of the agreement reached at the Wells Unit discharge CPA meeting held on 25 April 2016. They were of the opinion that because Mr N was under the care of Ealing CAMHS he should remain there, albeit that he had only been under the care of the service for a short period of time and was not established on a care and treatment plan.

5.38 The EIP care coordinator saw Mr N at the Ealing CAMHS medical review on 3 June 2016 to commence an assessment. Mr N did not want to engage in this assessment and was reluctant to answer questions. He believed that he had become unwell prior to his admission because he was using cannabis and starving himself. Mr N had told Ealing CAMHS and the EIP care coordinator that he was no longer experiencing psychosis and he thought that if stopped taking his medication the psychosis would not come back. Mr N said he would not stop using cannabis but agreed to continue with the depot because it improved his clarity and rate of thought.

5.39 At this assessment Mr N was reluctant to discuss his recent arrest for common assault and he denied attacking anyone. He said that his mother escalated his temper, that she was embarrassed by him and did not want him to smoke tobacco or cannabis near to her home.

5.40 Mr N's mother was seen alone as part of this medical review. She was of the opinion that the recent assault had been a way of Mr N getting out of attending a dental appointment. His mother told the meeting that she had confiscated a box cutter knife from Mr N. SW1 told the Ealing CAMHS junior doctor and EIP care coordinator that Mr N had been excluded from the study centre in the past for carrying a knife. His mother was asked if she felt at risk from Mr N and she said she did not. She denied that Mr N had any involvement with gangs at that time. The EIP care coordinator wrote to Mr N's GP stating he had seen Mr N at CAMHS on 3 June 2016.

5.41 SW1 told the 3 June medical review that when Mr N was in Ealing, he was able to buy cannabis and queried where he got the money from. It was

unclear how much Mr N was spending on cannabis, £10 a day or £10 every three days. There were concerns raised in the meeting about his money management skills, stealing from the family home and asking his mother for money. Mr N had never disclosed to the police the details of people in Ealing who he said had threatened him in the past.

5.42 It was agreed in both the CPA meeting and the medical review on 3 June 2016 that the EIP STR worker would provide Mr N with support in the community. This did not happen, and this was a missed opportunity for a mental health professional to develop a relationship with Mr N.

5.43 The Ealing CAMHS medical review meeting was the only face to face contact that the EIP care coordinator had with Mr N following his discharge from the Wells Unit. There is no evidence that the EIP care coordinator demonstrated an assertive approach in engaging with Mr N. They made one arrangement to complete a home visit on 13 July 2916 which they cancelled by text and did not re-arrange, and they attended court once to 'try and catch' Mr N. SW1 was in regular contact with Mr N and his mother. They told us as part of this investigation that they would have been willing to complete a joint home visit with the EIP care coordinator had they requested one.

5.44 Mr N was reviewed by the EIP MDT on a weekly basis and was placed in the red zone after each review.

5.45 The red zone is for patients who have a 'high likelihood of relapse, or of serious and/or imminent harm to self, and/or to/from others.' He met the criteria for this zone because he was displaying early warning signs of relapse (with a history of violence), was disengaging from the team (or in his case had not engaged with the team), and there were concerns from his family and other professionals. The minimal clinical intervention that Mr N should have received based on his zoning was:

- A medical review every one to two weeks.
- The care coordinator to make an attempt to review him twice a week.
- A weekly review at the MDT meeting.

5.46 The care coordinator saw Mr N at the Ealing CAMHS base on the 3 June 2016, this was before his care was transferred to EIP and the EIP care coordinator had no further face to face contact with Mr N. There were no concerns about caseload sizes or workload pressures raised with the investigation by EIP staff.

5.47 We have concluded the EIP care coordinator did not take an assertive approach to engaging with Mr N. There was an expectation that Mr N would attend the team base for his depot and all appointments. The EIP care coordinator relied on letters, text messages and voicemail messages to communicate the arrangements for these appointments.

5.48 The EIP care coordinator was unable to confirm if Mr N was receiving the letters, text messages and voicemails. They did not explore other possible options for engaging with Mr N, e.g. completing a home visit with SW1 to meet

with him, or in his absence his mother who may have been able to suggest ways of engaging with Mr N.

5.49 Once Mr N was located at address 3 (the bail hostel) the EIP care coordinator did not make any plans for a visit. It is acknowledged that this address was about an hour's drive away from the team office. Nor did they consider asking the local Crisis Team to review Mr H when the hostel manager raised concerns about Mr H's behaviour. Furthermore, they did not make plans to visit Mr H when he moved to address 4 which was a 20 minutes' drive from the team office.

5.50 Mr N was offered medical reviews with the EIP consultant psychiatrist for 24 June 2016, 15 July 2016, 26 July 2016 and 16 August 2016. Mr N was not offered any support from the EIP care coordinator or the team to attend these appointments and he was not offered a medical review at home.

5.51 There was no strategy developed or agreed by the MDT for engaging with Mr N beyond the established approach. We have been unable of find any evidence that the barriers to Mr N engaging with EIP were explored or solutions sought.

Findings 1: Assessment and capacity

The Wells Unit completed a psychiatric assessment of Mr N that resulted in a revised diagnosis and medication regime.

A thorough psychological assessment was completed while Mr N was on the Wells Unit which drew together a number of other assessments that had been completed in the past together with assessments completed while he was on the Unit, including a speech and language therapy assessment.

Mr N himself discussed approaches to mental health issues by his community in a psychology appointment, but there is no evidence available that this was not shared with the wider team.

Ealing CAMHS made extensive efforts to engage him and to ensure his depot medication was administered. We have concluded that the Ealing CAMHS junior doctor developed a rapport with Mr N, and Mr N did attend for some of the planned appointments.

EIP accepted Mr N for an extended assessment of his mental health needs. However, in our view EIP staff spent a considerable amount of time looking for evidence that this was not Mr N's first episode of psychosis. A review of the notes indicates that psychosis was only considered a feature of Mr N's mental health issues immediately before his admission to the Wells Unit.

Capacity

There were no capacity assessments completed with regard to Mr N's capacity with regard to medication, finances, or substance misuse.

Recommendation 1
The Trust must ensure that there is a clear system for ensuring that capacity assessments are completed and recorded where indicated.

Findings 2: Clinical care and treatment

Wells Unit

Mr N was treated in line with NICE guidance, psychosis and schizophrenia in children and young people: recognition and management.

He was offered and accepted psychological therapy.

He was offered choice with regard to his medication and was supported in making his choice.

His family were offered and accepted family therapy.

He was provided with physical health care and treatment, and was offered advice about his illicit substance misuse, but did not accept it.

Mr N was provided with opportunities to leave the ward on escorted and unescorted leave. However, the plan for phased leave including home leave and overnight leave was not followed through.

Ealing CAMHS

The CAMHS team could be viewed as a 'holding' service until Mr N's care and treatment could be transferred to EIP on Mr N's 18th birthday.

EIP

Mr N had an identified care coordinator while under the care of EIP.

The Support Time and Recovery worker did not work with Mr N as agreed on 3 June 2016. This was a missed opportunity for a member of the EIP team to develop a relationship with Mr N.

The EIP team did not have face to face contact with Mr N in the following six weeks that he was under the care of the team. Although Mr N was in the red zone, this did result in a more assertive approach.

EIP did not negotiate with Mr N to provide his depot at a time and location that would have increased the chance of his compliance.

In our view the EIP team did not make sufficient efforts to engage with the police, courts and social workers in the face of a deteriorating situation, and no direct contact was made with Mr N.

Recommendation 2
The Trust CAMHS service must ensure that all patients under its care that are subject to CPA have a named care coordinator.

Recommendation 3
The Trust must revise the EIP Zoning Policy to more clearly define the care and treatment that a patient in the red zone can expect, to support a more assertive approach.

Care Programme Approach (CPA)

5.52 The Wells Unit met the CPA policy expectation to establish a comprehensive assessment and care plan within 72 hours of admission to inpatient clinical services, throughout the admission and at discharge.

5.53 Regular CPA review meetings were held while Mr N was detained at the Wells Unit and these were planned with the intention of ensuring that the teams who supported him in the community were able to attend and participate. These were in line with the CPA policy which expects that reviews will be carried out at regular intervals throughout the admission.

5.54 The discharge CPA meeting and plan did not address Mr N's rights under Section 117 MHA.[42]

5.55 Mr N was six weeks short of his 18th birthday at the time of the discharge from the Wells Unit. EIP were not willing to accept Mr N until his 18th birthday, so the plan agreed by Ealing CAMHS and EIP was for him to be discharged to the care of Ealing CAMHS until his birthday and then for his care to be transferred to EIP.

5.56 Ealing CAMHS did not complete a CPA review when Mr N was discharged to their team. The Trust CPA Policy states that, '*For community, the CPA should be carried out as close to acceptance as possible onto the team's caseload*.' Mr N was accepted by the team at the discharge planning meeting on the 25 April 2016 and was discharged to the care of CAMHS on 29 April 2016.

5.57 A CPA plan would have identified that the service was not equipped to provide Mr N with his depot. This would have been identified as an unmet need as defined in the CPA Policy:

'Service deficiencies, therefore, can be defined as the differences between those services necessary to deal appropriately with the assessed social care and mental health needs, and the services actually available to meet them. Where service deficiencies are identified they should be recorded under the heading 'Unmet Need' on the CPA review and reported to line managers for consideration by service managers.'

5.58 EIP were present at the discharge CPA meeting and attended the CAMHS medical review on 3 June 2016. At both meetings, the care and treatment that Mr N would receive from EIP was discussed. However, following his discharge from the Wells Unit up to the formal transfer of care on 29 June 2016 EIP continued to seek information to support their belief that he was not experiencing a first episode psychosis.

[42] *Section 117 MHA is the duty of the CCG and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies. http://www.legislation.gov.uk/ukpga/1983/20/section/117*

5.59 There was a professionals meeting held on 29 June 2016. This was attended by the EIP team manager, EIP care coordinator, Leaving Care Team manager and SW1. In relation to Mr N there were concerns about his:

- deteriorating mental health,
- increasing criminality,
- mother's ability to manage him,
- reported behaviours towards his mother,
- drug use,
- depot - he had not had a depot since 1 June 2016, and
- lack of engagement with mental health services.

5.60 The Leaving Care Team told us that they believed that Mr N's discharge from the Wells Unit had been too early and that this was because the ward could not manage him, and that they would be making a complaint about this. This investigation has not been provided with any details of a complaint from the Leaving Care Team.

5.61 There were concerns about Mr N's use of cannabis and support options for him regarding this were discussed. EIP was to discuss with Mr N the previous disclosure of sexual abuse and seek further information from him. His mother's home was not considered helpful to Mr N's recovery and the EIP care coordinator was to pursue options of semi-independent accommodation with Mr N. His educational needs were also discussed.

5.62 EIP were not able to decide if they were the right service for Mr N. SLaM CAMHS had been supporting Mr N before he was admitted to the Wells Unit which in their view implied that this was not his first episode of psychosis.

5.63 SW1 expressed concerns that Mr N was relapsing. Mr N had not had a depot since 16 June 2016. Concerns about Mr N's capacity with regard to financial management were discussed. His mother had also disclosed concerns about a gang taking his phone. The meeting discussed concerns about Mr N's mother's mental health.

5.64 The plan from the professionals meeting was for:

- EIP to continue to try and engage with Mr N and if the deterioration in his mental health continued to consider an assessment under the MHA.
- Another meeting was planned for 12 August 2016.
- The EIP care coordinator was to arrange for a medical review with the EIP consultant psychiatrist as soon as possible. The EIP care coordinator was to continue to offer Mr N a depot.
- The meeting discussed a crisis and contingency plan and contact numbers were shared.

5.65 A transfer CPA meeting was not completed when Mr N transferred from Ealing CAMHS to EIP. The transfer of care was completed over the phone following the professionals meeting on 29 June 2016. The Trust CPA Policy states that:

'*The CPA is especially relevant to transitions between child and adult services, and between inpatients and outpatient care. Therefore, when children and young people (who are under the CPA) are discharged from inpatient services into the community, and when young people (who are under CPA) are transferred from child to adult services their continuity of care must always be ensured by the use of CPA and these changes in care should be supported by locally agreed protocols, which should also comply with the Care Act in relation to transitions.'*

Findings 3: Care Programme Approach

Ealing CAMHS did not complete a CPA review for Mr N when he was discharged to the care of the team. Had a CPA review been completed in line with the Trust policy it would have allowed for the team to articulate the challenges in providing Mr N with his depot, as an unmet need.

The CAMHS junior doctor did complete thorough mental health state assessments for Mr N on the occasions that he saw him, and these are clearly recorded in the clinical notes.

The CAMHS junior doctor completed a good transfer of care to EIP. Although this was completed over the phone, there was a professionals meeting prior to this with EIP and the social worker.

EIP did not complete an assessment or CPA review for Mr N. They saw him on one occasion when they attended a CAMHS appointment on 3 June 2016.

EIP accepted Mr N for an extended assessment of his mental health needs.

It is to be noted that EIP spent a considerable amount of time looking for evidence that this was not Mr N's first episode of psychosis. A review of the notes indicates that psychosis was only considered a feature of his mental health issues immediately before his admission to the Wells Unit.

Recommendation 4

The Trust should develop a performance matrix to monitor and improve compliance with the Trust CPA policy, and this matrix must identify patients who have transferred between services and if a CPA was completed.

Management of depot

5.66 Depot antipsychotic medication is a special preparation of the medication which is given by injection.[43] This medication is exactly the same as the medication given in tablet form but is slowly released into the body over a number of weeks.

5.67 The NICE Guidance: 'psychosis and schizophrenia in children and young people: recognition and management' describes the treatment options for children and young people with first episode psychosis in terms of prescribing oral anti-psychotic medication and psychological interventions. It does not identify or provide guidance on prescribing depot medication to children and young people.

5.68 The guidance explores the action to take if a child or young person is not responding adequately to oral medication. It does identify that compliance with prescribed medication may be an issue but does not offer any guidance on how to manage this.

Wells Unit

5.69 Mr N was prescribed a depot injection of 37.5mg risperidone and was given his first depot on 17 March 2016 while he was on the Wells Unit, to be given fortnightly thereafter. Mr N acknowledged that he would not take medication on a regular basis in the community and that a depot was a more reliable option. He received three depot injections while at the Wells Unit.

5.70 The arrangements for the provision of Mr N's depot following his discharge were not robust.

Ealing CAMHS

5.71 The CAMHS team was not able to provide the depot and the RTW agreed to provide the first depot on the 29 April 2016 as a 'favour'. However, this arrangement was not agreed for the whole of the six weeks that Mr N was under the care of CAMHS. The RTW were under the impression that they were only committed to providing the depot once.

5.72 A member of the CAMHS team agreed to provide Mr N with his depot, but there was a period of confusion when it was unclear when, where and who was to give the depot. This was not helpful with a patient who was reluctant to use medication, was difficult to engage with, and whose mother had expressed the belief that Mr N did not need medication as he was not ill.

5.73 Mr N was provided with a second depot on 1 June 2016 by the CAMHS team at the assessment team base.

5.74 We have been unable to establish how or why the depot prescription was lost.

[43] *Depot medication.* https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/depot-medication

5.75 We would like to acknowledge the lengths that the CAMHS junior doctor went to in navigating the prescribing and dispensing process to ensure that Mr N received his depot on two occasions while under the care of CAMHS. The CAMHS junior doctor developed a relationship with Mr N and his mother which enabled them to engage with him.

EIP

5.76 Responsibility for providing Mr N with his depot was accepted by EIP at the meeting with Mr N and his mother on 3 June 2016. Mr N failed to attend for his depot at the EIP base on 16, 17, 20 and 30 June 2016.

5.77 We have been unable to identify any clear arrangements for EIP to provide a depot in July and August 2016 but have concluded that the plan was to provide Mr N with a depot if he attended any of the medical appointments he was offered for 15 and 26 July 2016, and 16 August 2016.

5.78 EIP were not proactive or assertive in the approach that they took to providing Mr N with his depot. They were reliant on Mr N attending the team base for the depot notwithstanding his chaotic lifestyle, his previous non-compliance with medication and his reluctance to engage with mental health services.

5.79 The EIP response to Mr N mother's request to provide the depot at his home was to decline on the grounds that they did not know him and were concerned about risk. We suggest that the SAVRY completed by the Wells Unit was a comprehensive assessment of Mr N's risk and EIP could have relied on this. This risk assessment also identifies the importance of developing a relationship with Mr N that would support him to engage with services.

5.80 We consider that the EIP should have explored ways of managing any perceived risks, including exploring the details of the practitioner's concerns, gathering information from other agencies, and possible joint visits with other professionals involved in his care.

5.81 Given Mr N's previous non-compliance with medication, his reluctance to engage with mental health services and his mother's reported ambivalence to him taking medication, we hold the view that it was critical that there was a clear, agreed plan in place to provide Mr N's depot in one agreed location by both CAMHS and EIP.

5.82 In the Trust internal investigation, it was noted that there were limited resources for the provision of depot injections in CAMHS because it was unusual for these to be prescribed to a young person. We carried out a short review of the available guidance and literature and conclude that the use of depot injections in adolescents is unusual, and usually associated with compliance issues as in the case of Mr N. We consider that the Trust should provide practical guidance on this issue for CAMHS and EIP.

5.83 Anti-psychotics are used for a variety of presentations in children and young people, however, very few anti-psychotics are licensed for use in childhood

disorders and the evidence base for their use in children and young people is poor.

5.84 Anti-psychotics are less well tolerated in children and young people than in adults. This population appears to have a higher risk of experiencing or developing adverse effects including extrapyramidal symptoms, prolactin elevation, sedation, weight gain and metabolic side effects.[44] [45]

5.85 Risperidone is licensed for use in children and young people in conduct disorder, but not for psychosis. It is, however, widely used for children and young people for the management of psychosis, although weight gain and raised prolactin levels have been reported.[46] There are no licensed long-acting injections for use in under-18s. The safety and clinical data in this age group is limited. There has been limited research on the use of depot injections in adolescents and in 2016 it was demonstrated there was a need for outpatient community resources with the ability to provide long-acting injectable medication.[47] A literature review in 2017 highlighted that there was limited data and more research was needed.[48]

5.86 Ealing CAMHS were not able to provide Mr N with a depot and the RTW agreed to provide the first depot. This was not apparently clear to CAMHS, Mr N and his mother who believed that the RTW would provide the depot until his care was transferred to EIP and as evidenced by Mr N attending the Recovery Team on 13 May 2016 for his second depot in the community.

Findings 4: Management of depot

The **Wells Unit** engaged Mr N in the discussions and decision making about his medication choices. Mr N recognised that when he was in the community there was a risk that his compliance with medication could be poor.

The Wells Unit did not recognise that a young person in receipt of depot medication was rare and that community services might not have been equipped to provide this for Mr N.

The Wells Unit should have sought to understand how the depot would have been provided in the community and ensure that a more robust plan was in place.

The **CAMHS** plan for the provision of Mr N's depot when he was discharged into the community was not robust. No named member of the CAMHS team took initial responsibility for managing the provision of the depot. CAMHS did not provide depot injections and the Recovery team

[44] *Correll CU, Carlson HE. Endocrine and metabolic adverse effects if psychotropic medications in children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry (2006): 45(7); 771-791.*

[45] *Correll CU. Assessing and maximizing the safety and tolerability of antipsychotics used in the treatment of children and adolescents. Journal of Clinical Psychiatry (2008); 69(4): 26-36*

[46] *BNF for children 2016-17. London: BMJ Publishing Group Ltd and RPS Publishing; 2016.*

[47] *Efficacy of Long-Acting Injectable Antipsychotics in Adolescents. Pope & Zaraa, Journal of Child and Adolescent Psychopharmacology, vol 26,4.*

[48] *Long-Acting Injectable Antipsychotics in Children and Adolescents. Lytle et al 2017, Journal of Child and Adolescent Psychopharmacology Vol. 27, No. 1.*

provided the initial depot as a favour; there was no plan in place for future depot injections.

The CAMHS junior doctor endeavoured to provide Mr N with his depot in the face of a number of challenges, such as the CAMHS service not providing depots, not understanding the prescribing process etc.

EIP were not assertive in their approach to providing Mr N with his depot. They were reliant on Mr N attending the team base and would not provide a depot at home because Mr N was not known to them and this was identified as a risk.

EIP did not recognise that Mr N's non-compliance with his medication was a relapse indicator.

Recommendation 5
The Trust must revise the current arrangements to ensure that missed depots are reported to the care coordinator within 48 hours and what plans need to be put in place to provide the missed depot.

Recommendation 6
The Trust must ensure that there is a clear and transparent process in place that will support all patients to be provided with a depot, irrespective of the team providing care and treatment. These arrangements must identify the criteria for providing a depot in a patient's home**.**

Recommendation 7
Trust medicine management policies for long acting antipsychotic injections should provide guidance for their use in young people.

5.87 We have concluded that there was not a proper exploration during discharge planning of the challenges in providing a depot to a young person under the care of CAMHS. Mr N was on a fortnightly depot and the plan was for him to be under CAMHS for 6 weeks. The discharge plan should have been explicit about who was to provide the depot during these six weeks, along with the dates the depots were due and the location of the team to provide the depot.

5.88 The lack of a clear agreed plan for all of the depot injections between 25 April 2016 and 29 June 2016 caused confusion for Mr N and his mother and compounded his non-compliance with medication.

5.89 Given his previous non-compliance with medication, his reluctance to engage with mental health services and his mother's reported ambivalence to him taking medication we hold the view that it was critical that there was a clear, agreed plan in place to provide his depot in one agreed location by both CAMHS and EIP.

5.90 There is no evidence that Mr N was offered information about his medication choices, beyond the form that the medication could take. Whilst detained in the Wells Unit the efficacy of his medication was monitored, with staff observing him for symptoms and changes in his behaviour.

Alcohol and substance misuse

5.91 The NICE guidance, 'Psychosis and schizophrenia in children and young people: recognition and management' states that children and young people should be '*routinely monitored for other coexisting mental health problems, including depression and anxiety, and substance misuse, particularly in the early phases of treatment.'*

5.92 Mental health services were aware of Mr N's co-existing substance misuse but did not consider managing Mr N under a dual diagnosis pathway.

5.93 He is reported to have been using cannabis since the age of 12 and drinking alcohol. Mr N was open about his use of cannabis, stating that it relaxed him, but he was less open about his use of alcohol and services did not explore this with him. It was reported that he had engaged with a substance misuse worker while under the care of SLaM CAMHS in 2015.

5.94 Mr N tested positive for cannabis when he was admitted to the Wells Unit and once when he returned from AWOL. While he was detained to the Wells Unit the team regularly discussed Mr N's drug and alcohol use with him, but he was reluctant to talk about it and declined to accept any support with it from the team.

5.95 He was offered an appointment with the substance misuse worker from the Leaving Care team on 29 June 2016, but he did not attend.

Findings 5: alcohol and substance misuse management
Mr N declined offers of support from mental health services to manage his substance misuse. It is reported that he did attend a session with the local authority substance misuse worker, but he did not continue to engage with them. Given Mr N's history of substance misuse mental health services did not consider Mr N to be a dual diagnosis patient and he was not offered an assessment, treatment and advice as such.
Recommendation 8 The Trust to review the approach that it takes to young people with established substance misuse issues and to develop a dual diagnosis approach to these patients.

Discharge and transition between CAMHS and EIP

5.96 Mr N and his mother were both in agreement that he should return to live with her. However, he had not lived full-time with her for two years, having spent weekdays accommodated by the local authority and only returning to the family home at weekends. During his detention on the Wells Unit both Mr N and his mother changed their minds about Mr N going to live at her address on more than one occasion. Mr N's mother displayed an ambivalence to Mr N's need for medication and was considered unable to maintain boundaries with him.

5.97 When the Wells Unit was planning Mr N's discharge the plan was for him to spend time at his mother's on leave from the ward. This was so that the ward and SW1 could monitor the situation and determine if his mother's home was appropriate.

5.98 This investigation was told that the planned home leave did not take place because Mr N would go AWOL when given unescorted leave from the ward. Furthermore, his mother was reluctant to allow mental health staff to visit her home. She was concerned about what the neighbours would think if they saw mental health staff visiting her address.

5.99 There was no assessment made of Mr N's mother's ability to manage him when he returned to live with her.

5.100 There was a plan for the psychologist from the Wells Unit to complete a home visit with Mr N. We were unable to determine why this home visit did not take place.

5.101 The discharge CPA plan from the Wells Unit refers to SLaM CAMHS providing a handover to Ealing CAMHS and for Mr N to be transferred to EIP on his 18th birthday. The only agreement for ongoing care and support for him following his discharge from the Wells Unit was for the provision of his first depot in the community. There was no structured plan agreed before his discharge for contact and support with Mr N and his family.

5.102 The NICE guidance 'Transition from children's to adults' services for young people using health or social care services'[49] sets out expectations as to how a child or young person should transition between services:

'*Ensure that such changes, especially discharge and transfer from CAMHS to adult services, or to primary care, are discussed and planned carefully beforehand with the child or young person and their parents or carers, and are structured and phased; the care plan supports effective collaboration with social care and other care providers during endings and transitions, and incudes details of how to access services in times of crisis; when referring a child or young person for an assessment in another service, they are supported during the referral period and arrangements for support are agreed with them beforehand.'*

5.103 We were unable to find any evidence of a crisis plan for Mr N developed with by the Wells Unit, CAMHS or EIP that met the standards expected by the NICE Guidance. This requires services to:

- 'Develop a crisis plan ... jointly with the young person and their parents. The plan should be respected and implemented, incorporated into the care plan and include:
- Possible early warning signs of a crisis and coping strategies.

[49] *Transition from children to adults' services for young people using health or social care services. NICE guideline [NG43] (2016). https://www.nice.org.uk/guidance/ng43*

- Support available to prevent hospitalisation.
- Where the child or young person would be admitted in the event of hospitalisation.
- Definitions of the roles of primary and secondary care professionals and the degree to which parents are involved.
- Information about 24-hour access to services.
- The names of key clinical contacts.'

Findings 6: Discharge from the Wells Unit

The discharge was informed by Mr N's approaching 18th birthday and he became the victim of 'birthday services', i.e. services choosing to strictly impose age criteria to exclude a patient's access to the service.

The discharge from the Wells Unit did not consider the NICE guidance on transitions which contains advice about the risk of transferring children and young people between services and warns against transitions between multiple services in a short period of time.

The discharge plan from the Wells Unit did not identify and address Mr N's support needs when he was in the community.

The plan to discharge Mr N to the care of CAMHS for six weeks and then to transfer his care to EIP was not robust. There was no clear care plan agreed with CAMHS about the care and treatment that they would provide, beyond an ad hoc agreement for the team to support Mr N's depot.

There was no relapse plan in place with clear relapse indicators and a contingency plan other than to take Mr N to A&E.

From the discussion at Mr N's discharge CPA meeting the Wells Unit and CAMHS believed that the EIP team had accepted Mr N for assessment/care and treatment on his 18th birthday.

We have concluded that this was not the case and that the EIP team accepted Mr N as a transfer from CAMHS after their assessment meeting with him on the 3 June 2016.

Recommendation 9

The Trust must provide assurance that all transitions between services for children and young people are completed in line with NICE guidance on the Transition of children and young people.

Findings 7: Transition between services

The NICE guidance 'transition from children's to adult's service for young people using health or social care services should have informed Mr N's discharge from the Wells Unit, as he was six weeks short of this 18th birthday.

Had this been used to inform the process better consideration might have been given to:

ensuring that Mr N received appropriate support with his psychosis;

his social and personal circumstances, especially the appropriateness of him returning to live with his Mother; and,
address outcomes such as education, community inclusion, health and well-being, including his emotional health and his independent living and housing options.

The guidance is clear that *'The point of transfer should not be based on a rigid age threshold and take place at a time of relative stability for the young person.'*

Mr N's rapid transfer through CAMHS to EIP was based on the application of a rigid age threshold and there was no period of stability for Mr N.

There was no agreed protocol to inform the transition between CAMHS and EIP.

There was a misunderstanding between the services about the CAMHS service offer. EIP described an understanding that CAMHS could provide an EIP service for a patient under the age of 18 and that this could be extended by 3 years. This would have been applicable to a young person who was on a clear pathway with CAMHS prior to their 18th birthday. However, EIP had agreed at the discharge planning meeting that Mr N would transfer to their care on his 18th birthday.

This series of rapid transfers between services is not in keeping with the NICE guidance that states young people should '*routinely receive care and treatment from one single MDT community team; are not passed from team to team unnecessarily; do not undergo multiple assessments unnecessarily.'*

Recommendation 10
The Trust CAMHS to review its approach to transferring patients and to benchmark itself against the NICE guidance on the Transition of Children and Young People, to use the findings to develop a robust patient centred approach to transfer and discharge.

Use of the Mental Health Act

5.104 Mr N was detained to the Wells Unit under Section 2 MHA. A further assessment under the MHA was completed on 15 December 2016 and he was detained under Section 3 MHA.

5.105 We are concerned that he may not have been treated in the least restrictive manner. The Wells Unit is a medium secure unit. We have not seen any evidence of a secure services assessment having been completed for Mr N. There was referral paperwork prepared, but it appears that the decision to admit him to the Wells Unit was made by the individual clinicians involved. We discuss this with current NHS England & Improvement Specialised Commissioners, and were informed that at the time of his admission, local provider had discretion about admissions. We were assured that this situation would not occur now, because there are formal processes in place.

5.106 When interviewed, the Wells Unit consultant psychiatrist told us that Mr N needed to be nursed in a PICU setting but due to the limited number of CAMHS PICU beds nationally in 2015/16 he was nursed in a more secure setting. The NICE guidance requires that services '*think about the impact on the child or young person and their parents… especially when an inpatient unit is a long way from where they live.'* At that time, the alternative to the Wells Unit would have been a CAMHS provision in Manchester.

5.107 We have concluded that although the Wells Unit was not the least restrictive option, on balance it presented the best way at that time of meeting his and his family's needs. To place him a considerable distance from his home would have made it very difficult for his family to meaningfully contribute to his assessment and treatment planning.

5.108 Mr N appealed his detention in February 2016 and following an MHA Tribunal Hearing he remained detained under Section 3 MHA.

5.109 Mr N's detention under the Act was rescinded prior to his discharge from the Wells Unit on 25 April 2016.

5.110 No consideration was given at the CPA discharge meeting to the application of Section 117 MHA.

Findings 8: Application of the Mental Health Act

The Mental Health Act was correctly applied to Mr N throughout his detention at the Wells Unit.

There is no justification given for admission to medium security. We would have expected to see evidence of a discussion at the CAMHS national network meeting, however there was no record of such a discussion in the clinical notes. It appears that the decision to admit to the Wells Unit was made by the individual clinicians.

We have not been able to find any evidence of the proper application of Section 117 MHA in relation to the social care support available to Mr N following his discharge from the Wells Unit.

Recommendation 11

The Wells Unit operational policy should include the expectation that all admissions make reference to the clinical rationale for the level of security.

Recommendation 12

The Trust must ensure that the expectations of Section 117 MHA are applied when patients are discharged from out of area CAMHS forensic admissions.

Risk assessment and management

5.111 Best practice in managing risk is based upon structured clinical judgement. This involves the practitioner making a judgement about risk based on combining:

- an assessment of clearly defined factors derived from research (historical risk factors);
- clinical experience and knowledge of the service user including the carer experience; and
- the service users' own views of their experience.

5.112 The Trust Clinical Risk Policy states that, '*Risk assessment and effective management is a core component of mental health care and Care Programme Approach (CPA). All staff, both clinical and non-clinical, have a responsibility to contribute to the safety and welfare of service users*.'

5.113 It identifies the points about which risk must be assessed or reviewed:

- Community follow up within 7 days of discharge from inpatient care.
- Prior to the individual moving from one service to another or prior to discharge from a ward
- The other points at which risk should be reviewed include:
- Following an incident.
- When new information is received significantly changing the individual's risk status.

The policy affirms that, '*The Trust considers clinical risk assessment to be one component of good clinical risk management*.'

5.114 Mental health clinicians are required as a minimum to conduct a risk assessment using the RiO risk assessment tool, recording risk information, formulation of risk identified, setting up crisis/care plan and sharing risk information where indicated.

5.115 Mr N is regularly described in the clinical notes as a 'polite', 'quiet' young man who would often decline to answer questions or provide information about his life and his lifestyle choices. This could be viewed as a barrier to services completing assessments. For example, this can be clearly seen in the assessments completed while Mr N was in police custody. These barriers and lack of overt threat may have acted as a distraction to services who did not consider him as a threat to himself or others, even in the face of his history and escalating behaviours.

Wells Unit

5.116 The SAVRY was completed by the psychologist. In doing this they accessed information from the initial assessment completed by the responsible clinician, the SLaM CAMHS notes, social services chronology and a report provided by YOT.

5.117 The report identified Mr N's risk triggers as:

- drug and/or alcohol use;
- dislocation from family;
- bullying and rejection from peers, possible rejection from family; and,
- lack of clarity about his peer group affinity, possible pro-criminal association.

5.118 The protective factors that might decrease his risk are identified as:

- further support to reinforce his understanding about the effects of substances on his mental health and thinking;
- stronger social supports and bonds, family therapy sessions were being offered by the Wells Unit;
- support to build pro-social relationships and engage in activities;
- support to obtain a college place;
- continued engagement in psychological support to build his self-esteem and better manage difficult emotions;
- ensuring Mr N had clear rules and behavioural expectations. He needed to be made aware of the benefits of adherence to rules and consequences of breaking rules; and
- possibly benefitting from having key/named people in the team who he can talk to when distressed.

5.119 The report goes on to make suggestions about the monitoring arrangements for Mr N:

- Offer 1:1 sessions so that he can express himself.
- Regular assessments of mental state, psychiatrist and GP.
- Random drug screening.
- Incident reporting, rule breaking more likely to occur when he is experiencing social stressors.

5.120 This risk assessment was sent to the Ealing CAMHS team along with the discharge summary from the Wells Unit, however, this risk assessment was not put onto Mr N's RiO record until September 2016.

5.121 Mr N had a forensic history that included carrying a bladed article and GBH. We have found no evidence that these behaviours were explored with him while he was detained to the Wells Unit.

5.122 As previously stated, Mr N was polite and quiet and would not disclose information to staff. Mr N's manner could be seen as a mask that prevented staff from completing assessments and developing an understanding of Mr N's risks.

5.123 However, he was viewed as a risk to staff, although it is not clear from the clinical notes what this risk was. This is evidenced by the ward team's decision not to place Mr N on 'one to one' support when he was requesting it towards to the end of his admission. He was on general observations, with advice to remain in his bedroom and that staff would monitor the situation when he was in the communal areas. We have not been able to understand the nature of this risk, although it can be surmised that this was because of his history of making allegations about sexual abuse, and more recently bullying on the ward.

5.124 While on leave from the ward Mr N attempted to abscond on two occasions and did abscond three times. The investigation was told that because of his history of absconding he was not given any overnight leave prior to his discharge. Overnight leave might have given an opportunity to assess his risks in the community and any risks to his mother and family whilst still under the care of the Wells Unit.

5.125 Mr N's risk to others were not identified and shared with the community teams prior to his discharge from the Wells Unit. There was no risk management plan in place when he was discharged from the Wells Unit. The Wells Unit did not explore any potential risks that Mr N posed to his mother and grandmother. See also Findings 6 'discharge from the Wells Unit'.

Ealing CAMHS

5.126 CAMHS completed two face to face assessments with Mr N between 25 April and 29 June 2016.

5.127 Mr N attended a medical review with the CAMHS junior doctor on 16 May 2016. A mental state assessment and a narrative risk assessment were completed.

5.128 He attended a further medical review with the CAMHS junior doctor on 3 June 2016, this appointment was also attended by the EIP care coordinator, STR worker and SW1.

5.129 Mr N's risks as defined by CAMHS on 3 June 2016 were:

- cannabis use;
- worsening insight and worse since the last time seen;
- police bail for common assault and significant forensic history noted;
- having a penknife that his mother had confiscated;
- risk of financial vulnerability and unable to assess full risk because Mr N would not answer questions; and
- educational risk as not currently in education.

5.130 This was not a formal risk assessment and it describes a mixture of historical evidence of risk of violence and factors that may increase the risk of violence.

5.131 The plan from this meeting was for Mr N to be offered another medical review with CAMHS on 23 June 2016 in the event that EIP did not accept Mr N for their service. This appointment was later cancelled. The CAMHS junior doctor was to discuss Mr N's capacity to manage his finances with the CAMHS consultant psychiatrist. Mr N and his mother agreed to a crisis plan, for Mr N to attend A&E if he had any thoughts of deliberate self-harm or suicide.

5.132 We have concluded that CAMHS did not consider Mr N's risk to others in the light of escalating criminality; he was on police bail for common assault, with reports that he was carrying a penknife.

5.133 Our overall conclusion is that CAMHS considered itself to be providing a temporary service to Mr N until he was transferred to EIP and as a result did not follow its normal processes of care planning and risk assessment.

EIP

5.134 Following the CAMHS medical review on 3 June 2016, EIP wrote to Mr N's GP and identified the following risks:

- History of violence and threatening behaviour.
- History of possessing weapons.
- History of theft and damage to property.
- There had been an incident of arson for which he was not charged.
- His risk of deliberate self-harm was low.
- Inadequate work completed around his drug use.
- Inadequate work completed around relapse prevention.
- Insight into his mental health was limited.
- Concordance with medication had been a problem in the past.
- Risk of harm from others – need to explore disclosure about abuse by close family member further.
- Risk of financial inappropriateness and/or vulnerability with reports from his mother that he might be being exploited by his peers.

5.135 The EIP care coordinator did not complete a formal risk assessment for Mr N.

5.136 In addition, the EIP care coordinator did not complete a risk assessment to support the decision not to complete a home visit to provide Mr N's depot.

5.137 Mr N was discussed at the weekly EIP MDT meetings and was in the red zone for the entire time he was under the care of the team. When in the red zone a care coordinator should be making attempts at least twice a week to make contact and engage with the patient. We have not seen any evidence of this level of contact. The care coordinator saw Mr N on 3 June 2016, arranged to see him at home on 13 July 2016 which was cancelled on the day and went to the Magistrates Court on 27 July 2016, but Mr N was not there.

5.138 The one home visit arranged with Mr N and his mother was cancelled because the care coordinator was not available for work, and another appointment was not arranged.

Findings 9: Risk assessment and management

Wells Unit

The Wells Unit completed a SAVRY for Mr N. We have not been able to establish how widely this was shared with community services. We were told by the Wells psychologist that this was shared with the CAMHS consultant along with the Wells Unit discharge summary.

However, this assessment was not uploaded to RiO until September 2016, so we are unclear if this assessment was available to EIP.

There was no obvious assessment or care planning in response to the risks presented by Mr N when he absconded from the ward area.

He was not assessed through the use of Section 17 leave prior to discharge.

CAMHS

Did not update the Trust risk assessment in line with the Clinical Risk Policy:

When Mr N transitioned from the Wells Unit.
When high risk incidents were reported by Mr N's, i.e. criminality.
When he missed his depot.

EIP

Did not update the Trust risk assessment:

When Mr N transitioned from CAMHS
When Mr N was not engaging with EIP.
When he missed his depot.
Increasing criminality.
When there were reports that Mr N had spat at his mother when she would not give him money

EIP was not assertive in their approach to the care and treatment provided to Mr N. Mr N was placed in the red zone for the whole of the time he was under the care of EIP.

However:

The strategies and plans were not comprehensively documented.
The plan remained the same from week to week.
No timeframe identified for escalation if Mr N did not engage with the team.

No risk assessments were completed for Mr N after he left the Wells Unit so there was no assessment made of his risk to others.

Recommendation 13
The Trust should audit current risk assessments completed in CAMHS and EIP against the Clinical Risk Policy, and then develop a plan to improve performance and quality.

Interagency Communication

Wells Unit

5.139 The Wells Unit worked in a collaborative manner, seeking to arrange CPA meetings at a time that would allow all the agencies supporting Mr N in the community to attend. This facilitated multi-agency working and decision making. This was evidenced by the attendance of YOT, CAMHS from both SLaM and Ealing, EIP and SW1 at these meetings.

5.140 The Wells Unit also worked collaboratively with SW1, e.g. they attended psychology sessions with Mr N in addition to attending CPA meetings and information sharing.

5.141 Whilst the Leaving Care Team manager told us that they believed that he had been discharged too soon from the Wells Unit, we have not been able to find anything in the clinical record that notes this view.

Ealing CAMHS

5.142 The Ealing CAMHS junior doctor worked collaboratively with SW1 and was responsive to the concerns that they raised.

5.143 The Ealing CAMHS junior doctor responded to requests for information from EIP about Mr N's previous contact with CAMHS. Unfortunately, the request was made of the wrong team. Mr N had been under the care of SLaM CAMHS before his admission to the Wells Unit, not Ealing CAMHS.

5.144 The Ealing CAMHS junior doctor sought to work collaboratively with EIP, inviting the EIP care coordinator to the CAMHS medical review on 3 June 2016 and the professionals meeting on 29 June 2016.

5.145 The CAMHS junior doctor facilitated the professionals meeting on 29 June 2016 bringing together CAMHS, the Leaving Care Team and the EIP care coordinator.

EIP

5.146 EIP were reactive rather than proactive in the approach they took to communication with other agencies, in particular with SW1 and SW2.

5.147 The Leaving Care Team manager described feeling that EIP were 'not on board' with regard to Mr N, his escalating criminality and potential mental health relapse. The Leaving Care Team told the professionals meeting on 29 June 2016 that they believed that Mr N was relapsing and that EIP did not take appropriate action.

5.148 The Trust internal report concluded that the communication with external agencies was 'ad hoc' with no mechanism in place for a formal update of Mr N's current risks and care. This should have been agreed at the professionals meeting on 29 June 2016. Furthermore, this should have been agreed through the CPA process.

Findings 10: interagency communication

Wells Unit

The Wells Unit worked collaboratively with all the agencies in the community who supported Mr N.

Ealing CAMHS

The CAMHS junior doctor worked collaboratively with the local authority social worker.

EIP

EIP was reliant on the Leaving Care Team contacting them.

EIP was not proactive in seeking communication with or information from the Leaving Care Team.

Recommendation 14

The Trust must review its CPA policy to ensure that where there are multiple agencies providing care and support to a patient the care plan identifies:

- The lead agency for communication between the agencies
- Information and reporting channels
- Reporting intervals
- How urgent information will be effectively shared
- Contingency plans for information sharing when staff are absent from work
- Consideration of the application of Section 117 MHA were applicable.

Safeguarding

5.149 The Trust Safeguarding Policy sets out the Trust's responsibility with regard to safeguarding, provides a framework for managing allegations and defines staff responsibilities. This is done in the context of the Care Act (2014).

Sexual abuse allegation

5.150 In 2014/15 Mr N repeatedly reported that he had been sexually abused by a close family member, but he was not willing to pursue a complaint. In September 2015 there was a plan for Ealing social services to hold a strategy meeting in light of the allegation and Mr N's refusal to share information with his mother and the police.

5.151 A safeguarding strategy meeting was held by SLaM CAMHS on 28 October 2015.On 10 December 2015 while detained at the Wells Unit, Mr N repeated the allegations he had made earlier about a close family member. The support worker recommended that Mr N not be allowed any male visitors because of the risk of further allegations. However, the view of this risk was not shared by the ward or local authority staff and no visitor restrictions were imposed on Mr N and his family.

5.152 Services did not take any formal safeguarding action about the allegations that Mr N made about the close family member because despite numerous discussions with different staff and services he was not willing to provide any further information or support an investigation.

5.153 EIP took further advice about Mr N's allegations of sexual abuse from the Trust safeguarding lead and the conclusion was that without support from Mr N this allegation could not be investigated any further.

5.154 The Safeguarding Policy states that there are circumstances in which Mr N's wish not to be involved in a safeguarding investigation could be overridden. The first test is whether Mr N had capacity regarding the safeguarding allegation. Mr N was assumed to have capacity, although as we have explored in another section of the report, no capacity assessments about any issue were completed for Mr N. Furthermore, no consideration was given to any potential risk that Mr N was being coerced to not support the safeguarding complaint by the close family member or the wider family.

5.155 Mr N complained to staff on the Wells Unit that he was subject to bullying by peers in his final few weeks at the Wells Unit. Ward staff were unable to corroborate this from their observations and he gave conflicting accounts of events. Moreover, the staff considered him to be an inconsistent, unreliable witness and as a result his allegations were not subject to formal investigation. In our view this should have been treated as safeguarding issue and investigated in line with the Policy.

Criminality

5.156 The Leaving Care Team and mental health services supporting Mr N did not identify any safeguarding concerns with regard to Mr N's criminality.

5.157 Mr N's criminal activity escalation in June and July 2016, with him committing a number of offences that required him to attend more than one court to answer charges. EIP were aware of this and did not consider if the escalation in his criminal behaviour was related to a deterioration in his mental health.

Concerns at address 4

5.158 Three days before the homicide an ambulance was called by Mr N to address 4, just before midnight on Friday 12 August 2016. Mr N initially complained of an injury to his mouth as result of a fall, but it was noted that the details he and the hostel staff gave were very vague. He was brought to Hillingdon Hospital A&E by ambulance just after midnight on 13 August and later

complained of pain following being hit in the face. Information available after the homicide suggested that this incident may have involved L.

5.159 At A&E Mr N refused to give any more details regarding his injury, refused bloods, refused an examination and refused a facial x-ray. He therefore did not receive any treatment. Mr N was noted to be verbally abusive and spitting in the department. He was discharged at 06:00 on 13 August 2016 (Saturday morning).

5.160 Neither the ambulance service or Hillingdon Hospital noted any issues with vulnerability or any safeguarding concerns. This information was conveyed to SW2 by the hostel on Monday 15 August 2016. SW2 in turn emailed the care coordinator on the same day to inform them, and of the concerns about his having information pertaining to ISIS.

5.161 After the homicide, the staff from address 4 informed the Leaving Care Team that there had been a tension between Mr N and the victim, this information was shared with the Trust. Services were unable to explore either of these issues with him prior to the homicide (which occurred at about 3.30 pm on 16 August 2016) or report any concerns through PREVENT structures.[50]

Other people

5.162 Services did not complete a carer's assessment for Mr N's mother to determine if she had any care and support needs. She was caring for Mr N with some support from his father, but Mr N's father was not in Mr N's life on a day to day basis, his mother was the primary carer. She reported that she was unable to maintain boundaries with Mr N. In June 2016 she reported that he put pressure on her to give him money, had threatened her, destroyed property in her home and spat at her if she refused.

5.163 While Mr N was under the care of EIP it was reported that his mother was having to keep her phone and money locked away to prevent Mr N taking it.

5.164 Neither CAMHS or EIP followed up on this, they did not consider his mother to be at risk and did not make a safeguarding referral for her. The Care Act 2014 makes it clear that abuse of an adult is linked to circumstances rather than the characteristics of the people experiencing the harm.[51]

5.165 The Trust Policy quotes the London Multi-Agency Safeguarding Adults Policy and Procedure which refers to potential safeguarding risks, '*where harm or abuse has occurred (or is suspected) to adults with care and support needs and where considered that they are unable to protect themselves as a result of their care and support need.'* This is a narrow definition that may not be in the spirit of the Act.

Findings 11: Safeguarding

[50] *Prevent' includes countering terrorist ideology and challenging those who promote it, supporting individuals who are especially vulnerable to becoming radicalised and working with sectors and institutions where the risk of radicalisation is assessed to be high. https://www.gov.uk/government/publications/prevent-duty-guidance'*

[51] https://www.anncrafttrust.org/resources/safeguarding-adults-at-risk-definitions/

Trust safeguarding policies were not followed when information about sexual, financial and physical vulnerability were reported involving Mr N. Trust policies regarding carer support and risk assessment were not followed.
Recommendation 15 The Wells unit must ensure that all patient reported allegations of bullying are appropriately investigated, and safeguarding procedures instigated.
Recommendation 16 The Trust must ensure that the policy expectations regarding risks to family members are incorporated into risk assessment and care planning.

Gang involvement

5.166 Mr N's father had raised concerns about Mr N's potential involvement with gangs in August 2012.

5.167 Mr N lived in London, and some of his behaviours are indicative of someone who may have been a victim of 'county lines' drug gangs. In July 2017, the Home Office issued 'Criminal Exploitation of children and vulnerable adults: County Lines guidance'. This listed a number of factors that could heighten young people's vulnerability to county lines exploitation:

- Having prior experience of neglect, physical and/or sexual abuse.
- Lack of a safe/stable home environment, now or in the past (domestic violence or parental substance misuse, mental health, or criminality for example).
- Social isolation or social difficulties.
- Economic vulnerability.
- Mental health or substance misuse issues,
- Being in care (particularly those in residential care and those with interrupted homelessness or insecure accommodation status.
- Connections with other people involved in gangs.
- Having a physical or learning disability.
- Having care histories.

5.168 Mr N was a young person who 'ticked' many of the boxes that would have heightened his vulnerability to gang exploitation.

5.169 The Home Office's 2010 document 'Safeguarding children and young people who may be affected by gang activity' set out signs that a young person may be involved in gang activity and while recognising that many are common behaviours for adolescents, a number could be applied to Mr N including:

- Being withdrawn from family.

- Being emotionally ‘switched off’, but also containing frustration/rage.
- Holding unexplained money or possessions.
- Staying out unusually late without reason or breaking parental rules consistently.
- Expressing aggressive or intimidating views towards other groups of young people, some of whom may have been friends in the past.
- Being scared when entering certain areas.
- Concerned by the presence of unknown youths in their neighbourhoods.

5.170 An important feature of gang involvement is that the more heavily a child is involved with a gang, the less likely they are to talk about it. Mr N is consistently described by services as a guarded young man.

5.171 It is known that: from the age of 12 Mr N was using cannabis; from the age of 14 he was involved in criminal acts; his mother was not able to maintain boundaries with him; he was in the care of the local authority; and would regularly go missing from his accommodation.

5.172 The mental health services who worked with Mr N appeared to lack curiosity about a number of issues that may have indicated that Mr N was vulnerable to gang involvement. These included:

- The Wells Unit lacking professional curiosity about where Mr N went when he was AWOL from the ward, how he obtained money and how he spent his time. For example, they accepted at face value that on one of the occasions he was AWOL he had spent the night riding around on a bus. The Wells Unit did not explore with Mr N where he obtained money from when he was missing from the ward.
- While Mr N was under the care of Ealing CAMHS his mother also told services that he had gone to Southampton and back on the train, without paying a fare. Community services lacked professional curiosity about this incident and did not explore it with Mr N.
- CAMHS and EIP not exploring his mother’s concerns about his ‘lost’ bank cards in June 2016.
- CAMHS and EIP not exploring SW1’s concerns about where Mr N was getting money from.
- Mr N’s lack of friends and reliance on undisclosed acquaintances.

5.173 Mr N told the Wells consultant psychiatrist in February 2016 that he was afraid to return to the Northolt area (where his mother lived) because he was concerned that some people in the area might want to hurt or stab him. This concern was not explored any further with him because he was reluctant to provide any more information. His concern was shared with SW1.

5.174 There was no curiosity from services about why Mr N went to Southampton in June 2016, who he went with or how the trip was funded. In June 2016 Mr N lost his phone and two bank cards in a short space of time. His mother

expressed the belief that they had not been lost but had been taken off him. She did not identify who may have taken them.

5.175 Services could have done more to explore the possibility of Mr N being involved with gang activity and considered this in the context of his vulnerability.

5.176 There was no police information about Mr N being at risk in the community when he was discharged from hospital, but services did not seek any further reassurances in June 2016.

Findings 12: Gang involvement
Services did not demonstrate an awareness of Mr N's risk with regard to gang activity. They lacked professional curiosity and did not seek further assurances from the police when presented with further information that may have supported the idea Mr N was involved in gang activity.
Recommendation 17 The Trust and Local Authority should complete a review of the current processes in place for identifying children and young people who may be vulnerable to child exploitation, county lines drug gangs or general involvement with gangs to ensure that these are in line with current national best practice and local expectations on exploitation.

Family engagement and carer's assessment

5.177 The Wells Unit provided Mr N and his parents with family therapy. Sessions were attended by his parents both separately and together.

5.178 The sessions were an opportunity for Mr N and his mother to explore the option of him returning to live with her and concerns about this.

5.179 We have concluded that Mr N and his family were offered good support by the Wells Unit and made good use of the family therapy sessions that were available to them.

5.180 Mr N's family were engaged with the care and treatment provided by the Wells Unit and Ealing CAMHS.

5.181 The Wells Unit identified in the discharge summary dated 25 April 2016 that the relationship between Mr N and his mother would need support and monitoring by the professional network because of their history of arguing. There is evidence that SW1 provided Mr N and his mother with support following his discharge and that CAMHS did interview his mother on her own during one appointment to obtain information and to understand her perspective.

5.182 The Trust CPA Policy states:

'Carers should be offered an assessment, assessed and provided with a separate care plan detailing required support with their full involvement where

they lead the decisions with professional support and in line with the requirements of Care Act 2014 and in line with the principles of the Triangle of Care. Assessment of children as carers should be based on a thorough understanding of the developmental needs of children, taking into account the capacities of parents or carers to respond appropriately to those needs and the impact of wider family and environmental factors on parenting capacity and children including the impact on parental mental illness. Newly arising problems and interventions in response to these should be discussed with relevant individuals and clearly documented in the care plan which should be readily available to all those concerned.'

5.183 There is no evidence available that the Wells Unit, CAMHS or EIP offered Mr N's mother a carer's assessment.

Culture and community

5.184 NICE guidance, psychosis and schizophrenia in children and young people: recognition and management states that

'*When working with children and young people with psychosis or schizophrenia and their parents or carers: take into account that stigma and discrimination are often associated with using mental health services and be respectful of and sensitive to children and young people's gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability be aware of possible variations in the presentation of mental health problems in children and young people of different genders, ages, cultural, ethnic, religious or other diverse backgrounds.'*

5.185 Furthermore, it states that;

'*When working with children and young people and their parents or carers who have difficulties speaking or reading English: provide and work proficiently with interpreters if needed.'*

And,

'Health and social care professionals working with children and young people with psychosis or schizophrenia and their parents or carers should have competence 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 possible causes of psychosis and 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 possible causes of mental health problems; and
- conflict management and conflict resolution.

Health and social care professionals inexperienced in working with children and young people with psychosis or schizophrenia from diverse ethnic and cultural backgrounds, and their parents or carers, should seek advice and supervision from healthcare professionals who are experienced in working transculturally.'

5.186 The Wells Unit could have sought to understand better the cultural context in which Mr N and his family lived, and the impact that this had on their ability to accept and manage Mr N's mental health problems. His mother discussed the stigma that Mr N's mental health problems carried.

5.187 In family therapy sessions Mr N's mother shared her concerns about how their local community would view Mr N's mental health problems. She was reluctant to agree to home leave for Mr N because she did not want mental health professionals to be seen visiting her home.

5.188 There were discussions at the Wells Unit which highlighted significant concerns from his mother which appeared to be based on her perception of how her own community would see Mr N and how this would reflect on her as a parent.

5.189 There is no evidence of how cultural issues might have impacted on his parents', and especially his mother's ability to accept that Mr N had mental health problems and required treatment. His mother expressed the belief that Mr N did not have any mental health problems and did not need medication to the team treating him at the Wells Unit. Her main concerns were about his use of drugs and alcohol.

5.190 We have been unable to find any evidence to suggest that the teams supporting Mr N and his family sought to understand the cultural context in which they lived and how this might impact on Mr N and his family's ability to accept support from western style mental health services.

5.191 Mr N experienced problems within his own community. In April 2014 he had been told to stay out of the housing estate that his mother lived on because there were concerns for his safety. It was also reported that whilst he was in the Wells Unit there was an issue between himself and another patient relating to problems between the two families.

5.192 On 8 April 2016 Mr N was assaulted by another patient on the ward. The nursing notes attributed this to an incident between the two families in the community.

5.193 On 12 February 2016 Mr N talked to the psychologist about the attitude to mental illness in Kenya and Somalia. He told them that there was stigma

attached to issues of mental illness and this could make it difficult for him to discuss his experiences of being mentally unwell.

5.194 Whilst Mr N's mother's spoke Somali and Swahili, and it is noted in the Wells Unit discharge summary that her use of English was 'reasonable', there was no consideration to whether this was sufficient to allow her to fully understand all of the nuances of the circumstances in which Mr N found himself. Assurance could have been obtained by using an interpreter on the first occasion that his mother met with the ward team.

5.195 The family would have benefitted from the health and social care professionals working with Mr N being able to address any '*cultural and ethnic differences in belief's regarding biological, social and family influences on the possible causes of mental health problems.'* Mr N's mother expressed the belief that he was not experiencing any mental health problems and that he did not require medication, but there is no evidence available that her beliefs were explored.

Findings 13: family engagement, carers assessment, culture and community

Family engagement and carers assessment

The Wells Unit developed a good working relationship with Mr N's parents and provided them with family therapy.

The CAMHS junior doctor developed a good working relationship with Mr N's Mother.

EIP did not develop a relationship with Mr N's mother.

Mental health services did not complete a carer's assessment for Mr N's mother to determine her care and support needs.

Culture and Community

The Wells Unit did not fully explore with Mr N and his family the impact that their cultural background had on their understanding of the mental illness that Mr N was experiencing and his need for treatment.

Although the family therapy at the Wells Unit was of value the ward did not fully identify the cultural factors that were at play within the family dynamic, or the impact that cultural factors had on Mr N's mother's attitude to his mental health problems, care and treatment.

Recommendation 18
The Trust must ensure that all families caring for young people in inpatient services are offered access to a carers assessment.

Recommendation 19
The Trust should assure itself that the perspective of families is included in care planning, and appropriate cultural awareness is applied when communicating with families.

Accommodation

5.196 Mr N was placed into the care of the local authority under Section 20 of the Children Act in 2014. This meant that whilst his parents retained responsibility for him, he was accommodated by the local authority. This was at the request of his mother who at the time felt unable to cope with him. He was accommodated at address 1. He repeatedly went missing from this accommodation and in October 2014 it was reported that he went missing a total of 18 times.

5.197 The local authority moved Mr N to a second placement (address 2), but this placement was breaking down prior to his admission to the Wells Unit because of his deteriorating behaviour and mental health issues.

5.198 Mr N was discharged from the Wells Unit to his mother's address, although he had not lived at the address full time since 2014. Both Mr N and his mother had changed their minds several times during his admission to the Wells Unit about whether he would return to live with her or to go to semi-supported accommodation. Immediately prior to his discharge he requested supported accommodation but when he was told this would delay his discharge he agreed to be discharged to his mother's address.

5.199 Following his appearance in court on 18 July 2016 Mr N was placed in a bail hostel (address 3) because his mother was not willing for him to return home. The EIP care coordinator did not have any contact with the bail hostel until they received a phone call from the hostel manager on 3 August 2016.

5.200 At the time he was placed there it would appear the bail hostel had been provided with little information about Mr N and were not aware of his mental health problems. When the bail hostel manager spoke to the EIP care coordinator on 3 August 2016, the manager told them that they were concerned about Mr N's behaviour and were considering ending his tenancy. Once the EIP care coordinator had provided the bail hostel with information about Mr N's mental health issues the tenancy terminated.

5.201 The local authority supported Mr N to return to live with his mother, which was his choice, on a temporary basis until the local authority could identify somewhere suitable for him to live. The EIP care coordinator was aware that Mr N had returned to live with his mother on a temporary basis and did not take this as an opportunity to complete a home visit.

Findings 14: Mental health services and accommodation

We have concluded that his mother was not able to manage Mr N and the breakdown of this placement was inevitable.

At the professionals meeting on the 29 June 2016 the EIP care coordinator agreed to start to look for supported accommodation for Mr N, we have not been able to find any evidence that they did this.

The EIP care coordinator was aware that Mr N had been asked to leave the bail hostel and the local authority were seeking an alternative placement for him. The EIP care coordinator did not consider that Mr N might have required a placement to meet his specific mental health needs and agreed to look for accommodation for him. This was a missed opportunity.

Recommendation 20
The Trust must provide assurance that appropriate accommodation is addressed in all patients' care planning at the point of discharge from out of area CAMHS forensic admissions.

Local authority process for placing Mr N in Hayes

5.202 A referral form was completed for Mr N to the Access to Resources Team (ART) by SW1 on 7 August 2016. We have concluded that the referral was of the necessary quality, containing sufficient information about him, his mental health problems and behaviour to allow an accommodation provider to make an initial informed decision about accommodating him.

5.203 This referral identified that SW1 believed that Mr N had experienced a trauma in his childhood and that he used substances to lessen the pain. It went onto identify that:

- He was generally polite with adults.
- He did not provide much information about himself, was intentionally guarded and provide calculated/controlled responses to questions.
- Furthermore, it was suspected that he spoke in a low volume so that others would have difficulty hearing what he had to say and so limit conversations.
- The 'smoke screen' of a quiet, polite young man had the effect of limiting assessments of his mental health, e.g. this can be seen in the mental health assessment completed by the Court Diversion worker.

5.204 The referral identified the key risk factor to be Mr N splitting the professional network supporting him and that communication across the group was important.

5.205 The information provided about 'why the placement is required' identifies that Mr N had a mental health diagnosis of psychosis, that he was on bail and due in the Magistrates' Court on 4 August, and that the court would be informed that Mr N had been unable to return to his current accommodation because of his behaviour. It was also noted that at his current placement other residents

had complained about the noise that Mr N made, that he talked to himself and was displaying signs of psychosis.

5.206 A placement was required because the temporary placement with his mother was breaking down, he needed intensive support to identify potential mental health relapse and to make sure he was taking his medication regularly.

5.207 The referral identified that Mr N would be able to remain at his mother's in the short term to allow him to attend court and a mental health assessment. A placement was needed to commence on 16 August 2016.

5.208 He was to be placed under Section 24 Children Act,[52] leaving care 18+.

5.209 The referral identified the need for a unit with 24-hour staff support and cameras because of the uncertainty of his behaviour and activities, and the need for further evidence to identify the best ways to continue to support him.

5.210 The referral also identified that Mr N could not be placed in Ealing due to the potential for gang related activity and retaliation. No evidence was provided to support this statement.

5.211 The referral stated that at that point in time here were not tried and tested strategies for dealing with his behaviour.

5.212 Whilst there were no restrictions on the contact that Mr N could have with his parents the referral did identify that they were unable to cope with his behaviours and there were concerns for his safety in the area local to his home.

5.213 The referral notes that he had recently been referred to Ealing EIP and that they were working with him, but it does not provide the name of or contact details for the EIP care coordinator.

5.214 In line with the ART process this referral was shared across the London wide supported accommodation providers (both regulated and unregulated). The local authority followed the appropriate process to find a placement for Mr N. There was a lack of available accommodation options, because of Mr N's risk only one provider was prepared to offer him accommodation. The only provider to reply to the request and accept Mr N was the unregulated accommodation provider in Hayes.

5.215 Mr N moved into the property (address 4) on 4 August 2016.

Findings 15: Local authority process for placement at address 4

The local authority supported Mr N's return to live with his mother, completing home visits to monitor the situation and sharing concerns with mental health services.

[52] *Children Act 1989 [F1 24] Persons qualifying for advice and assistance.* https://www.legislation.gov.uk/ukpga/1989/41/section/24

The local authority completed a comprehensive referral for a placement through ART at the end of July 2016. The placement at Hayes was the only provider to offer to accommodate Mr N.

We have been unable to conclude that the unregulated status of this accommodation was a directly influencing factor in the homicide.

Recommendation 21

The Trust must ensure that there are effective processes in place for working with the Local Authority to meet the accommodation needs of young people with mental health problems.

6 Analysis of internal investigation

6.1 The terms of reference require us to critically review the Trust internal investigation and report. We have reviewed the report using our internal framework for assessing credibility, thoroughness and impact of serious incident reports. We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency, NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths.

6.2 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA2 (or Root Cause Analysis and Action, hence 'RCA Squared') which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

6.3 We review the investigation and report under three themes: credibility, thoroughness, and impact.

6.4 **Credibility:** The Trust commissioned a level two investigation and terms of reference were clear, but the scope of the investigation was ill defined, and this resulted in treatment and care prior to Mr N's discharge from the Wells Unit not being reviewed. The NHS England standard for completing investigations is 60 days from the date the incident is identified. The final report for this investigation was not signed off by the Trust Board until 25 April 2017, this is well in excess of 60 days.

6.5 The internal investigation team comprised a consultant child & adolescent psychiatrist from Hillingdon, a consultant child & adolescent psychiatrist from another Trust, the deputy director of high secure services and the clinical governance lead for the Trust. We consider this to be good practice.

6.6 **Thoroughness:** The report clearly identifies the information used and interviews completed during the investigation. It is to be noted that whilst Mr N's family were informed of the investigation and the terms of reference, the Trust did not contact the family of L. The Trust did liaise with the police but did not establish the identity of the police main point of contact.

6.7 We have concluded that the chronology developed in the report does not cover a sufficient period of time, the tone is not impartial, and it fails to identify that Mr N was under the care of the local authority.

6.8 The investigation states that there is no root cause to the incident although it does go on to identify care delivery problems (CDP). We consider this to be incorrect, and that there could have been a more in-depth review which might have identified a root cause.

6.9 The report does not identify any service delivery problems (SDP) as such but makes two statements that it considers to be SDPs:

- there was a lack of collaborative involvement from other agencies to obtain engagement from the patients, and
- a possible lack of identification of interpersonal issues between residents by hostel staff and communication of this with care teams.

6.10 The investigation did not consider the appropriateness of Mr N being discharged to CAMHS for six weeks before being transferred to EIP. The internal investigation considered the transfer of care between the services rather than whether he should have been under the care of CAMHS and required the transfer of care.

6.11 The internal investigation failed to consider the arrangements for the provision of depots for children and young people in the community. The fact that Mr N did not receive his depot is considered by the investigation to be because he disengaged from services. The investigation did not give any consideration to the impact that the lack of a clear plan to provide the depot at one location, at a regular time by staff that Mr N had built a relationship with might have had on his engagement.

6.12 The investigation did not consider if EIP had any responsibility for sourcing accommodation for Mr N, even though this had been discussed in the professionals meeting on 29 June 2016.

6.13 In the panel findings and analysis, the report identified the lack of an appropriate transition protocol as an SDP, but this is not carried through into the list of CDPs and SDPs later in the section.

6.14 **Impact:** The report made nine recommendations to address the identified care and service delivery issues. The potential impact of the recommendations on practice across the Trust is limited because the findings of the investigation were flawed, transactional and limited to the three services that supported Mr N in the nine months prior to the homicide.

Recommendation 1: The Clinical Directors of Wells Unit, CAMHS and EIP should meet to review the report and consider ways to minimise the risk of multiple transitions in the future.

6.15 Recommendation 2: The Service Manager for CAMHS and EIP Manager must develop a written protocol for transition of patients from CAMHS to EIP.

6.16 Comment: the first two recommendations are local, transactional recommendations that will not impact on practice across the Trust as a whole. They are process changes and not outcome focused. These recommendations will not support wider learning across the Trust.

6.17 Recommendation 3: The Service Manager for CAMHS must ensure that all aspects of care/treatment for a patient discharged into their care are adequately planned and that the patient is fully aware of arrangements.

6.18 Comment: this recommendation is a local, transactional recommendation. It does not identify the issue it is intended to resolve. It is written in subjective language using words such as ‘adequately and ‘fully’, this will not support the measurement of the impact of any action taken regarding this recommendation.

6.19 Recommendation 4: EIP Lead must ensure that the 7-day risk plans are comprehensively documented with agreed timescales for escalation should the patient still not engage.

6.20 Comment - this recommendation is a local, transactional recommendation. The recommendation does not make any reference to the policies and procedures that might inform the completion of risk plans or the escalation process for patients who did not engage with services.

6.21 Recommendation 5: The Service Manager for CAMHS and EIP Lead must ensure that risk assessments are reviewed and updated in line with the Clinical Risk Policy.

6.22 Comment: this recommendation is a local, transactional recommendation. It is not outcome focused or measurable.

6.23 Recommendation 6: The Service Manager for CAMHS and EIP Lead must ensure that management of dual diagnosis is included in relevant patient’s care plans.

6.24 Comment: Mr N was not diagnosed with a dual diagnosis and so it is difficult to understand this recommendation. The recommendation does not identify if this recommendation relates to all patients who use illicit drugs or is limited to patients with a diagnosis of dual diagnosis.[53] This recommendation is a local, transactional recommendation.

6.25 Recommendation 7: The EIP Lead must ensure that professionals meetings with all services involved with the patient are convened at key points to manage identified and escalating risks.

6.26 Comment - this recommendation is a local, transactional recommendation. It is not specific or measurable.

6.27 Recommendation 8: The EIP Lead must ensure that care co-ordinators arrange a regular update at agreed intervals with all agencies involved with the patient to facilitate effective collaborative working.

6.28 Comment: this is broadly similar to recommendation 7.

6.29 Recommendation 9: The Incident Review Facilitator must ensure that the report is shared with all agencies involved for shared learning.

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[53] *NICE: Coexisting severe mental illness and substance misuse: community health and social care services. NICE guideline [NG58] Published date: 30 November 2016. https://www.nice.org.uk/guidance/ng58*

6.30 Comment: this recommendation is not specific and measurable. It does not draw on good practice in interagency working and the sharing of lessons learned across the whole care economy.

6.31 In our view these recommendations miss the point that Mr N was discharged to the care of CAMHS six weeks short of his 18th birthday and that a more patient centred approach would have been to discharge him directly to the care of EIP.

6.32 The internal report identifies a service delivery problem in the lack of planning of care on discharge from the Wells Unit, and in transition from CAMHS to EIP. We regard these as two distinct service delivery issues. We would expect a robust discharge planning process in a service such as the Wells Unit. The internal report does not identify this as an issue, and the recommendation that involves the Wells Unit focusses only on minimising transitions, rather than any assurance about the quality of discharge planning.

6.33 Our detailed review of the Trust internal investigation can be seen at Appendix D. In summary the Trust internal investigation report examined what happened with Mr N following his discharge from the Wells Unit.

6.34 The report attributed all the issues with Mr N's care and treatment to the community teams. No consideration was given to the quality of the discharge planning and discharge from the Wells Unit.

6.35 The investigation report does not identify the implications for Mr N of being a Looked After Child and the role the Leaving Care team played in his care.

6.36 Good practice: we commend the Trust for putting together a panel that included a psychiatrist from another Trust to provide an addition level of scrutiny and independence

Implementation of Trust Action Plan

6.37 The terms of reference require a review of the Trust's implementation of the recommendations resulting from the Trust internal investigation. The requirement is for a review of the implementation of the recommendations through the Trust's action plan and to identify:

- Progress made against the plan.
- Trust processes to embed the key learning from this incident.
- If the resulting changes have had a positive impact on the safety of Trust services.

6.38 To review the implementation of the Trust action plan we have used the Niche Investigation Assurance Framework (NIAF).

6.39 Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a useful numerical grading system to support the representation of 'progress data'. We deliberately avoid

using traditional RAG ratings, instead preferring to help our clients to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

6.40 **Recommendation 1:** The Trust action plan was for the clinical directors to convene a meeting and develop an appropriate strategy/protocol to address risk. The evidence provided by the Trust was an email between the Clinical Directors suggesting that a meeting be arranged and develop a 'Memorandum of Understanding: Cross service line transitions of young persons aged 18'.

6.41 The memorandum is brief and would not have influenced the decision-making process with regard to Mr N. In our view it will not mitigate or prevent multiple moves between services in a short space of time. It states that should services be at an impasse as to how to manage a patient's transfer, this would be agreed by the three Clinical Directors. The decision to refer to CAMHS for six weeks and then transfer to EIP was made by the Clinical Directors.

6.42 There was no evidence provided as to how this memorandum was shared with services.

6.43 **Recommendation 2**: The Trust action plan was for the development of an agreed transition protocol for transition between services. The evidence provided by the Trust provided their Transition protocol: transfer of young persons' care between CAMHS and adult mental health services – dated September 2017.

6.44 This protocol does not provide advice for the management of patients who are referred to services close to a transition point and how services manage this. There was no evidence provided as to how this memorandum was shared with services.

6.45 **Recommendation 3**: The Trust action plan required the CAMHS Clinical Improvement Group to agree and cascade an addition of prompts to protocols. The evidence provided for this recommendation was the CAMHS draft supervision policy and a range of clinical and business meeting minutes.

6.46 There was no evidence provided that the meetings discussed care/treatment plans for patients at discharge and how to ensure that patients were aware of the plans. It is difficult to see how the draft supervision policy relates to this recommendation.

6.47 **Recommendation 4**: The Trust action plan requires a review of the existing risk monitoring (traffic light system) minimal clinical actions with addition of stated timescales and possible further escalation. The evidence that the Trust provided for this recommendation was the draft EIP Standard Operating Policy, the EIP risk monitoring/zoning system dated March 2016 and the

'Trust Transition Protocol: transfer of young persons' care between CAMHS and adult mental health services', dated September 2017.

6.48 The Trust did not provide any evidence of changes to the systems which were in place at the time of the homicide to ensure that 7-day risk plans are comprehensively documented with agreed timescales for patients who were not engaging with the service.

6.49 **Recommendation 5:** The Trust action plan required a review in Clinical Improvement Groups (CIG) and communication to staff on the requirements of the Clinical Risk Policy.

6.50 The evidence provided for this recommendation was the CAMHS draft supervision guidance, minutes for a CIG meeting and a CAMHS senior management business meeting, along with an email asking for the information to be entered on the action plan and to be shared with the Board. None of this evidence related to the review and update of risk assessments in line with the Clinical Risk Policy.

6.51 **Recommendation 6**: The Trust action plan required the cascading of the new Trust strategy on co-existing mental health and substance use issues. The evidence provided for this was the CAMHS draft supervision policy and the minutes of CIG meetings.

6.52 The evidence provided does not relate to the management of patients with dual diagnosis and their care plans.

6.53 **Recommendation 7**: The Trust action plan did not identify any evidence for this recommendation but did contain the following statement, 'SI report has been discussed in Quality Matters and Quality Committee as well as PPC, MST and team CIG.'

6.54 We would have expected to see Standard Operating Procedures for the services that define when a professionals meeting should be held and the staff/organisations that would be invited.

6.55 **Recommendation 8**: The Trust action plan required a review in CIG for the development of an agreed procedure and implementation of this (the facilitation of regular updates to all agencies involved with the patient).

6.56 The evidence provided for this recommendation was the 'WLMHT Transition Protocol: transfer of young persons' care between CAMHS and adult mental health services' dated September 2017, and an email from the Clinical Director to EIP staff attaching the protocol and stating that there may be a CQUIN[54] for 2017-19 relating to it.

6.57 The protocol relates to the sharing of information about a patient at the point of transfer between CAMHS and adult services, there is no reference to the

[54] *CQUINs are quality improvement goals that NHS services aim for. https://www.england.nhs.uk/nhs-standard-contract/cquin/*

sharing of information between agencies during the patient's ongoing care and treatment.

6.58 **Recommendation 9**: The Trust action plan required the internal SI report to be shared with the relevant people. The evidence provided for this was: an email to staff at the Wells Unit, CAMHS and EIP with a copy of the report attached; an email to administration support at the Trust requesting that they share a paper copy of the report with the local authority; and a copy of a letter sent to Mr N's mother with a copy of the report.

6.59 The evidence provided demonstrates that the sharing of the SI report was restricted to providing staff and other interested parties with a paper copy of the report. This is an absolute bare minimum and not good practice. We would have expected to see the report shared face to face either with individuals and/or team.

6.60 The Trust EIP service is now accessible to young people from the age of 14.

6.61 For more detail about our findings and further advice for the Trust please see Appendix E.

6.62 NHS Ealing Clinical Commissioning Group (Ealing CCG) was responsible for oversight of the Trust internal investigation, assurance of the report and the completion of the action plan, with further oversight from NHS Central London, West London, Hammersmith & Fulham, Hounslow and Ealing Clinical Commissioning Groups (CWHHE). Responsibility for oversight and sign off of the incident on StEIS[55] transferred to the North West London Collaborative of Clinical Commissioning Group (NWLCCG) in July 2018.

6.63 The Trust internal SI report was submitted to NHS Ealing CCG in April 2017, eight months after the incident, and it was shared with CWHHE. Feedback from CWHHE stated that, '*The action plan is not robust enough to meaningfully describe how recommendations will be implemented with an overreliance on MDT/supervision as a monitoring method (without an associated measure). On this basis, we would recommend that each existing recommendation on the action plan is reviewed*.' We have not been provided with any evidence that the action plan was revised as a result of this feedback.

6.64 Throughout the first half of 2018 NHS Ealing CCG and CWHHE sought information from the Trust about the progress of the action plan. The CCG contact with the Trust was a mixture of emails and meetings with a range of staff from the Trust, including the Trust Associate Director of Clinical Governance and the Trust Safeguarding Adults Named Professional.

6.65 Although there were a significant number of attempts to seek assurance about the completion of the action plan, a number of queries remained outstanding. On 16 August 2018 NHS Ealing CCG wrote to the Trust requesting the outstanding queries were addressed within one week. The Trust did not

[55] *StEIS is the Strategic Executive Information System used in the NHS to report a serious incident. https://improvement.nhs.uk/resources/steis/*

provide complete and satisfactory responses to the CCG about these outstanding queries.

6.66 The Trust went on to submit evidence that the action plan had been completed in December 2019. The CCG met with the Trust in January 2020 to provide feedback and discuss gaps in the evidence and a further meeting was suggested for February 2020. This meeting did not take place.

6.67 NWLCCG closed the incident on StEIS on 30 March 2020. At this time there was a review of Trust open cases on StIES, and this case was on the list. The Trust SI report and evidence associated with the action plan had been submitted. There were some outstanding queries however, based on the work to date, and a plan for continued CCG monitoring of the implementation of the Trust actions the decision was made to close the case on StEIS.

6.68 NWLCCG shared with us the CWHHE Serious Incident Operational Policy dated November 2016 with us and told us that this was broadly the Policy currently followed by NWLCCG when managing serious incident investigations, reports and action plans. This only references to action plan oversight in this policy are: *'Commissioners may close incidents on StEIS once they are assured the action plan is in place and is being monitored to completion'* and '*Closure of the Never Event will only be complete where a commissioned provider is able to demonstrate evidence of implementation of all actions points in the action plan within 6 months.'*

Findings 16: Internal investigation Management of depot
The narrow scope of the investigation did not allow for a full exploration of the care and treatment provided to Mr N prior to the incident. This narrow scope limited the findings of the investigation. He was supported by the Leaving Care Team; it would have been good practice to have invited the team to be part of the investigation. This would have helped the panel to develop a more rounded picture of the care and support available to Mr N. The recommendations made are not, in our view, sufficiently focused on systemic issues, so are unlikely to prevent a reoccurrence.
Recommendation 22 The Trust to review its existing management of investigations against the requirements of the NHS England SIF, and develop and implement a methodology for the management of investigations that meets the requirements of the NHS England SIF.

Findings 17: CCG oversight
There was insufficient CCG oversight of the Trust action plan.
Recommendation 23 The North West London Collaborative of CCGs should revise the CWHHE Serious Incident Operational Policy (November 2016) against the

requirements of the NHS England SiF to ensure that it meets with national policy and guidance with regard to the monitoring of action plans. It should also be explicit about the criteria that must be met before an incident can be closed on StEIS.

7 Overall analysis and recommendations

7.1 The terms of reference for this investigation are focussed on Mr N's NHS care and treatment. However, his mental health presentation should be seen in the context of the wider system. Mr N was a care leaver,[56] [57] having been a Looked After Child, and had support and accommodation needs that added another layer of complexity to his presentation.

7.2 Although the local authority records were not shared with us, we were provided with information that evidences that Ealing Local Authority staff provided Mr N with regular input. The Local Authority social worker-maintained contact with NHS services and tried to ensure the social work perspective was included in meetings and in decision making.

7.3 We recognise that working with young people with complex mental health issues is challenging, and in this case the complexity was amplified by Mr N's lack of compliance. Mr N was a guarded young man, and this created a challenge for the professionals working with him. However, this behaviour was well known and should have been considered when communicating with him.

7.4 We have concluded that Mr N was not provided with an acceptable level of support by mental health services in the community after his discharge from the Wells Unit. A robust care plan with regular monitoring, as would be expected under Section 117 MHA, we believe could have increased his compliance, provided information on risk management, and ultimately responded to his relapsing mental state.

7.5 However, a weakness in the system around Mr N was the lack of a coordinated multiagency care plan, which recognised his social situation and mental health as stressors. The transient nature of his living accommodation between his mother's home, bail hostel and the unregulated accommodation no doubt contributed to his chaotic lifestyle. The lack of curiosity about his life choices resulted in there being no understanding if he was involved in gang activity and what if any risks this exposed him to.

7.6 We consider this to be symptomatic of a lack of coordination across agencies, which meant his needs were not seen holistically. We have made a recommendation for the Trust to develop a Communication Policy that defines what communication plans must be in pace for patients involved with multiple agencies (recommendation 14).

7.7 Although we have not had access to the Ealing Local Authority information about unregulated accommodation, it is our view that the lack of robust care plans regarding his mental health care and treatment was the causal contributory factor in his relapse, and the subsequent assault on L.

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[56] *A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours. A care leaver is between 16 – 18 and has previously been in care but is no longer legally "looked after" by Local Authority Children's Services.*
www.communitycare.co.uk/2007/05/23/children-in-care/

[57]

7.8 The Wells Unit did not fully explore Mr N and his mother's support needs when considering his discharge to her address. His mother had commented that she did not believe that Mr N was experiencing mental health problems and that he did not need medication. Furthermore, she reported that she felt threatened by Mr N when she refused to comply with his requests for money.

7.9 The Wells Unit plan had been for the psychologist to complete a home visit to assess the home environment and for Mr N to be given periods of home leave. This did not happen. His mother was reluctant to allow mental health staff to visit her home. Mr N would go AWOL when he was given leave from the ward, so the ward considered there to be limited value in Mr N being given home leave.

7.10 The principles of good CPA, risk assessment and planning were not followed when Mr N was in the community under the care of Ealing CAMHS or EIP. No formal care plan and risk assessment had been completed by Ealing CAMHS or EIP. The lack of proper risk assessment and planning resulted in Mr N's risks being described in the care narrative, and not being accurately identified, escalation in risk not being quantified and no plans developed to manage his risks.

7.11 We have concluded that there are two key points on the care pathway at which a different approach by services could have altered the outcome. These are:

- the discharge from the Wells Unit; and
- the mental health services response to the professionals meeting on 29 June 2016.

7.12 The discharge from the Wells Unit was not robust, there were three flaws in the plan:

- there was no clarity about the provision of the depot;
- the transfer to EIP after only six weeks; and
- the decision to discharge him home to his mother's address.

7.13 The unclear plan with regard to the provision of the depot was not helpful for someone who found it difficult to develop relationships with people, was reluctant to engage with services and to accept medication. However, the CAMHS junior doctor did work to provide Mr N with his depot and to build a rapport with him.

7.14 Mr N and his needs should have been central to the discharge planning process. There was an awareness that Mr N found it difficult to establish relationships and there was a risk that he would not comply with his medication regime in the community. With this and the NICE guidance in mind it would have been prudent to discharge Mr N directly to the care of EIP.

7.15 The third flaw in the discharge plan was discharging Mr N to his mother's address. During his admission to the Wells Unit Mr N and his mother had both changed their minds several times about him returning to live with her. For this

option to be a success there was going to be a need for support for his mother, but no carers' assessment was completed and there was no understanding of her support needs. There was also no real understanding of Mr N and his behaviours when living at his mother's, both in relation to his mother and the wider community.

7.16 The lack of proper risk assessment and planning for Mr N was a missed opportunity for services to determine what if any were the risks that Mr N posed to his mother.

7.17 By the time the professionals met on 29 June 2016 the relationship between Mr N and his mother was beginning to show signs of strain and it was identified by SW1 that Mr N was experiencing a relapse in his mental health. The plan from this meeting was insufficient given the levels of concern being expressed, and Mr N's escalating behaviours.

7.18 In our view this meeting should have resulted in an assessment under the MHA. However, the plan was for the EIP care coordinator to continue to assess his mental health and consider an assessment under the Act if needed. The EIP care coordinator had no contact with Mr N and did not consider an assessment under the Act as an option in the MDT meetings when Mr N was placed in the red zone.

7.19 The EIP care coordinator continued with their less than assertive approach to engaging with Mr N. Furthermore, they had agreed at the meeting on the 29 June 2016 to seek semi-supported accommodation for Mr N. There is no evidence that they did this.

7.20 There were some opportunities that the EIP care coordinator could have taken to try and engage with Mr N. They could have visited the bail hostel following the phone call with the hostel manager who reported Mr N 's strange behaviour. Given their commitment in the meeting on 29 June 2016 to complete an assessment under the MHA should Mr N's presentation deteriorate, this would have been the time to do this. This could also have been carried out when Mr N was back at his mother's address for a short time before the placement at address 4.

7.21 In 2019 the Trust revised the EIP offer, and the service is now available to patients from the age of 14. Had this been the service offer when Mr N was discharged from the Wells Unit in 2016, we believe that he could have been discharged to an appropriate team for his longer-term care in the community.

7.22 The Wells Unit was closed in September 2020 and the Trust no longer provides an inpatient forensic CAMHS service, patients requiring this type of placement is cared for in an out of area bed.

7.23 We have identified five recommendations made by this review relating directly to the Wells Unit. As a result of the closure of the Unit we consider two of the recommendations (Recommendations 11 and 15) no longer applicable and there is no expectation that the Trust will address these recommendations in their action plan. There is one recommendation no longer applicable to the

Trust but applicable to the wider system, therefore Recommendation 12 has been removed, but has been included in the regional recommendations, for the North West London Integrated Care System.

Predictability and preventability

7.24 Prevention means to "stop or hinder something from happening, especially by advance planning or action"[58] and implies "anticipatory counteraction"; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.25 We have been able to conclude that the homicide was preventable. Mr N had not been seen by his EIP care coordinator since 3 June 2016. At the professionals meeting on the 29 June 2016, it was recognised that:

- He was experiencing a relapse in his mental health.
- He had not received any medication since the beginning of June 2016.

7.26 There were two missed opportunities for EIP to take an assertive approach to reviewing his mental health, on 29 June 2016 and 27 July 2016. We believe that had EIP completed a face to face assessment with Mr N at either of these points his mental health needs could have been identified and a plan could have been developed to manage him in the community, that may have included an assessment under the MHA.

7.27 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[59] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. [60]

7.28 We have concluded that the homicide was not predictable. To support a finding that the homicide was predictable we would have expected to see a direct causal link between Mr N's deteriorating mental health and a propensity for serious violence.

7.29 Mental health services did not identify a link between a deterioration in his mental health and his offending history. From 2012 he committed a number of offences as a juvenile - theft, assault and carrying a bladed weapon, which were not necessarily directly linked to his mental health. Following his discharge from the Wells Unit he committed a number of similar offences, shop lifting, common assault and criminal damage and we have not been able to conclude that any of these offences could be attributed to his deteriorating mental health.

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[58] *http://www.thefreedictionary.com/prevent*

[59] *http://dictionary.reference.com/browse/predictability*

[60] *Role of risk assessment in reducing homicides by people with mental illness. Munro & Rumgay (2000) https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/role-of-risk-assessment-in-reducing-homicides-by-people-with-mental-illness/F032313089EE7F91E4CA4A95AA4D5380*

Findings and recommendations

7.30 We have made a series of 17 findings, under the following headings:

- Assessment and capacity
- Clinical care and treatment
- Care Programme Approach
- Management of depot
- Alcohol and substance misuse management
- Discharge from the Wells Unit
- Transition between services
- Application of the Mental Health Act
- Risk assessment and management
- Interagency communication
- Safeguarding
- Gang involvement
- Family engagement, carers assessment, culture and community
- Mental health services and accommodation
- Local authority process for placement at address 4
- Internal Investigation
- CCG oversight

Findings 1: assessment and capacity

The Wells Unit completed a psychiatric assessment of Mr N that resulted in a revised diagnosis and medication regime.

A thorough psychological assessment was completed while Mr N was on the Wells Unit, which drew together a number of other assessments that had been completed in the past together with assessments completed while he was on the Unit, including a speech and language therapy assessment.

Mr N himself discussed approaches to mental health issues by his community in a psychology appointment, but there is no evidence available that this was not shared with the wider team.

Ealing CAMHS made extensive efforts to engage him and to ensure his depot medication was administered. We have concluded that the Ealing CAMHS junior doctor developed a rapport with Mr N, and Mr N did attend for some of the planned appointments.

EIP accepted Mr N for an extended assessment of his mental health needs. However, in our view EIP staff spent a considerable amount of time

looking for evidence that this was not Mr N's first episode of psychosis. A review of the notes indicates that psychosis was only considered a feature of Mr N's mental health issues immediately before his admission to the Wells Unit.

Capacity

There were no capacity assessments completed with regard to Mr N's capacity with regard to medication, finances, or substance misuse.

Findings 2: clinical care and treatment

Wells Unit

Mr N was treated in line with NICE guidance, psychosis and schizophrenia in children and young people: recognition and management.

He was offered and accepted psychological therapy.

He was offered choice with regard to his medication and was supported in making his choice.

His family were offered and accepted family therapy.

He was provided with physical health care and treatment, and was offered advice about his illicit substance misuse, but did not accept it.

Mr N was provided with opportunities to leave the ward on escorted and unescorted leave. However, the plan for phased leave including home leave and overnight leave was not followed through.

Ealing CAMHS

The CAMHS team could be viewed as a 'holding' service until Mr N's care and treatment could be transferred to EIP on Mr N's 18th birthday.

EIP

Mr N had an identified care coordinator while under the care of EIP.

The Support Time and Recovery worker did not work with him as agreed on 3 June 2016. This was a missed opportunity for a member of the EIP team to develop a relationship with Mr N.

The EIP team did not have face to face contact with Mr N in the following six weeks that he was under the care of the team. Although Mr N was in the red zone, this did result in a more assertive approach.

EIP did not negotiate with Mr N to provide his depot at a time and location that would have increased the chance of his compliance.

In our view the EIP team did not make sufficient efforts to engage with the police, courts and social workers in the face of a deteriorating situation and no direct contact was made with Mr N.

Findings 3: Care Programme Approach

Ealing CAMHS did not complete a CPA review for Mr N when he was discharged to the care of the team. Had a CPA review been completed in line with the Trust policy it would have allowed for the team to articulate the challenges in providing Mr N with his depot, as an unmet need.

The CAMHS junior doctor did complete thorough mental health state assessments for Mr N on the occasions that he saw him, and these are clearly recorded in the clinical notes.

The CAMHS junior doctor completed a good transfer of care to EIP. Although this was completed over the phone, there was a professionals meeting prior to this with EIP and the social worker.

EIP did not complete an assessment or CPA review for Mr N. They saw him on one occasion when they attended a CAMHS appointment on 3 June 2016.

EIP accepted him for an extended assessment of his mental health needs.

It is to be noted that EIP spent a considerable amount of time looking for evidence that this was not Mr N's first episode of psychosis. A review of the notes indicates that psychosis was only considered a feature of Mr N's mental health issues immediately before his admission to the Wells Unit.

Findings 4: Management of depot

The Wells Unit engaged Mr N in the discussions and decision making about his medication choices. Mr N recognised that when he was in the community there was a risk that his compliance with medication could be poor.

The Wells Unit did not recognise that a young person in receipt of depot medication was rare and that community services might not have been equipped to provide this for Mr N.

The Wells Unit should have sought to understand how the depot would have been provided in the community and ensure that a more robust plan was in place.

The **CAMHS** plan for the provision of Mr N's depot when he was discharged into the community was not robust. No named member of the CAMHS team took initial responsibility for managing the provision of the depot. CAMHS did not provide depot injections and the Recovery team provided the initial depot as a favour, there was no plan in place for future depot injections.

The CAMHS junior doctor endeavoured to provide Mr N with his depot in the face of a number of challenges, CAMHS not providing depots, not understanding the prescribing process etc.

EIP were not assertive in their approach to providing Mr N with his depot. They were reliant on Mr N attending the team base and would not provide a depot at home because Mr N was not known to them and this was identified as a risk.

EIP did not recognise that Mr N's non-compliance with his medication was a relapse indicator.

Findings 5: alcohol and substance misuse management

Mr N declined offers of support from mental health services to manage his substance misuse. It is reported that he did attend a session with the local

authority substance misuse worker, but he did not continue to engage with them.

Given Mr N's history of substance misuse mental health services did not consider Mr N to be a dual diagnosis patient and he was not offered an assessment, treatment and advice as such.

Findings 6: Discharge from the Wells Unit

The discharge was informed by Mr N's approaching 18th birthday and he became the victim of 'birthday services', i.e. services choosing to strictly impose age criteria to exclude a patient's access to the service.

The discharge from the Wells Unit did not consider the NICE guidance on transitions which contains advice about the risk of transferring children and young people between services and warns against transitions between multiple services in a short period of time.

The discharge plan from the Wells Unit did not identify and address Mr N's support needs when he was in the community.

The plan to discharge Mr N to the care of CAMHS for six weeks and then to transfer his care to EIP was not robust. There was no clear care plan agreed with CAMHS about the care and treatment that they would provide, beyond an ad hoc agreement for the team to support Mr N's depot.

There was no relapse plan in place with clear relapse indicators and a contingency plan other than to take Mr N to A&E.

From the discussion at Mr N's discharge CPA meeting the Wells Unit and CAMHS believed that the EIP team had accepted Mr N for assessment/care and treatment on his 18th birthday.

We have concluded that this was not the case and that the EIP team accepted Mr N as a transfer from CAMHS after their assessment meeting with him on the 3 June 2016.

Findings 7: Transition between services

The NICE guidance 'transition from children's to adult's service for young people using health or social care services should have informed Mr N's discharge from the Wells Unit, as he was six weeks short of this 18th birthday.

Had this been used to inform the process better consideration might have been given to:

ensuring that Mr N received appropriate support with his psychosis; his social and personal circumstances, especially the appropriateness of him returning to live with his Mother; and, address outcomes such as education, community inclusion, health and well-being, including his emotional health and his independent living and housing options.

The guidance is clear that 'The point of transfer should not be based on a rigid age threshold and take place at a time of relative stability for the young person.'

Mr N's rapid transfer through CAMHS to EIP was based on the application of a rigid age threshold and there was no period of stability for Mr N.

There was no agreed protocol to inform the transition between CAMHS and EIP.

There was a misunderstanding between the services about the CAMHS service offer. EIP described an understanding that CAMHS could provide an EIP service for a patient under the age of 18 and that this could be extended by 3 years. This would have been applicable to a young person who was on a clear pathway with CAMHS prior to their 18th birthday. However, EIP had agreed at the discharge planning meeting that Mr N would transfer to their care on his 18th birthday.

This series of rapid transfers between service is not in keeping with the NICE guidance that states young people should 'routinely receive care and treatment from one single MDT community team; are not passed from team to team unnecessarily; do not undergo multiple assessments unnecessarily.'

Findings 8: Application of the Mental Health Act

The Mental Health Act was correctly applied to Mr N throughout his detention at the Wells Unit.

There is no justification given for admission to medium security. We would have expected to see evidence of a discussion at the CAMHS national network meeting, however there was no record of such a discussion in the clinical notes. It appears that the decision to admit to the Wells Unit was made by the individual clinicians.

We have not been able to find any evidence of the proper application of Section 117 MHA in relation to the social care support available to Mr N following his discharge from the Wells Unit.

Findings 9: Risk assessment and management

The Wells Unit completed a SAVRY for Mr N. We have not been able to establish how widely this was shared with community services. We were told by the Wells psychologist that this was shared with the CAMHS consultant along with the Wells Unit discharge summary.

However, this assessment was not uploaded to RiO until September 2016, so we are unclear if this assessment was available to EIP.

There was no obvious assessment or care planning in response to the risks presented by Mr N when he absconded from the ward area.

He was not assessed through the use of Section 17 leave prior to discharge.

CAMHS did not update the Trust risk assessment in line with the Clinical Risk Policy:

When Mr N transitioned from the Wells Unit.
When high risk incidents were reported by Mr N's, i.e. criminality.
When he missed his depot.

EIP did not update the Trust risk assessment:

When Mr N transitioned from CAMHS
When Mr N was not engaging with EIP.
When he missed his depot.
Increasing criminality.
When there were reports that Mr N had spat at his mother when she would not give him money

EIP was not assertive in their approach to the care and treatment provided to Mr N. Mr N was placed in the red zone for the whole of the time he was under the care of EIP.

However:

The strategies and plans were not comprehensively documented.
The plan remained the same from week to week.
No timeframe was identified for escalation if Mr N did not engage with the team.

No risk assessments were completed for Mr N after he left the Wells Unit so there was no assessment made of his risk to others.

Findings 10: interagency communication

The Wells Unit worked collaboratively with all of the agencies in the community who supported Mr N.

The **Ealing CAMHS** junior doctor worked collaboratively with the local authority social worker.

EIP was reliant on the Leaving Care Team contacting them.

EIP was not proactive in seeking communication with or information from the Leaving Care Team.

Findings 11: Safeguarding

Trust safeguarding policies were not followed when information about sexual, financial and physical vulnerability were reported involving Mr N.

Trust policies regarding carer support and risk assessment were not followed.

Findings 12: Gang involvement

Services did not demonstrate an awareness of Mr N's risk with regard to gang activity. They lacked professional curiosity and did not seek further assurances from the police when presented with further information that may have supported the idea Mr N was involved in gang activity.

Findings 13: Family engagement, carers assessment, culture and community

Family engagement and carers assessment

The Wells Unit developed a good working relationship with Mr N's parents and provided them with family therapy.

The CAMHS junior doctor developed a good working relationship with Mr N's Mother.

EIP did not develop a relationship with Mr N's mother.

Mental health services did not complete a carer's assessment for Mr N's Mother to determine her care and support needs.

Culture and Community

The Wells Unit did not fully explore with Mr N and his family the impact that their cultural background had on their understanding of the mental illness that Mr N was experiencing and his need for treatment

Although the family therapy at the Wells Unit was of value the ward did not fully identify the cultural factors that were at play within the family dynamic, or the impact that cultural factors had on Mr N's Mother's attitude to his mental health problems, care and treatment.

Findings 14: Mental health services and accommodation

We have concluded that his mother was not able to manage Mr N and the breakdown of this placement was inevitable.

At the professionals meeting on the 29 June 2016 the EIP care coordinator agreed to start to look for supported accommodation for Mr N, we have not been able to find any evidence that they did this.

The EIP care coordinator was aware that Mr N had been asked to leave the bail hostel and the local authority were seeking an alternative placement for him. The EIP care coordinator did not consider that Mr N might have required a placement to meet his specific mental health needs and agreed to look for accommodation for him. This was a missed opportunity.

Findings 15: Local authority process for placement at address 4

The local authority supported Mr N's return to live with his mother, completing home visits to monitor the situation and sharing concerns with mental health services.

The local authority completed a comprehensive referral for a placement through ART at the end of July 2016. The placement at Hayes was the only provider to offer to accommodate Mr N.

We have been unable to conclude that the unregulated status of this accommodation was a directly influencing factor in the homicide.

Findings 16: Internal investigation

The narrow scope of the investigation does not allow for a full exploration of the care and treatment provided to Mr N prior to the incident. This narrow scope limited the findings of the investigation.

Mr N was supported by the Leaving Care Team, it would have been good practice to have invited the team to be part of the investigation. This would have helped the panel to develop a more rounded picture of the care and support available to Mr N.

The recommendations made are not, in our view, sufficiently focused on systemic issues, so are unlikely to prevent a reoccurrence.
Findings 17: CCG oversight
There was insufficient CCG oversight of the Trust action plan.

7.31 We have made 23 recommendations as set out below:

Recommendation 1
The Trust must ensure that there is a clear system for ensuring that capacity assessments are completed and recorded where indicated.

Recommendation 2
The Trust CAMHS service must ensure that all patients under its care that are subject to CPA have a named care coordinator.

Recommendation 3
The Trust must revise the EIP Zoning Policy to more clearly define the care and treatment that a patient in the red zone can expect, to support a more assertive approach.

Recommendation 4
The Trust should develop a performance matrix to monitor and improve compliance with the Trust CPA policy, and this matrix must identify patients who have transferred between services and if a CPA was completed.

Recommendation 5
The Trust must revise the current arrangements to ensure that missed depots are reported to the care coordinator within 48 hours and what plans need to be put in place to provide the missed depot.

Recommendation 6
The Trust must ensure that there is a clear and transparent process in place that will support all patients to be provided with a depot, irrespective of the team providing care and treatment. These arrangements must identify the criteria for providing a depot in a patient's home.

Recommendation 7
Trust medicine management policies for long acting antipsychotic injections should provide guidance for their use in young people.

Recommendation 8
The Trust to review the approach that it takes to young people with established substance misuse issues and to develop a dual diagnosis approach to these patients.

Recommendation 9

The Trust must provide assurance that all transitions between services for children and young people are completed in line with the NICE guidance on the Transition of children and young people.

Recommendation 10
The Trust CAMHS to review its approach to transferring patients and to benchmark itself against the NICE guidance on the Transition of Children and Young People, to use the findings to develop a robust patient centred approach to transfer and discharge.

Recommendation 11
The Wells Unit operational policy should include the expectation that all admissions make reference to the clinical rationale for the level of security.

Recommendation 12
The Trust must ensure that the expectations of Section 117 MHA are applied when patients are discharged from out of area CAMHS forensic admissions.

Recommendation 13
The Trust should audit current risk assessments completed in CAMHS and EIP against the Clinical Risk Policy, and then develop a plan to improve performance and quality.

Recommendation 14
The Trust must review its CPA policy to ensure that where there are multiple agencies providing care and support to a patient the care plan identifies:

- The lead agency for communication between the agencies
- Information and reporting channels
- Reporting intervals
- How urgent information will be effectively shared
- Contingency plans for information sharing when staff are absent from work
- Consideration of the application of Section 117 MHA were applicable.

Recommendation 15
The Wells unit must ensure that all patient reported allegations of bullying are appropriately investigated, and safeguarding procedures instigated.

Recommendation 16
The Trust must ensure that the policy expectations regarding risks to family members are incorporated into risk assessment and care planning.

Recommendation 17
The Trust and Local Authority should complete a review of the current processes in place for identifying children and young people who may be vulnerable to child exploitation, county lines drug gangs or general

involvement with gangs to ensure that these are in line with current national best practice and local expectations on exploitation.

Recommendation 18
The Trust must ensure that all families caring for young people in inpatient services are offered access to a carers assessment.

Recommendation 19
The Trust should assure itself that the perspective of families is included in care planning, and appropriate cultural awareness is applied when communicating with families.

Recommendation 20
The Trust must provide assurance that appropriate accommodation is addressed in all patients' care planning at the point of discharge from out of area CAMHS forensic admissions.

Recommendation 21
The Trust must ensure that there are effective processes in place for working with the Local Authority to meet the accommodation needs of young people with mental health problems.

Recommendation 22
The Trust to review its existing management of investigations against the requirements of the NHS England SIF, and develop and implement a methodology for the management of investigations that meets the requirements of the NHS England SIF.

Recommendation 23
The North West London Collaborative of CCGs should revise the CWHHE Serious Incident Operational Policy (November 2016) against the requirements of the NHS England SiF to ensure that it meets with national policy and guidance with regard to the monitoring of action plans. It should also be explicit about the criteria that must be met before an incident can be closed on StEIS.

Healthcare Safety Investigation Branch 2018 report

7.32 The terms of reference require that the Health Service Investigation Branch (HSIB) report findings and recommendations into transitions of care[61] are considered.

7.33 In July 2018 HSIB published a report into the care and treatment of a young person who committed suicide as they transitioned between CAMHS and

[61] *Transition from child and adolescent mental health services to adult mental health services. HSIB July 2018. https://www.hsib.org.uk/investigations-cases/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/*

adult mental health services. The report made six safety recommendations and two safety observations.

7.34 These are high level recommendations for NHS England, NHS Improvement, the Care Quality Commission and Clinical Commissioning Groups. This investigation has reviewed a period of care in 2016, which is before the HSIB report was published. We have therefore considered whether the Trust approach to the transition of young people to adult mental health services has considered the three relevant high-level safety recommendations.

Safety recommendation three:

'That NHS England and NHS Improvement ensure that the transition guidance pathways or performance measures require structured conversations to take place with the young person transitioning to assess their readiness, develop their understanding of their condition and empower them to ask questions. NHS England and NHS Improvement must then ensure that the effectiveness of this is robustly evaluated.'

7.35 We have not seen any mechanism put in place by the Trust to ensure that these structured conversations take place. We are therefore unable to comment on the impact that this expectation has had on the experience of young people who have transitioned from CAMHS to adult mental health services.

7.36 The Trust Transition Protocol: Transfer of Young Persons' Care between CAMHS and Adult Mental Health Services identifies that planning for a young person's transfer of care should start six months before the transfer date to support assessment and joint working and a transfer of care meeting should be held three months before the transition, this meeting should be attended by the young person.

7.37 This protocol was to be monitored via CQUIN for 2017-19. We have not been provided with any information about this CQUIN by the Trust or the CCG to consider the impact of this on the experience of young people who have transitioned from CAMHS to adult mental health services.

Safety recommendation four:

'That NHS England within the 'Long Term Plan', requires services to move from age-based transition care towards more flexible criteria based on an individual's needs.'

7.38 The Trust Transition Protocol: Transfer of Young Persons' Care between CAMHS and Adult Mental Health Services does describe age-based transition but requires CAMHS and adult services to have a flexible approach to transfer. The protocol asks that there should be flexibility about the date of the young person's transfer of care dependent on their assessed care needs.

Safety recommendation five:

'That NHS England and NHS Improvement work with commissioners and providers of mental health services to ensure that the care of a young person

before, during and after transition is shared in line with best practice, including joint agency working.'

7.39 The Trust Transition Protocol: Transfer of Young Persons' Care between CAMHS and Adult Mental Health Services describes the process for transferring young people to adult mental health services and to primary care, there is no reference in the protocol to joint agency working.

7.40 We would hope that the recommendations in this report will support the Trust to embed best practice for the transition of young people from CAMHS to adult services as identified in the NICE guidance and highlighted in the HSIB report.

Appendix A – Terms of reference

Purpose of the Review

To independently review the care and treatment provided to the perpetrator prior to the homicide 16th August 2016, and to establish the effectiveness of learning across the Trust following completion of the Trust Serious Incident report.

The outcome of this review will be managed through governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

Review the care and treatment provided to the perpetrator prior to the homicide in particular:

- To review the assessment, clinical care and treatment provided and explore legal status of the perpetrator whilst he was an inpatient in the Wells Unit.
- To understand if behaviours and risk to others was explored, communicated and managed by all care teams.
- To understand communication with Local Authority prior to discharge
- To review the engagement with the patient and his parents in relation to depot and medication management in community, in particular the location and contact details.
- To review the multiagency communication in safeguarding perpetrator.
- To review the effectiveness of systems to manage perpetrator depot prescription and the causes of the prescription being lost.
- To review the multiagency communication and response in safeguarding the perpetrator and others across care pathway.
- To understand the rationale for a carer's assessment not being considered
- To understand his history and managements of illicit substance and alcohol misuse.
- To explore possible financial abuse and actions taken.
- To review possible gang involvement and affiliation.
- To review if his cognitive function was considered.
- To review the quality of communication between Wells Unit/CAMHS/ Adult Ealing Recovery Team/ Ealing Early Intervention Service/Local Authority and accommodation staff, in particular in developing joint care plan for the patient

The Trust internal serious incident report has identified some key learning and recommendations from this incident therefore not to replicate these the independent investigation will review the implementation of the Trust's internal investigation action plan and identify:

- Review progress made against the action plan.
- Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services
- Review the CCG monitoring process of the action plan
- Make further recommendation for improvement as appropriate.
- Ealing local authority
- To review the decision making and oversight made by Local Authorities in placing the perpetrator in address four.
- To review the extent of communication of provider wide risks regarding placements across local authority across London.
- To ensure the HSIB report findings and recommendations into transitions of care is considered.

Appendix B – Documents reviewed

West London Mental Health Trust

- Clinical records – Wells Unit, CAMHS and EIP
- Mental Health Act records, including MHA Tribunal reports
- Safeguarding Adults Policy, 2017
- Being Open Policy, 2014
- Clinical Risk Policy, 2016
- Care Programme Approach and Care Planning Policy, 2019
- Trust 72 Hour Report
- Serious Incident Report
- Notes for interviews completed for the Trust internal investigation
- Trust action plan and supporting evidence
- Early Intervention in Psychosis Traffic Lights Risk Monitoring System Criteria, 2014
- Ealing Adult Early Invention in Psychosis Team Operational Policy, draft 2011, with amendments October 2016
- Early Intervention for Psychosis Operational Policy 3 December 2019
- South London and Maudsley NHS Foundation Trust
- Clinical records
- Ealing Adults Safeguarding Board
- Chronology of Significant Events

London Borough of Ealing

- Looked After Children and Care Leavers Placements – commissioning strategy 2014-2017
- Services for Ealing Looked After Children and Care Leavers
- ART placement referral form
- High-level referral, sourcing and purchasing process
- ART team
- Foster placement process

Care Quality Commission

- Review of health services for Children Looked After and Safeguarding in Ealing, June 2018

Other

- Crown Court Sentencing Remarks
- Healthcare Safety Investigation 12017/008

- NICE Guidance – Looked-after children and young people, October 2010

Appendix C – Analysis of Trust investigation and report

Standard		Niche commentary
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident:	The Trust commissioned a level 2 homicide investigation. Standard met
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The terms of reference are clear about what is to be investigated, and the type of investigation. However, the scope is ill defined in terms of the timeline and this has resulted in the time period 25 November 2015 to 26 April 2016 while Mr N was detained to the Wells Unit not being considered by the investigation. These were set by the Head of Governance and agreed by the executive team and clinical directors. The investigation panel did not revise the terms of reference set for them because they considered them to be holistic enough. Standard partially met
1.3	The person leading the investigation has skills and training in investigations	The investigation panel was led by a CAMHS consultant psychiatrist from a network in the Trust that had not been involved with Mr N's care and treatment. The investigation lead was not RCA trained but described to us his extensive experience in completing other types of investigations and reports. The panel included a clinical governance lead who was RCA trained. The Trust are to be commended for putting together a panel that included panel members from another Trust, to provide impartiality and scrutiny. Standard partially met
1.4	Investigations are completed within 60 working days	The incident took place on 16 August 2016, the Trust commissioned the investigation on 28 October 2016 and the final investigation report was signed off by the Trust on 26 April 2017.

		This is in excess of 60 working days. We were told that there was a delay in the commencement of the investigation because of the police enquiry into the incident. We were also told that there was a delay in the report going through the quality assurance process in the Trust due to the volume of incidents at the time. Standard not met
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is a description of the investigation written in plain English. However, it does not describe how RCA methodology was used to reach its conclusions. Standard partially met.
1.6	Staff have been supported following the incident	The report does not identify the support provided to staff following the incident. The 72-hour report identified that 'debriefs have been held with all relevant staff.' Standard partially met
Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident	The investigation report contains a description of the incident, with details of the outcome and the severity of the incident. Standard met
2.2	The terms of reference for the investigation should be included	The investigation report contains the terms of reference. The terms of reference are not specific about the time period to be covered by the investigation, '*To establish the sequence of events, as far as the Trust was involved, leading up to the incident on 14 August 2016 when it is alleged that a patient fatally wounded a fellow supported accommodation resident by stabbing.'* It is to be noted that the terms of reference were shared with Mr N's family but not with the victim's family. The terms of reference do not contain reference to any of the family concerns. Standard met

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	The methodology is clearly described in the report, including: • the staff interviewed • documents reviewed, • use of the Root Cause Analysis Toolkit Guidance Factors Framework. However, it is not clear from the report how the RCA methodology was applied. Standard not met.
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	The investigation panel met with Mr N's parents and shared the terms of reference for the investigation with them. The final report was shared with them. At the time the investigation was completed the police identified the main point of contact for the victim as his girlfriend. She was under the age of 18 at the time and it was not considered appropriate to meet with her. The Trust was informed that the victim's girlfriend was being supported by the police family liaison officer. The Trust did not make any further enquiries about next of kin for the victim. The victim was under the care of the local authority at the time of their death. Prior to this they had been cared for by an aunt. He also had a mother, but the Trust was not provided with details for either of them by the police. Standard partially met
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	The investigation panel met with Mr N's parents and shared the terms of reference for the investigation with them. We have been told that Mr N's parents had no comments to make about the terms of reference. Standard partially met
2.6	A summary of the patient's relevant history and the process of care should be included	The report includes brief information about Mr N's childhood. However, this summary does not include details of his offending history or the impact that being a Looked After Child would have on the care and support available to Mr N. Both these elements of Mr N's life are important, and his mental health issues cannot be considered as a 'standalone' but in the context of his wider life.

		This section of the report provides no details of Mr N's admission to the Wells Unit. This is a fundamental flaw in this investigation.
		Standard partially met
2.7	A chronology or tabular timeline of the event is included	The report contains a narrative chronology from April 2016 when Mr N was discharged from the Wells Unit to the date of the homicide. This chronology is brief, not impartial in tone and does not clearly identify that Mr N was under the care of the SW1in addition to mental health services. The chronology for the event is brief, this could be attributed to services having little involvement in the event itself.
		Standard partially met
2.8	The report describes how RCA tools have been used to arrive at the findings	The investigation report identifies the Root Cause Analysis Toolkit Guidance Factors Framework under the list of documents that the panel members referenced during the investigation. However, the investigation report does not identify how RCA tools were used to develop and agree the report's findings. While the report identifies no root cause, it does identify care and service delivery issues along with contributory factors.
		Standard not met
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	The report identified five care delivery problems (CDPs) and two service delivery problems (SDPs). CDPs relate to direct provision or process of care and are usually actions or omissions by members of staff. However, the first CDP identified is not a CDP: CDP 1 – The patient underwent a transition of care between three teams and a number of accommodation moves in a period of 12 weeks. This rapid transition between the teams is a process or decision-based issue and as such is an SDP.

		The remaining CDP's identified in the investigation report are statements that had a number of care delivery problems that could have been attributed to them. The investigation report does not identify all of the care delivery problems. CDP 2 – The patient did not receive depot at the time intervals required. CDP 3 – The patient did not have face to face contact with the EIP team for six weeks that he was under their care and so was not assessed or on treatment. CDP 4 – Formal risk assessments were not reviewed in line with Trust policy. CDP 5 – There was no evidence of consideration of dual diagnosis and efforts to engage him with substance misuse services. SDPs are acts or omissions that are identified not associated with direct provision of care. They might be associated with the decisions, procedures and systems that are part of the whole process of service delivery. The investigation report does not in fact identify service delivery problems but makes suggestions about what might be considered service delivery issues. This is not appropriate. A thorough investigation should reach conclusions based on evidence. SDP1 - A possible lack of collaborative involvement with other agencies to obtain engagement from the patient. SDP 2 – A possible lack of identification of interpersonal issues between residents by the hostel staff and communication of this with the care teams. Standard partially met
2.10	Contributory factors are identified (including whether they were contributory factors, use of	For each of the identified CDPs and SDPs the investigation report identifies contributory factors.

	classification frameworks, examination of human factors)	CDP 1 – The patient underwent a transition of care between three teams and a number of accommodation moves in a period of 12 weeks. The investigation report identifies task, patient and communication contributory factors for this CDP. The description of the task and communication factors support the conclusion that this is an SDP. CDP 2 – The patient did not receive depot at the time intervals required. The investigation report identifies patient, team and organisational contributory factors for this CDP. The team factors identified are not team factors, they are communication factors and some of the issues could be considered an SDP. The tone of the description of the patient and team factors implies patient blaming. This is not in the spirit of the NHS England that requires investigations to seek to not apportion blame but to understand what happened and identify opportunities for learning. CDP 3 – The patient did not have face to face contact with the EIP team for six weeks that he was under their care and so was not assessed or on treatment. The investigation report identified patient and team contributory factors for this CDP. The tone of the narrative for these factors implies patient blaming. Communication is not identified as a contributory factor for this CDP but the narrative under team factors described communication issues between EIP and other services involved with Mr N. CDP 4 – Formal risk assessments were not reviewed in line with Trust policy. The investigation report identifies team factor as the only contributory factors for this CDP. The investigation report describes the risk assessments as not being completed at various points on the care pathway but does not address why.

		CDP 5 – There was no evidence of consideration of dual diagnosis and efforts to engage him with substance misuse services. The investigation report identified patient and team contributory factors for this CDP. The tone of the narrative for these factors implies patient blaming. The investigation report identifies a team contributory factor as the only contributory factor for both of the SDPs identified. The investigation report does not consider the influence of communication or organisational factors on the identified SDPs. SDP1 - A possible lack of collaborative involvement with other agencies to obtain engagement from the patient. SDP 2 – A possible lack of identification of interpersonal issues between residents by the hostel staff and communication of this with the care teams. The report does not identify any human factors that might have impacted on the incident, or the CDPs and SDPs. Standard not met
2.11	Root cause or root causes are described	The investigation report did not determine a root cause. This was because there was an ongoing criminal investigation and when Mr N was assessed by the medical officer at the time of his arrest mental health was not considered to be a dominant or clear feature. The investigation report references the CDPs and SDPs as resulting in Mr N being untreated for a period of time and being high risk. Standard not met
2.12	Lessons learned are described	The investigation does not include a description of lessons learned. Standard not met
2.13	There should be no obvious areas of incongruence	The Trust internal report does not provide the evidence to clearly support the SDPs and CDPs that it identifies.

2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The findings of the investigation are set out in the investigation report under each heading of the terms of reference. The investigation report fails to identify that it has not provided any information about or reviewed Mr N's care and treatment between 25 November 2015 and 26 April 2016 while he was detained to the Wells Unit. Standard partially met
Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues	In the main the terms of reference cover the right issues. The description of the timeframe for the investigation, *To establish the sequence of events, as far as the Trust was involved, leading up to the incident on 14 August 2016 when it is alleged that a patient fatally wounded a fellow supported accommodation resident by stabbing.'* Combined with the headings in the report, '*7. A brief patient psychiatric history'* and '*6. Relevant chronology of events leading to the incident.'* Have resulted in the investigation and report not considering the period 26 November 2015 and 26 April 2016 when Mr N was detained to the Wells Unit. Some of the terms of reference do not support the level of scrutiny required for a level 2 investigation. For example, '*To identify if any safeguarding children or vulnerable adult issues were present and establish if they were acted on as required.*' This is a closed question, and the result was a one line response in the report that only one safeguarding concern was identified and 'it was confirmed that this was addressed by the Wells Unit.' There were other safeguarding concerns including potential financial exploitation that the investigation and report does not address. Standard partially met
3.2	The report examined what happened, why it happened	The report examined what happened with Mr N following his discharge from the Wells Unit.

	(including human factors) and how to prevent a reoccurrence	The report attributed all of the issues with Mr N's care and treatment to the community teams. No consideration was given to the quality of the discharge planning and discharge from the Wells Unit. The investigation report does not identify the implications for Mr N of being Looked After Child and the role the Leaving Care team played in his care. The investigation does not explore fully why the incident happened because of the narrow scope of the investigation. This has resulted an investigation that does not identify a root cause. The recommendations made will not prevent reoccurrence. Standard not met.
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	The recommendations are described in relation to the identified CDPs and SDPs. However, these recommendations do not address all of the underlying contributory factors, will not lead to sustainable change in practice and will not support system change. CDP 1 resulted in two recommendations. Recommendation 1 – this would not lead to a change in practice. Recommendation 2 – this has the potential to lead to a change in practice, it asks for a transition protocol to be written for transfers between CAMHS and EIP. However, there is no requirement for the protocol to be implemented. CDP 2 resulted in one recommendation. Recommendation 3 – this recommendation does not address the CDP and is vague in nature and would not result in a change in practice. CDP 3 resulted in one recommendation. This recommendation does not address the CDP, it is more suited to CDP 4. This recommendation will not lead to sustainable change in practice. It identifies

		issues relating to the practice of one member of staff. This is not appropriate in the context of this report as there are no failings identified attributed to this member of staff. CDP 4 resulted in one recommendation. This recommendation describes staff working to the requirements of an existing policy, this is not going to result in sustainable change in practice. CDP 5 resulted in one recommendation. This recommendation will not result in sustainable change. The investigation did not sufficiently explore why Mr N was considered for a dual diagnosis service and this has resulted in a weak recommendation. SDP1 resulted in two recommendations. The first recommendation is weak because it describes addressing a systems issue at a service level. The second recommendation is aimed at changing the practice of one member of staff with regard to how staff are supervised and supported. This will not result in sustainable change. SDP2 resulted in one recommendation. This recommendation describes how this report will be shared with other agencies. This is covered in the report under 16 'distribution' list and as such should not require a recommendation.
		Standard not met.
3.4	Recommendations are written in full, so they can be read alone	The recommendations are written in full and can be read alone.
		Standard met.
3.5		The recommendations are not measurable, and outcome focused.

	Recommendations are measurable and outcome focused	Seven of the recommendations are written as ‘must ensure’. These recommendation describe care being provided within existing protocols and policies and do not seek any revision of policies. One recommendation requires a protocol; to be written.
		Standard not met.

Appendix D – Implementation of the Trust action plan

Recommendation 1 The Clinical Directors of the Wells Unit, CAMHS and EIP should meet to review the report and consider ways to minimise the risk of multiple transitions in future.		
Trust action plan	Trust response and evidence submitted	Niche comments
Convene a meeting and develop appropriate strategy/protocol to address the risk.	Copy of an email seeking to arrange a meeting. Memorandum of understanding: cross service line transitions of young person age 18 signed by the clinical directors for the Wells Unit, CAMHs and EIP. Includes details of process for resolving any impasse between CAMHS, AMHS and WLFS should the clinicians be unable to agree any aspect of a transfer of care.	There is no evidence available that this memorandum of understanding was shared with services. The memorandum of understanding does not seek to address the risk of multiple transfer of care and how these might be reduced. There is insufficient detail about what would constitute an impasse and how it would be resolved.
NIAF rating: 1		

Recommendation 2 The Service Manager for CAMHS and EIP lead must develop a written protocol for transition of patients from CAMHS to EIP.		
Trust action plan	Trust response and evidence submitted	Niche comments
Development of an agreed protocol for transition between services	WLMHT Transition protocol: transfer of young persons' care between CAMHS and adult mental health services – dated September 2017.	The protocol does not address the issue of patients who are new to Ealing community mental health services shortly between their 18th birthday and a process for deciding who should provide care that minimises the need for a transfer. There is no evidence available that demonstrates how the protocol was shared and embedded into practice.

NIAF rating: 1

Recommendation 3
The service manager for CAMHS must ensure that all aspects of care/treatment for a patient discharged to their care are adequately planned and that the patient is fully aware of arrangements.

Trust action plan	Trust response and evidence submitted	Niche comments
Review at CAMHS Clinical Improvement Group to agree cascade and addition of prompts to protocols.	CAMHS draft supervision guidance. CIG and Business meeting minutes 12 October 2017 and 9 November 2017. CAMHS senior management team business meeting 25 May 2017. Ealing CAMHS local business meeting the CIG 14 November 2017 CAMHS business meeting 10 October 2017	There is no evidence available that the meetings discussed the care/treatment plans for patients on discharge and that the patients are aware of the plans. The draft supervision policy was discussed at some of the meetings, but it is difficult to see how this related to the recommendation.

NIAF rating 0

Recommendation 4
EIP lead must ensure that 7 day risk plans are comprehensively documented with agreed timescales for escalation should the patient still not engage.

Trust action plan	Trust response and evidence submitted	Niche comments
Review of the existing Risk Monitoring – Traffic Light System – Minimal Clinical Actions with addition of stated timescales	Draft EIP Operational Policy dated October 2016, the SOP does not make reference to 7-day risk assessments or escalation for patients who do not engage. EIP risk monitoring/traffic light/zoning system date March 2016. This is the zoning system that was in place when Mr N was under the care of EIP.	The Trust did not provide any evidence that any changes had been made to the existing system to ensure that 7-day risk assessments were completed for patients who did not engage with the service.

and possible further escalation.	WLMHT Transition protocol: transfer of young persons' care between CAMHS and adult mental health services – dated September 2017.	

NIAF rating: 0

Recommendation 5

The service manager for CAMHS and EIP lead must ensure that risk assessments are reviewed and updated in line with the Clinical Risk Policy.

Trust action plan	Trust response and evidence submitted	Niche comments
Review in CIGs and communication to staff on requirements of the policy	CAMHS draft supervision guidance. CIG and Business meeting minutes 12 October 2017 and 9 November 2017. Email to investigation asking for information to be entered on the action plan and presented to Board. CAMHS senior management team business meeting 25 May 2017.	None of the evidence provided relates to the review of risk assessments in line with Trust policy.

NIAF rating: 0

Recommendation 6

The Service Manager for CAMHS and the EIP lead must ensure that the management of dual diagnosis is included in the relevant patient's care plans.

Trust action plan	Trust response and evidence submitted	Niche comments
Implementation of the Cascade of actions required for the new Trust	CAMHS draft supervision guidance. CIG and Business meeting minutes 12 October 2017 and 9 November 2017.	The evidence provided does not relate to the recommendation which is about the management of patients with a dual diagnosis and their care plans.

Strategy on 'Co-existing mental health and substance use.'	Email to investigation asking for information to be entered on the action plan and presented to Board. CAMHS senior management team business meeting 25 May 2017. CAMHS local service and CIG meeting 12 October 2017	

NIAF rating: 0

Recommendation 7 The EIP lead must ensure that professionals meetings with services involved with the patient are convened at key points to identify and manage escalating risks.		
Trust action plan	Trust response and evidence submitted	Niche comments
The plan did not identify the evidence that was to be provided to meet this recommendation.	The Trust action plan contained the following statement: *'SI report has been discussed in Quality Matters and Quality Committee as well as PPC SMT and team level CIG.'*	No evidence was provided for this recommendation. We would have expected to see SOPs for services that define when a professionals meeting should be held and who should be invited to attend.

NIAF rating: 0

Recommendation 8 The EIP lead must ensure that care coordinators arrange a regular update at agreed intervals with all agencies involved with the patient to facilitated effective collaborative working		
Trust action plan	Trust response and evidence submitted	Niche comments

Review in CIG for development of an agreed procedure and implementation of this.	WLMHT Transition protocol: transfer of young persons' care between CAMHS and adult mental health services – dated September 2017. Email to EIP staff from clinical director attaching the transition protocol and stating that there may be some CQUIN work about transition in 2017-19	The evidence provided only relates to information sharing at the point of transition. This recommendation is about information sharing with all agencies involved with the patient along the whole care pathway.
NIAF rating: 0		

Recommendation 9 The Incident Review Facilitator must ensure that the report is shared with all agencies involved for shared learning.		
Trust action plan	Trust response and evidence submitted	Niche comments
Share the report with relevant people	Letter to Mr N's mother informing her the investigation was complete and offering to share the report with her. Email from the local authority stating they do not have an NHS.net email address. Email requesting Trust admin send a copy of the report register post to the local authority. Email to staff at the Wells Unit, CAMHS and EIP attaching a copy of the report.	The Trust shared a copy of the report internally and externally. We would have expected to see meetings with each of the teams to review the report and a multi-team/multi-agency meeting to discuss the report and the lessons learned.
NIAF rating: 2		

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

Tel: 0161 785 1000

Read more about us at: **www.nicheconsult.co.uk**

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