



Independent Investigation into the Care and Treatment Provided to Mr C and Mr D

***Commissioned by
NHS England, London Regional Office***

**Prepared by Lynda Winchcombe
December 2013**



Date of Publication: 30th June 2014

Contents

	Acknowledgements	7
	Executive Summary	9
1.	General Introduction	23
2.	Purpose of the Investigation.	25
3.	Terms of Reference	27
4.	Panel Membership	29
5.	Methodology	31
	Trust Meetings	31
	Family Support	32
6.	Trust Service Profile	33
	Barnet, Enfield and Haringey Mental health NHS Trust	33
	Camden and Islington NHS Foundation Trust	33
7.	Outline of Events – Mr C	37
	Background – Mr C	37
	Forensic History	37
	First Contact with Psychiatric Services	38
	Post Incident	45
	Background – Mr D	47
	Contact with Psychiatric Services	47
8.	Analysis of the Evidence	55
	Care and Care Planning	55
	Care Coordination	59

	Discharge/Transition Process – Forensic Service	63
	Use of the Mental Health Act	66
	Medication	67
	Supervision	68
	Community Resettlement Project	69
	Contract Monitoring	69
	Information Sharing	70
	Housing Information Application	72
	Primary Care	72
	Clinical Leadership	72
	Psychology Services – Mr C	73
	Post Incident Assessment and Actions – Mr C	73
9.	Internal Investigation	77
	Initial Actions	77
	The Internal Investigation Process	78
	Family Support	78
	Staff Support	78
	Internal Investigation Methodology	78
	Findings	79
	General Comments by the Independent Investigation Panel	80
	Tabular Review of the Internal Investigation’s Recommendations and Action Plans	81
10.	Findings and Recommendations	89
	Positive Practice	89
	Significant Changes – Camden and Islington NHS Foundation Trust	90
	Findings – General Comments	90
	Recommendations	93

Appendices

Appendix One – Interview Letter	101
Appendix Two – Documentation Received	103
Appendix Three – Investigation Procedure	105
Glossary	107

Acknowledgements

The members of the Independent Investigation Panel were asked to examine the care and treatment provided to Mr C by Mental Health Services delivered by both the Barnet, Enfield and Haringey NHS Trust and Camden and Islington NHS Foundation Trust, prior to an incident in which a fellow resident in a supported hostel was attacked and killed. Mr D, the victim, was also in receipt of Mental Health Services from Camden and Islington NHS Foundation Trust and therefore his care and treatment has been included.

The methodology undertaken by the Investigation Panel necessarily revisits the circumstances and events in great detail causing all of those involved to re-examine often difficult and sometimes disturbing experiences. The Investigation Panel wishes to acknowledge this, as well as the discomfort caused by the process itself. The Investigation Panel recognise the importance of ensuring that such processes are properly conducted in order to learn from them, contribute to the improvement in services to individuals, and facilitate services operating in such a way as to minimise and manage unnecessary risk. The overriding impetus for the Investigation Panel and the commissioning body is to ensure that there is a comprehensive effort to support the delivery of this objective.

Many of the individuals who were asked to contribute to this investigation by participating in interviews or by providing information in other ways had already participated in two formal investigation processes. This was recognised by the commissioning authority; NHS England, London Regional Office, and the Investigation Panel were requested to limit those interviewed to key personnel. It is also the case that some individuals the Investigation Panel would have wished to meet were not available for interview.

Those who attended to give evidence were asked to account for their roles, and provide information to the Investigation Panel. All have done so in accordance with expectations, and frank openness for which they must be commended. We are grateful to all of those who have given evidence directly, who have supported those giving evidence, and who granted access to facilities and individuals throughout this process. The level of cooperation from both Trusts has allowed the Investigation Panel to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

Condolences to the Family and Friends

The Investigation Panel would like to take this opportunity to publicly offer their condolences to the families and friends of the individual who died.

Executive Summary

Introduction

On the evening of Thursday 12 May 2011 an incident occurred on the premises of the Camden Resettlement Project (CRP) located in Camden, London, that resulted in the fatal stabbing of Mr D, a resident. Mr C, also a resident, was witnessed by a staff member attacking Mr D and holding a knife. CRP staff immediately initiated emergency life support for Mr D and an ambulance and the police were called. Mr D was taken to University College Hospital but sadly was pronounced dead on arrival.

After the incident Mr C was seen running from the hostel and his whereabouts were unknown until he was arrested by the police on the evening of Friday 13 May 2011 and taken to Holborn Police Station where he was charged with murder and remanded in custody to HMP Pentonville.

Both Mr C and Mr D were in receipt of psychiatric services provided by Camden and Islington NHS Foundation Trust (CANDI). Mr C was also known to the Barnet, Enfield and Haringey NHS Trust, (BEH), having been an inpatient of the North London Forensic Service based at Chase Farm Hospital prior to his move to the hostel.

Background – Mr C

In 1969 Mr C was born in West London of African-Caribbean parents. His parents separated when he was very young and his father went to live in Gambia. His mother reportedly suffers from a schizophrenic illness and lives in a care home in South London. Mr C had not had any contact with her or other members of the family for some years but resumed contact with relatives while in the forensic services and more recently he had resumed contact with his mother with the help of his key worker at his supported housing. Between the ages of 5 and 8 years Mr C was under the care of the local authority.

Mr C is reported to have found it difficult to settle and concentrate at school and completed a vocational course at the age of 16 after which he worked briefly in a McDonald's restaurant and a timber yard. Between 1985 and 1991 he was charged on nine occasions with offences including burglary, theft, attempted theft, assault and obstructing a police officer, shoplifting, robbery, and being allowed to be carried in a stolen vehicle. He served a number of custodial and youth custodial sentences as well as probation and community sentences.

Mr C's Contact with Psychiatric Services

Mr C's first contact with psychiatric services was when he was transferred to hospital from HMP Brixton under Section 48/49 of the Mental Health Act (MHA). He was diagnosed as having schizophrenia that was treatment resistant.

Mr C had six or seven admissions to hospital throughout the 1990s, most of which resulted in treatment with depot antipsychotic medication. In December 1998, he had an eight month admission to the Psychiatric Intensive Care Unit (PICU) in Napsbury Hospital and subsequently at Edgware under Section 3 of the Mental Health Act. He was started on clozapine and made a good recovery, but developed mild neutropenia resulting in a temporary cessation of his clozapine. He was, however, discharged on clozapine. In the two years 2001 and 2002, Mr C had four admissions to hospital because of a relapse of psychotic symptoms following him not taking his prescribed medication.

In 2003, Mr C was arrested in France and was admitted to hospital. He had a further admission in August 2003 from which he was discharged in September 2003 on treatment with clozapine. He was re-admitted in December that year. Following a number of incidents on the ward and having been found in possession of a knife and a replica gun, he was placed on Section 3 of the MHA and transferred to the PICU and restarted on clozapine.

In 2004 Mr C was assessed by the North London Forensic Service and it was recommended that he be cared for in a secure unit. On 24 September 2004 he was restarted on clozapine and referred for admission to Stockton Hall Hospital where he spent the next two years.

Mr C was transferred to Camlet Lodge, part of North London Forensic Services, under Section 3 of the Mental Health Act 1983 in 2006.

Background – Mr D

Mr D was born in Iraq in 1976. His family still live there where his mother is a housewife and his father a retired teacher. He had three sisters and three brothers. There is no reported family history of psychiatric illness. He had cousins and uncles who live in London and Liverpool. He left school at the age of 14 with no qualifications.

When he left Iraq at the age of 16-17 years, he first went to Jordan, then Holland and finally to the UK. When Mr D arrived in Liverpool he stayed with his uncle for six months and obtained refugee status. He then stayed in London for three to five years living in a flat then moved to various cities in the UK living in hostels and flats.

Mr D appeared reluctant to reveal friends or family detail to the health services personnel. The records suggest he had a 3 ½ year old daughter with whom there was no contact, and her whereabouts are unknown.

Mr D's Contact with Psychiatric Services

Mr D's first contact with psychiatric services was in 1999 in Birmingham. At that time he reported that he had been previously admitted to hospital in Germany, but details including the date of his admission were not available.

In January 2002, Mr D became unwell, was assessed under the Mental Health Act and he was admitted to the Florence Nightingale Hospital, London, where he was detained under Section 2 of the Mental Health Act 1983. He was diagnosed as suffering from a Schizoaffective disorder and was known to abuse illicit substances and alcohol. He was discharged in October 2002 to a hostel where he remained until 2005 when he moved to a second hostel, finally going to live at the Community Resettlement Project (CRP) in 2006 where he died in May 2011.

No issues were noted in regard to Mr D's mental health until the latter part of 2009 when CRP staff reported that Mr D was self isolating, dirty and malodorous, although he denied any symptoms of depression. A pattern emerged of slow deterioration followed by attempts by Mr D to improve his physical and environmental appearance.

Early in 2011 Mr D was assessed in an outpatient clinic and found to be in need of further assessment of his mental state. It was decided that he should be admitted to hospital under a Section of the MHA as he refused to be admitted as an informal patient. For a variety of reasons a MHA assessment did not take place until 14 days later when he was detained under Section 2 of the MHA and admitted to hospital.

Two weeks later he was discharged back to CRP and in May 2011 as a result of Mr C's attack on him died of multiple stab wounds there.

The Investigation Panel have assumed that at some point during the period of Mr D's contact with mental health services his immigration status was formalised, but there is no record of when this occurred.

Findings and Recommendations

The following section sets out the Investigation Panel's findings and recommendations. These have been identified from a detailed analysis of the evidence, both oral and written, that has been presented to the Investigation Panel. The recommendations have been completed for the purpose of learning lessons and for the Trusts to put into progress any actions required to prevent a similar occurrence. It also sets out areas where the Investigation Panel have identified notable practice.

The Investigation Panel considers that this report identifies some serious shortcomings in the care and treatment of Mr C and Mr D, but has been encouraged by the response of the Trust Senior Management Teams from both Trusts to the investigation process. Considerable work has been undertaken to address the issues identified by the internal investigation processes and subsequent management processes.

Positive Practice

It is normal process in investigations into tragic circumstances such as the death of a patient to set out areas of notable practice. In this case there were several areas that the Investigation Panel found they specifically wished to single out as examples of good practice. These have been set out as follows: -

Trust Actions

The Investigation Panel would like to commend both Trusts for the prompt action that was taken to address the issues raised within the joint internal investigation. It was found that necessary actions were completed within a timely manner.

North London Forensic Service – Forensic Social Worker

The Investigation Panel would like to commend the Forensic Social Worker for their understanding of Mr C's care needs and the preparatory work with the staff at CRP.

North London Forensic Service – Forensic Psychologist

The Investigation Panel heard that Mr C's forensic psychologist maintained a short period of contact with him following his discharge as she considered he required some contact to be provided by the forensic service. This action is to be commended and the approach is seen as good practice.

Community Resettlement Project

The Investigation panel found that the CRP documented assessments in regard to both men were thorough and comprehensive.

Significant Changes - Camden and Islington NHS Foundation Trust

Since the incident in May 2011 the Trust has undertaken a major configuration of their teams. A transition period took place during 2012 in order for staff to ensure that the issues that required addressing within these changes were completed so that the patient pathway through the services was not disrupted. The Trust recognised that they have really high numbers of people with Personality Disorders, a lot people with very complex, untreatable or, difficult to treat, depression, trauma.

The main driver was to ensure that there was a rebalancing of services that are very much focussed on dealing with chronic psychosis. Training programmes are in place for managers across the Trust to enable them to have the skills to deal with the new way of working and identifies areas that require further input. This includes a new supervision policy which states that note keeping standards must be part of the process.

There is a central log held of appraisals, the percentages completed per team and Personal Development Plans that are part of the process.

Findings – General Comments

There were particular factors in **Mr C's** circumstances and difficulties which made his presentation and care arrangements unusual (although not exceptional). He had spent six years under the care of forensic services and yet was not detained under one of the more usual Sections of the Mental Health Act used in such circumstances. He was discharged directly into the community without a period under the supervision of the forensic outreach services. Both of these were unusual for patients referred to the local CMHT. Less unusual but nevertheless challenging was Mr C's tendency to use and be adversely affected by non prescribed drugs and his past history of non concordance with treatment.

Whether or not the circumstances of Mr C and Mr D were unusual many of the issues identified in this investigation are the same or similar to those identified in many other investigation reports from across the country. This suggests that this particular Investigation Panel's observations and concerns have some general applicability, and that the issues are ones that many organisations struggle to address effectively. In any case, the Investigation Panel was charged with examining the care and treatment of Mr C and Mr D, and in this regard we consider our findings and recommendations appropriate following our analysis of the evidence.

It is never a simple or straightforward matter to categorically link events in the care and treatment of an individual with causal factors producing a particular outcome. When incidents occur, there are usually many contributory factors interacting with many variables, and this is certainly the case in relation to Mr C and Mr D. It is therefore extremely difficult, if not impossible to precisely predict or anticipate events of this nature. Once one removes the benefits of hindsight from ones' understanding of such incidents then the complexity of many factors combining to result in one particular outcome, out of many possible outcomes, becomes apparent.

When considering if this event could have been predicted or prevented, the Investigation Panel reviewed **Mr C's** history, his involvement with psychiatric services, and how he presented over the course of several years. Given his history of violence related to abnormalities in his mental state, his use of alcohol and drugs, and history of non concordance with treatment, it seems reasonable to expect that professionals involved with him needed to be alert to the possibility that he might at some point stop taking his medication as prescribed and or use non prescribed drugs with a resulting deterioration in his mental state with the risk that he may become violent.

The evidence presented to and seen by the Investigation Panel suggests that Mr C's behaviour had included levels of violence such as kicking or punching, but up to this point had not included the use of weapons during any actual assaults.

Mr C's account after the homicide is that he had not been taking his medication properly for some considerable time and had been experiencing psychotic symptoms. This account needs to be understood in context. The assessment by a consultant psychiatrist following the homicide makes clear that in her view Mr C was exhibiting psychotic symptoms at the time he was assessed. The symptoms included auditory hallucinations and persecutory delusions. The assessment also makes clear some marked inconsistencies in Mr C's account of his symptoms. For example he told the Forensic Medical Examiner (FME) he was hearing two voices, but told the psychiatrist he was hearing eight voices. He also told the psychiatrist initially that he had been mentally well until the day of the alleged offence, and then later that he had been experiencing symptoms for nine months.

These inconsistencies do not make Mr C's account irrelevant to the attempt to assess his mental state prior to the incident, but do emphasise the need to interpret his comments carefully in the context of his situation and mental state at the time he was giving his account to the doctors. The context is that at the time of his assessment Mr C was in a police station, having been involved in a violent incident and having recently been apprehended by the police after 24 hours on the run. Prior to his arrest he had probably been without medication for 36 hours and by the time he was assessed may have been without medication for 60 hours, if he had not received medication in police custody.

Mr D was experiencing significant problems and had been admitted to hospital on 16 February 2011 and discharged two weeks later. He continued to present difficult behaviour at the hostel after his discharge from hospital. He was facing an eviction order from his accommodation and no plans had been put in place for an alternative placement. It does not appear that he was seen by a qualified mental health professional following his discharge and so it is difficult to judge what symptoms of mental ill health he was exhibiting leading up to his death.

The evidence contained in the clinical records up to the event suggested that **Mr C** was doing reasonably well, complying with his care plan, taking his medication and not showing any evidence of psychosis or exhibiting disturbed behaviour. Whilst it is possible that he was deceiving staff at the hostel, and CMHT; and was not actually taking medication, faking side effects, and masking psychotic symptoms this is not implied by the records we have seen or from the verbal evidence given to the Investigation Panel.

The notes and verbal evidence did not contain anything to suggest there were reasons for any concerns in regard to the relationship between Mr C and Mr D, and nothing to predict there was likely to be violence between them.

The Investigation Panel have reviewed the written account of the contact made on the afternoon of the incident, and that was entered into RiO after the incident had taken place. These state that when Mr C was seen by the care coordinator with a member of the CRP staff Mr C had appeared well and there were no concerns about his mental state. He was compliant with his medication and no symptoms of mental illness were found.

The fact that these views were recorded and expressed after the event rather than contemporaneously with the meeting, places them in a less secure position as an accurate

record of the facts. This said, however, having examined the CANDI RiO record, CRP progress notes, and testimony from the key worker at CRP, all are consistent with the account given by Mr C's care coordinator. There is no suggestion of observed symptoms of psychosis or concerns that Mr C was not taking his medication. While this does not rule out either possibility, this is the evidence that those looking after him would have based their judgement upon.

The analysis of evidence detailed in Section 8 has identified a number of issues, concerns and apparent shortcoming in the care and treatment of both Mr C and Mr D. There are some concerns about clinical practice within the CMHT in particular, but in relation to the homicide there was nothing to suggest this had a causal effect. The incident that led to Mr D's death did not appear to have been proceeded by any change in behaviour or circumstance that would have alerted staff that Mr C was likely to be violent having appeared to be progressing well, or that there were any difficulties in the relationship between Mr C and Mr D likely to lead to a violent altercation.

As a consequence the Investigation Panel consider that the incident was not predictable and therefore not preventable.

Recommendations

Maintaining Clinical Standards

An underlying requirement for the effective care and treatment of patients is the need to integrate the collection of appropriate information with systematic recording and processing of that information, to enable the formulation of relevant care plans, which are then delivered effectively. This integration was lacking in a number of areas of the care and treatment of both Mr C and Mr D. All of these processes need to be based on sound and up-to-date clinical knowledge. The skills required to obtain the necessary information and formulate the patient's problems in an accurate and helpful way, the skills necessary to be able to collaboratively develop plans to address the problems, and the skills required to contribute to carrying the plans out, all require training but also need constant honing and development. Trying to ensure that all that needs to be done is done, may be best achieved by focusing on constantly reviewing the process in action (in clinical reviews or ward round handovers), and during clinical supervision (both individual and team supervision).

The investigation panel wish to make a recommendation to address this general issue and to suggest a potential for assuring subsequent recommendations are implemented in a way that results in the change in practice required to improve patient care. The full implementation of this recommendation requires a cultural shift in relation to supervision that cannot be achieved in a single manoeuvre, and is likely to require a phased plan, with a clear programme for implementation, and regularly reviewed at a senior level within both Trusts.

Recommendation One

It is recommended that: -

- ***Both Trusts further develop their supervision policies and procedure to facilitate supervision being used to provide assurance to the Trust Board that patient care is of the required standard.***
- ***The supervision process includes scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the requirements of the clinician's professional duties.***
- ***The supervision process includes scrutiny of current samples of actual care delivery at every level to ensure adherence to prescribed changes in practice such as those required by the recommendations in this report.***
- ***Regular audits take place to demonstrate that the supervision chain is identifying and addressing any deficiencies in the quality of care being delivered to patients.***

.....

Care Programme Approach (CPA)

The Investigation Panel found that CPA meetings and the accompanying record prior to **Mr C's** discharge from Camlet Lodge did not provide the level of information that would have properly facilitated his discharge from a forensic unit into the community. Furthermore subsequent CPA documentation for Mr C did not contain information about his diagnosis, psychotic symptomatology nor drug or psychological treatment.

Following **Mr D's** admission to hospital in February 2011 there was no CPA arrangements made or planned. Nor was there any evidence that the ward or CMHT staff had included CRP staff in Mr D's discharge planning. Mr D's previous CPA meeting in November 2010, did not lead to any action in regard to his care needs despite the voiced concerns of staff at CRP and the presence of virtually all of his relapse indicators and significant physical deterioration.

The Investigation Panel consider that the evidence provided to them indicates that the clinical teams' understanding of the CPA process in 2010 and its application was not clear for either man in regard to how it should form the framework under which care is planned and structured.

Recommendation Two

It is recommended that:-

- ***Both Trusts reinforce the position of clinical care management as the cornerstone of patient care in their psychiatric services. The essentials of this are contained within the Trusts' CPA policies and include the appropriate use and***

sharing of clinical information to inform clinical decision-making, and the management of risk.

- ***The position of CPA be reflected and strengthened in the training programmes staff are required to attend, and the priorities identified in individual and group supervision.***
- ***Supervision facilitates the routine review of actual cases to ensure the appropriate application of the principles of CPA and to enable corrective action to be taken if required, as in Recommendation One.***
- ***The implementation of this Recommendation is monitored by periodic audit.***

.....

The content of Mr C and Mr D's clinical notes supplemented by other evidence presented to the Investigation Panel indicates that, for both men, care coordination fell short of what would be expected from mental health services functioning with the CPA as the underlying structure for coordinating clinical care.

Care Coordination

The position of the community CMHT as the team responsible for coordinating **Mr C's** care was undermined by the late allocation of a care coordinator, who's only direct contact with the forensic services and Mr C prior to discharge was at the CPA meeting on the day Mr C left the ward. The principle preparatory work prior to discharge was between the forensic service and the forensic link worker, and the forensic service and the staff of CRP. Despite considerable work in this area, the lack of involvement of the CMHT, and the fact that the discharge summary and CPC care plan were not sent to the CMHT in a timely way, suggests that the core role of care coordination within the framework of CPA was not recognised.

Mr D's care coordinator did not ensure he had seen and assessed him following Mr D's discharge from the inpatient unit in March 2011. This was despite the fact that Mr D had recently been admitted under Section 2 of the Mental Health Act and was causing sufficient concern to CRP staff for them to consider evicting him.

In the case of both Trusts most of the shortcomings in care coordination only came to light following the homicide and as a result of the internal investigation process. Some omissions (such as the failure to send the discharge care plan) may have been isolated lapses, but some (such as the failure to document proper risk assessments or to record contacts with the patient) were constantly repeated. This suggests that there were not processes in place to adequately monitor and support the clinicians functioning as care coordinators.

Recommendation Three

It is recommended that:-

- ***Both Trusts clarify explicit minimum standards for care coordinators and support these with documents to assist care coordinators in their role (for example the discharge check list produced by BEH in response to the findings of the internal investigation).***
- ***These standards form a benchmark within the supervision process which includes scrutiny of actual care delivery and records so as to enable corrective action to be taken if required, as in Recommendation One.***
- ***The implementation of this Recommendation is monitored by periodic audit.***

.....

Risk Management

From the documentation examined it was not clear that the CMHT had a properly managed process to routinely handle referrals. Such a process would have included appropriate information gathering and senior clinical scrutiny. The emails and document available to the Investigation Panel do not indicate that the referral of Mr C was discussed at any CMHT referral meeting or that the consultant was actively involved in contributing to decisions as to how this transfer should be handled.

Recommendation Four

It is recommended that:

- ***Meetings in which clinical decisions are made about an individual's care be organised so as to ensure that the necessary clinical records have been reviewed prior to the team making decisions about the care of the patient.***
- ***The effective implementation of this recommendation be monitored within the Team Supervision Process as outlined above in Recommendation One.***
- ***The standard practice of clinical teams in relation to this recommendation is monitored by periodic audit.***

.....

See also Recommendation Eight

The Investigation Panel found that in relation to Mr C there are several areas of concern regarding the identification of risk, the recording of relevant information, the sharing of information, and the management of risk by the agencies involved. Information in past clinical records was not utilised nor were standard risk forms completed properly. Evidence showed that written information was not shared between the CMHT and other agencies in relation to Mr C's risk management, and therefore relapse indicators were not responded to by the service.

Recommendation Five

It is recommended that:-

- ***Within both Trusts risk assessments and management plans are completed within an agreed acceptable timeframe and that these are reviewed at significant points of clinical decision making for all patients, and shared with all professionals involved in their care to inform current risk management.***
- ***Supervision facilitates the routine review of actual cases to ensure this is embedded as part of standard clinical practice, and to enable corrective action to be taken if required, as in Recommendation One.***
- ***The implementation of this Recommendation is monitored by periodic audit.***

.....

Recommendation Six

It is recommended that:-

- ***Within both Trusts the Quality Assurance Programme is revised to ensure that Teams assessing and caring for psychiatric patients are producing Care Plans that reflect a comprehensive understanding of the current psychiatric, social, family circumstances and risk characteristics of the individual they are treating.***
- ***These audits form part of regular Clinical Governance Team Meetings.***

.....

Discharge and Transition Process

The discharge and transition process from inpatient forensic services to local community services was flawed. The Investigation Panel found that there was a poorly managed transition with both the discharging and receiving services diverted from focussing on identifying Mr C's care needs in a community setting by attending to practical obstacles, such as funding and Mental Health Act problems. Furthermore there was a lack of clarity in relation to handover between the forensic link worker, Mr C's community care coordinator, CRP's key worker and his psychologist and their respective roles and responsibilities in regard to Mr C's discharge.

From the documentation seen it was unclear whether the CMHT had a properly managed process to routinely handle referrals which would have included appropriate information gathering and senior clinical scrutiny. The emails and document available to the Investigation Panel do not indicate that the referral of Mr C was discussed at any CMHT referral meetings or that the consultant was actively involved in contributing to decisions as to how this transfer should be handled.

Recommendation Seven

It is recommended that:

- ***Within both Trusts all transfers and discharges of patients follow a comprehensive protocol that sets out a checklist. The Investigation Panel are aware that the North London Forensic Service have developed and are now using such a list. CANDI should consider developing a similar process for all external and internal transfers and discharges.***
- ***Supervision facilitates the routine review of actual cases to ensure this is embedded as part of standard clinical practice, and to enable corrective action to be taken if required, as in Recommendation One.***
- ***The implementation of this Recommendation is monitored by periodic audit.***

.....

Medication

Mr C's treatment resistant schizophrenic illness and his physical sensitivity to clozapine (tendency for his white blood cell count to drop) made the management of his psychotic symptoms more complex. Although this was recognised in earlier care plans these issues and the importance of monitoring of clozapine was not recognised in the documentation sent to, or sought by the CANDI CMHT.

In the case of both Mr C, following discharge, and Mr D, the record of CPA meetings, and subsequent care plans did not include a list of medication or details of treatment (including psychological treatment). The care plans therefore omitted an essential component of their care and treatment. The CRP notes indicate that both Mr C and Mr D were receiving prescribed medication, but the CMHT care plans do not acknowledge the essential importance of medication in the men's treatment.

Recommendation Eight

It is recommended that: -

- ***CANDI's Medical Director informs all doctors in the Trust's Psychiatric services that they have a duty to ensure participation in the multidisciplinary decisions made for patients for which they are responsible.***
- ***The Trust's Medical Director to inform all doctors in the Trust Psychiatric services that they have a duty to ensure that a patient's medication is appropriate, and being suitably managed within the CPA process.***

- ***The implementation of this Recommendation is monitored by including this issue in individual and group supervision at all levels, and by periodic audit.***

.....

Supervision

The poor execution of CPA processes, the omissions in risk assessment and recording, the routine failure to make contemporaneous progress note entries, the long gaps without seeing patients on CPA, the lack of management of care coordinator caseloads all suggest a lack of appropriate supervision and systems to address deficiencies if they are identified.

See Recommendation One Clinical Leadership

The Investigation Panel found that the position of the forensic consultant as leader within the clinical team in regard to Mr C's transfer to the community was unclear. The consultant was present in the ward round discussions, CPA meetings and Mental Health Act Managers Hearings, but there were a number of ways in which the team's management of Mr C's discharge would have benefited from greater leadership from the consultant. He did not become aware that the two basic clinical documents, the medical discharge summary and CPA care plan had not been sent to the community mental health team until the internal investigation following the homicide. He did not take a lead in communicating with the community consultant or in clarifying the Mental Health Act issues, or challenging the Mental Health Act Administrator's assertion about the Community Treatment Order.

The Investigation Panel found that there was a lack of clarity in regard to the roles and responsibilities of the Community Team Manager and Consultant as leaders within the CMHT in regard to Mr C's transfer to the community. Mr C's referral to the CMHT and his initial management did not have medical input from the CMHT until November 2010, two months after his discharge into the community. There was no protocol for accepting cases from the forensic services and no expectation that the consultant psychiatrist or other experienced psychiatrist would be proactively involved in developing the community care plan for such a patient.

Recommendation Nine

It is recommended that:

- ***Both Trusts review their guidance to consultants, managers and senior clinicians making explicit the Trust's expectations with regard to their role in leading the teams in which they work.***
- ***The effectiveness of implementing this guidance is monitored through normal appraisal processes.***

.....

Use of the Mental Health Act

The actions of the Hospital Managers under the Mental Health Act and in particular the memo from a member of the Mental Health Act Administration Team led to confusion about Mr C's status under the Act and to the abandonment of plans to place Mr C under a Community Treatment Order (CTO).

The clinical team at the time did not challenge the issue of the CTO which they would have been justified in doing, and the Managers under the Act did not appear to understand the consequences of their comments about being minded to consider discharging Mr C.

Recommendation Ten

It is recommended that:-

- ***BEH review the regular training for the Trust's Managers under the Mental Health Act and ensure that regular meetings occur between the Managers and clinicians involved in Managers' Hearings to facilitate effective working.***
- ***The implementation of this Recommendation is monitored by including this issue in individual and group supervision for those clinicians involved in such hearings, and by periodic audit of decisions recorded by Managers.***

.....

The Investigation Panel requests that both Trusts consider this report and its recommendations and sets out actions that will make a positive contribution to improving local mental health services.

1. General Introduction

- 1.1 On the evening of Thursday 12 May 2011 an incident occurred on the premises of the Camden Resettlement Project (CRP) located in Camden, London, that resulted in the fatal stabbing of Mr D, a resident. Mr C, also a resident, was witnessed by a staff member attacking Mr D and holding a knife. CRP staff immediately initiated emergency life support for Mr D and an ambulance and the police were called. Mr D was taken to University College Hospital but sadly was pronounced dead on arrival.
- 1.2 After the incident Mr C was seen running from the hostel and his whereabouts were unknown until he was arrested by the police on the evening of Friday 13 May 2011 and taken to Holborn Police Station where he was charged with the murder of Mr D and remanded in custody to HMP Pentonville.
- 1.3 Both Mr C and Mr D were in receipt of psychiatric services provided by Camden and Islington NHS Foundation Trust (CANDI). Mr C was also known to the Barnet, Enfield and Haringey NHS Trust, (BEH), having been an inpatient of their forensic service based at Chase Farm Hospital prior to his move to the CRP.
- 1.4 BEH initially set up a desktop review of the care and treatment provided to Mr C prior to and following his transfer to CANDI. It was then agreed to set up a joint internal investigation between the two Trusts that commenced in July 2011, with the report being completed in March 2012. The internal investigation was led by an independent chair, and included a consultant psychiatrist, and representatives from the Trust providing local community psychiatric services, the forensic services Trust, the CRP and Local Authority.
- 1.5 This current Independent Mental Health Investigation was commissioned by NHS England, London Regional Office on 8 July 2013 under the auspices of Health Service Guidance (94) 27. *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.
- 1.6 The Panel responsible for the independent investigation report is referred to as the Investigation Panel throughout although in order to clarify specific points, Independent Investigation Panel may be used.

2. Purpose of the Investigation

- 2.1 The purpose of any independent investigation is to review the patient's care and treatment, leading up to and including the victim's death, in order to establish the lessons to be learned to minimise the risk of a similar incident re-occurring.
- 2.2 To fulfil this purpose the Investigation Panel need to gain a picture of what was known or should have been known at the time, regarding both patients by the relevant clinical professionals. Our investigation also examines the robustness of the internal investigation and whether the Trusts have subsequently implemented changes resulting from the internal investigation's findings and recommendations. Based on the findings identified by this process, the Investigation Panel wish to raise outstanding issues for the individuals and organisations involved with these men and issues that may have a more general relevance for similar services.
- 2.3 The Investigation Panel have been careful not to misuse the benefits of hindsight and have sought to avoid this in formulating this report. We hope those reading this document will also be vigilant in this regard. It is important to remember that those involved at the time were only able to act on the information they had available.
- 2.4 We have focused on the lessons that may be learned from examining the care of the individuals associated with this incident but also more generally from the detailed consideration of any complex clinical case. The Investigation Panel has endeavoured to retain the benefits of such a detailed examination but this does not assume that the incident itself could have been foreseen or prevented.
- 2.5 In addition the Investigation Panel is required to make recommendations for the Trusts to implement changes for the provision of an adequate service.
- 2.6 The process is intended to be a positive one that examines systems and processes in place in the Trust at the time of the incident working with the Trust to enhance the care provided to their service users. We can all learn from incidents and so contribute to making sure that the services provided to people with a mental illness are as comprehensive as possible. In order to achieve this we must try to ensure that the lessons learned are understood and appropriate actions are taken to inform those commissioning and delivering the services.

3. Terms of Reference

Commissioner

- 3.1 This independent investigation is commissioned by NHS England, London Office in accordance with guidance published by the Department of Health in circular HSG 94 (27). *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.

Terms of Reference

- 3.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr C to include: -
- A review of the Trust's internal investigation to assess the adequacy of its findings, recommendations and action plans:
 - Reviewing the progress made by the Trust in implementing the action plan from the internal investigations:
 - Involving the families of both Mr C and the victim, Mr D as fully as is considered appropriate:
 - A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident:
 - An examination of the mental health services provided to Mr C and the victim Mr D, including a review of the relevant documents:
 - The adequacy of the transfer for Mr C from Barnet, Enfield and Haringey Mental Health NHS Trust to Camden and Islington NHS Foundation Trust:
 - The management of the relationship between both patients whilst they were in the same accommodation:
 - The extent to which Mr C's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies:
 - The adequacy of the Risk Assessment and management of that risk to others:
 - The appropriateness and quality of assessments and care planning:
 - Consider whether the incident was predictable or preventable:
 - Consider other such matters as the public interest may require:
 - Complete an Independent Investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication:

Approach

- 3.3 The investigation team will conduct its work in private and will take as its starting point the Trust Internal Investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.
- 3.4 The investigation team will follow established good practice in the conduct of interviews, ensuring that the interviewees are offered the opportunity to be accompanied and given the opportunity to comment on the factual accuracy of the transcript of evidence.
- 3.5 If the investigation team identify a serious cause for concern then this will immediately be notified to the Manager, Homicide Investigations, NHS England, London Office.

4. Panel Membership

4.1 The Independent Investigation has been undertaken by a panel of professionals independent of the services provided by Barnet, Enfield and Haringey Mental Health NHS Trust and Camden and Islington NHS Foundation Trust and its preceding bodies.

4.2 The panel comprises of:

Dr Clive Robinson	Former Consultant Psychiatrist
Nick Georgiou	Former Director of Social Services
Lynda Winchcombe	External Management Consultant and Investigator

4.3 The above Investigation panel work as associates of L Winchcombe Associates and have had extensive experience in the management and investigation, both internal and independent, including Serious Case Reviews and untoward deaths of adults and children.

5. Methodology

- 5.1 The Independent Investigation Panel were asked by NHS London in March 2013 to undertake a desktop review of the care and treatment provided to both Mr C and Mr D prior to the incident.
- 5.2 Following the completion of a Summary Paper that was sent to NHS England, London Office in May 2013 reporting on the outcome from the desktop review, an Independent Investigation was commissioned. As the investigation proceeded the Investigation Panel became aware of other relevant documentation and this was sought, largely from records within the Trusts. Both Trusts facilitated the gathering of documents and other information requested helpfully and efficiently and there were no significant delays in collecting the necessary data.
- 5.3 A history of the main events in Mr C's and Mr D's life was produced, as was a chronology of the main events of clinical relevance. The chronology was initially developed in tabular form so that the sources of the information could be recorded, and comments of the Investigation Panel linked to the evidence. This enabled significant incidents and events to be mapped against other events, and interventions from the mental health team and others. A narrative form of the chronology is incorporated into the main report. A full list of the documentation, including the Internal Review Reports considered by the Investigation Panel is also appended (Appendix Two). The Internal Investigation Team findings and recommendations were reviewed in a systematic way and the process recorded in tabular form.

Trust Meetings

- 5.4 Meetings took place with both Trusts' senior managers early on in the process. This enabled the Investigation Panel to gain an understanding of the services provided by the Trust and their partners, and learn about the plans for future service developments. It also provided an opportunity for the Investigation Panel to hear about the actions taken following the joint internal investigation completed by the Trusts, as well as allowing the Investigation Panel an opportunity to meet the Trust's senior managers and discuss the present investigation process.
- 5.5 It was agreed with NHS England, London Office and both Trusts that the Investigation Panel would interview a limited number of staff and not everyone who had been involved directly or indirectly with both individuals. It was reiterated that rather than focusing on apportioning blame the process was involved in examining systems and processes with the aim of improving services and reducing the risk of a similar occurrence happening again.

5.6 Evidence was received from fifteen individual witnesses¹ in total over a period of two weeks during September 2013. Those identified for interview either had had direct contact with Mr C and Mr D or held managerial responsibility for some aspect of the services engaged with these cases. Representatives from related agencies such as CRP were also seen. The Investigation Panel were unable to interview some individuals that are no longer employed by the Trust. Unfortunately, two of these individuals had been directly involved with both patients prior to and at the time of the incident. Two Investigation Panel members met Mr C.

Each interview was recorded and the transcription sent to the relevant individual to check for accuracy and amended as deemed necessary. It was that final version that has been used for evidence in this report.

5.7 As part of their methodology for interviewing witnesses the Investigation Panel adopted Salmon compliant procedures, see Appendix One for a copy of the interview letter.

5.8 Analysis of the evidence was undertaken using Root Cause Analysis methodology. The report is divided into the following four sections:

- Section One – The Care and Treatment received by Mr C and Mr D.
- Section Two – Analysis of the Evidence
- Section Three – Review of Internal Review Report.
- Section Four- Independent Investigation Findings and Recommendations

Family Support

5.9 A letter was sent to Mr D's family via Victim Support but no response has been received. Following the meeting with Mr C it was decided not to approach his family as they were not be in the position to provide information to the investigation and would possibly have found their involvement distressing.

¹ Witnesses – the normal process prior to interview is for an informal staff meeting to be held at which a full explanation of the process to be taken is discussed and those present given the opportunity to ask questions about the investigation that are not directly about the two individuals. Due to the circumstances of this independent investigation it was decided between the two Trusts and Investigation Panel not to hold this meeting.

6. Trust Service Profile

Barnet, Enfield and Haringey Mental Health NHS Trust

- 6.1 The Trust is responsible for the North London Forensic Service comprising of both inpatient provision and outreach teams. It also provides both mental health and community health services across Barnet, Enfield and Haringey and the surrounding areas. Multi-disciplinary mental health teams provide specialist skills and care for children, young people, adults and older people in a number of centres across the area. Learning Disability services are provided across the service area.
- 6.2 The new acquisition of community services in Enfield includes sexual health, health visiting and nursing for long term illnesses including diabetes and heart failure. Care is also provided in people's homes where needed. The services are provided from the main St Michael's site in Enfield as well as local GP surgeries and clinics.
- 6.3 Current psychiatric services provide: specialist inpatient and community-based treatment and care for people experiencing acute mental illness, help for children and young people with emotional behavioural or mental health difficulties, care for people with dementia, and support for people with problems associated with drug and alcohol misuse.
- 6.4 Inpatient mental health services are provided from: single sex recovery wards, a low and medium secure unit, a psychiatric intensive care unit for men, a high dependency unit for women, a specialist unit for adults with learning disability, and a complex recovery ward.
- 6.5 Community mental health services include: psychological therapy services, locality based Community Support and Recovery Teams, Early Intervention in Psychosis Teams, Intensive Case Management Teams, Mental Health Liaison Teams, and Primary Care Assessment Teams.

Camden and Islington NHS Foundation Trust

- 6.6 In 2008 the Trust became one of the first care Trusts to successfully achieve Foundation Status which was authorised to commence operation from March 2008. The services include adult mental health, mental health for older people, substance misuse services and care for people with learning disabilities within Camden and Islington and surrounding areas.
- 6.7 Current psychiatric services include: crisis intervention, assertive outreach and early intervention teams as well as inpatient services. Since 2011, after the date of this incident, the Trust has reorganised all of their operational services around the service user journey or care pathway. There are five clinical divisions:

- Inpatient services
- Psychosis, Recovery and Rehabilitation
- Services for Aging and Mental Health
- Psychosis Services
- Non-Psychosis Services

6.8 These divisions are serviced by:

- Inpatient Teams, a Home Treatment Team, a Recovery Centre, use of a Crisis Bed and the Services for Aging and Mental Health.
- Four Recovery and Rehabilitation Teams across the two boroughs.
- The Assertive Outreach Team, an Early Intervention Service and Focus Outreach and Street Population Service.
- Complex Depression Anxiety and Trauma Service, Traumatic Stress Clinic, Psychotherapy Services, Personality Disorder Service and Specialist Therapies.

Section One

The Care and Treatment

Received by

Mr C and Mr D

7. Outline of Events

- 7.1 The information in the following outline of events was gathered from a variety of sources including paper and electronic clinical records, additional written material, and oral evidence from staff and Mr C.

Background – Mr C

- 7.2 In 1969 Mr C was born in West London of African-Caribbean parents. It is reported that his parents separated when he was quite young with his father returning to Gambia. His mother reportedly suffers from a schizophrenic illness and lives in a care home in South London. Mr C had not had any contact with her or other members of the family for some years but resumed contact with relatives while in the forensic services and more recently he resumed contact with his mother with the help of his key worker at his supported housing.
- 7.3 Records indicate Mr C reported that his parents had come to England from Jamaica and had met and married in the UK. They separated while he was still a baby. Mr C is reported to have no full siblings but several half siblings on his father's side. Between the ages of five and eight years old Mr C was placed under local authority care. He apparently temporarily moved back to live with his father but was received back into care because of physical abuse from his father. (The accuracy of this may be in question as it is unclear if his father returned to the UK from Gambia.)
- 7.4 He lived with his grandmother in the UK between the ages of eight to eleven years. Mr C found it difficult to settle and concentrate at school and reported that he had been excluded on a number of occasions. He completed a vocational course at the age of 16 years and worked briefly in a McDonald's restaurant and a timber yard. At the age of 18 years he worked in a glass factory and then spent two years working as a painter and decorator but did not have any significant employment since that time.

Forensic History

- 7.5 Between 1985 and 1991 Mr C was charged on nine occasions with offences including burglary, theft, attempted theft, assault and obstructing a police officer, shoplifting, robbery, and being allowed to be carried in a stolen vehicle. He served a number of custodial and youth custodial sentences as well as probation and community sentences.
- 7.6 In 1986, Mr C appeared in court on three occasions in relation to six offences and received a custodial sentence of 42 days. In 1998 he was charged and found guilty of two counts of burglary and later a further three counts of robbery and one of burglary for which he was sentenced to two years in a Young Offenders Institution (YOI).
- 7.7 In 1989, he received another 12 month custodial sentence in a YOI for burglary and theft. He received a further three years detention in 1990 for similar offences including allowing himself to be carried in a stolen vehicle.

- 7.8 The pattern of criminal activity continued throughout the 1990s with him also being found in possession of illicit drugs.

First Contact with Psychiatric Services

1990s

- 7.9 Mr C's first contact with local psychiatric services was in 1991 when he was transferred from HMP Brixton under Section 48/49 of the Mental Health Act, (MHA). He was treated with a depot antipsychotic medication but was lost to follow up from the services. His criminal offences continued but when later arrested and found guilty the court imposed hospital orders.
- 7.10 During the 1990s Mr C had six to seven hospital admissions most of which included treatment with depot medication and which followed relapses of his psychotic illness associated with non-concordance with treatment.
- 7.11 In 1998 Mr C was admitted to the Royal Free Hospital with evidence of thought disorder, persecutory, grandiose and religious delusions. He was also experiencing auditory hallucinations as well as suicidal and, the first report of, homicidal ideas. During the admission he punched a member of staff and was arrested and bailed. He was discharged on flupentixol decanoate 60 mg intramuscularly weekly, olanzapine 20 mg daily and benzhexol 5 mg daily. Six months later he was readmitted because he had not been concordant with his medication and his mental state had deteriorated.
- 7.12 In 1998 he was admitted to the Psychiatric Intensive Care Unit, (PICU) at Napsbury Hospital under Section 3 of the MHA for a period of eight months. He presented as grandiose with formal thought disorder, had visual hallucinations of dead spirits in trees and auditory hallucinations. He expressed paranoid delusions that his neighbour had stolen some belongings of his and that a policeman had stolen his wallet. He reported that he felt people were planning to kill him and, while he was under the influence of alcohol and drugs, had assaulted a neighbour with a dog lead.
- 7.13 During the admission he assaulted another patient. His diagnosis was given as chronic schizophrenia, paranoid and dis-organised type. Whilst an inpatient at Napsbury Hospital he was treated with clozapine medication with good effect. However he developed mild neutropenia² resulting in temporary cessation of the clozapine but this was reinstated on discharge.

2001

- 7.14 In 2001 Mr C went to live in a community forensic hostel remaining there until 2004. During this period he had three informal admissions and one under Section 2 of the

² Neutropenia - an abnormally low level of neutrophils (white blood cells) in the blood that results in an increased vulnerability to serious infections.

MHA following an arrest for robbery. He was noted to have paranoid thoughts, to be using illicit substances and refusing to take his clozapine medication. He was discharged on clozapine 300 mg twice daily.

2003

- 7.15 Throughout 2003 Mr C continued with the same pattern of admissions, commencing clozapine medication that resulted in an improvement in his mental state, being discharged and then re-admitted as he had relapsed having discontinued taking clozapine. In November 2003 he went missing from his hostel and was found in France by the police wandering the streets of Paris where he then spent two weeks in a psychiatric unit, returning to the hostel on 19 December 2003. He initially agreed to be admitted to hospital as an informal patient at St Pancras Hospital. While there he threatened a nurse with a replica gun and a flick knife. He was placed on Section 3 of the MHA and transferred to a Psychiatric Intensive Care Unit (PICU) and restarted on clozapine medication.

2004

- 7.16 Staff had noticed a pattern of mood swings that appeared to be repeated each year at the beginning of autumn and they considered starting a mood stabilising drug. His mental state improved and he was discharged from hospital.
- 7.17 However Mr C soon discontinued his clozapine and began drinking alcohol and taking illicit drugs. His mental state rapidly deteriorated and he was admitted to hospital on the 2 July 2004. He became extremely agitated and had to be placed on Section 3 of the MHA and transferred to another ward at St Luke's hospital. After eight days he had to be transferred again to an all male PICU at St Pancras Hospital where over a period of a month he became reasonably stable. Mr C then seriously assaulted another patient by repeatedly punching and kicking him without any provocation. He was transferred to another ward on 10 August 2004 to avoid further incidents with that patient.
- 7.18 His mood was found to be labile and at times he was quite volatile and unsettled. His paranoia continued. In mid August he was involved in a fight with another patient punching him in the face. His medication was changed from olanzapine to risperidone 4mg twice daily and chlorpromazine 800mg daily. He was assessed as being thought disordered and seen by the North London Forensic Service who recommended that he be cared for in a secure unit. On 2 September 2004 he was restarted on clozapine and referred for admission to Stockton Hall Hospital, a secure unit in Yorkshire.
- 7.19 Mr C was admitted to Stockton Hall Hospital in November 2004, under Section 3 of the MHA. He was calm, polite and co-operative but guarded in his answers. He denied experiencing any positive psychotic symptoms and his account of his previous violence was that he was acting in self defence having been provoked and bullied. Mr C appeared settled on the ward but the clozapine monitoring service suggested that he discontinued taking the medication as his blood test results had shown repeated low

counts of white blood cells. It was therefore decided to reduce and then stop clozapine and to substitute risperidone orally and later by injection.

- 7.20 By early December 2004 his mental state had deteriorated and the notes describe him being involved in several physical disputes with staff and other patients resulting in him being placed in seclusion at one stage. At a Managers Hearing on 21 December he appeared agitated, paranoid, assaultative and claimed that he was a victim of an unprovoked assault.

2005

- 7.21 During the first half of 2005 Mr C continued to be disturbed with paranoid delusions and hallucinations. He had episodes of violent and threatening behaviour. During this period there were a number of changes in his medication including aripiprazole, doxepin, acuphase and zuclopenthixol. At the end of February his aripiprazole was changed to olanzapine.
- 7.22 In early 2005 he was assessed by a consultant forensic psychiatrist from the North London Forensic Service who recommended that Mr C should have further mental health awareness and drug awareness training before being suitable for transfer to a local low secure facility.
- 7.23 By June 2005 his mental state was noticeably more stable and in July the olanzapine was gradually reduced and discontinued. Although his mental state had improved and he was able to control his behaviour and anger Mr C did not accept that he suffered from a mental illness and denied that he experienced any psychotic symptoms, although it was evident to staff that he had delusional ideas and at times experienced auditory hallucinations. By the beginning of October 2005 there were several signs of relapses and he was prescribed sodium valproate 1000 mg per day. Olanzapine velotab 15mg was added because he was increasingly disturbed and paranoid. By November 2005 he was profoundly thought disordered and had paranoid delusions involving members of the ward staff and fellow patients.
- 7.24 This pattern continued for the rest of the time Mr C remained at Stockton Hall Hospital. He had brief periods of improved mental state that then relapsed into disturbed behaviour, thought disorder, paranoid delusions and hallucinations with episodes of violence. He was treated with a number of antipsychotic and mood stabilising drugs including depot haloperidol and zuclopenthixol.

2006

- 7.25 On 17 October 2006 Mr C was transferred to Camlet Lodge, North London Forensics Service, (NLFS) under Section 3 of the MHA. He was found to be calm, denied any symptoms of psychosis and had no thoughts of self harm or homicidal ideation. On admission an assessment found no evidence of psychotic symptoms. His medication on admission was flupentixol decanoate 400mg intramuscularly weekly, olanzapine 5mg

three times daily, semi-sodium valproate 500mg twice daily, procycladine 5mg three times a day and an inhaler for asthma. After a few weeks staff became aware that Mr C could become irritable and had underlying paranoid ideas.

2007

- 7.26 By January 2007 he was found to be notably thought disordered and paranoid. The account of an assessment completed on 26 March 2007 describes Mr C wearing several layers of T-shirts, a tracksuit coat, dark glasses and a baseball cap despite it being a very sunny day. At that time Mr C stated that he believed he was in hospital because of a government conspiracy against him and said *“that he did not want to tell the truth about what was happening as people will think he is psychotic and therefore keep him in hospital longer”*.
- 7.27 Following transfer to a different ward an assessment on 30 May 2007 found Mr C to be calmer and was finding the environment quieter. He complained of having a toothache and reported that he had not slept well the previous night but had had a sleep that afternoon. He reported that *“his medication was correct but did cause him some problems with his seed and he was no longer able to ejaculate properly”*. He also said that *“it had taken away his gifts as previously he'd been on the seventh level and had the gift of sight, hearing and wisdom. Now only the gift of sight remained and that was the reason that he had to wear dark glasses as he could not look people in the eye without destroying them”*.
- 7.28 There appeared to be a strong sexual element to his delusional ideas and he said that he was the father of several children. Mr C reported that he'd been raped in the past by a patient on the ward and now avoided that person as otherwise there could be *“a clash of the titans”*
- 7.29 Mr C was transferred to a different ward on 17 September 2007 where he was initially calm and settled and showed an interest in participating in occupational therapy. On assessment he still described delusional beliefs that he had been sexually interfered with and at times would remain awake all night because of the fear of being molested. During the next eight months he continued to be guarded about his symptoms but he still expressed the delusions of being interfered with.

2008

- 7.30 An HCR-20 risk assessment was completed in January 2008 which stated that the most likely risk scenario would be *“Mr C assaulting another person as a response to delusional beliefs that he is either being attacked or threatened by others or that he has to assault another person to protect a third party. It is likely the level of violence used to be of a low to moderate severity, punching and kicking. Use of weapons or acts of violence with the intention of being life-threatening have not been a feature of his presentation”*. The conclusion of this risk assessment was that Mr C still required treatment in conditions of medium security.

- 7.31 Mr C's medication in June 2008 was flupentixol decanoate 400 mg IM weekly, quetiapine 300mg twice daily, semi-sodium valproate 750mg twice daily, procyclidine 5mg 4 times daily, multivitamins, lactulose, Senna, and steroid inhaler for asthma beclomethasone 100 µg 2 puffs twice-daily.
- 7.32 Over the next four months Mr C continued to express the delusional conviction that members of the nursing staff were sexually assaulting him while he was asleep. His mood fluctuated between despondency and elation with coming back to the ward from leave intoxicated with alcohol.
- 7.34 As the result of a fire in the unit (unconnected with Mr C) he was transferred to St Anne's hospital in Enfield.

2009

- 7.35 Over the next six months Mr C's mental state continued to fluctuate but on 12 May 2009 he was reported to have suddenly become much more paranoid and accused both male and female nurses of interfering with him sexually. It was thought that this marked deterioration had resulted from an upset following a disagreement with a friend. Fourteen days later the problem with his friend had been resolved and his mental state was much more stable.
- 7.36 Over the next four months Mr C's mental state and level of cooperation fluctuated with repeated complaints of being sexually abused by staff and others and intermittent periods of denying that this was the case.
- 7.37 During this period, in September 2009, Mr C informed staff that he was now prepared to try clozapine again in order to obtain a quick discharge. After an assessment by haematologist in November 2009 he restarted clozapine.

2010

- 7.38 By January 2010 Mr C's mental state was more settled with no overt symptoms. In February 2010 he began relapse and illness awareness prevention work with the psychologist on the team. He was experiencing some side effects from his clozapine medication.
- 7.39 On 23 February 2010 Mr C attended a ward round at which plans to move him out of the inpatient forensic services and transfer his care to Camden and Islington community psychiatric services were discussed. Mr C was initially reluctant to consider returning to Camden because of his past difficulties with drugs whilst living there. Subsequently it became clear that it was very unlikely that funding would be provided for placement in another area of London.
- 7.40 On 10 May 2010 a Mental Health Act Managers meeting was held by BEH. They received reports from the North London Forensic Service care coordinator and the forensic speciality registrar. The managers did not discharge Mr C but adjourned the

Hearing and decided to reconvene in July when they expected that a care plan for a residential placement would be in place for Mr C.

- 7.41 A possible place was found in the Camden Resettlement Project (CRP). On 19 May 2010, Mr C was taken there to meet staff and see the project for himself. He was assessed by the forensic link worker, employed by CANDI.
- 7.42 On 15 June 2010, Mr C approached a member of the ward nursing staff and asked to speak to them "*where no one else is around*". He proceeded to talk about delusional beliefs concerning his extraordinary powers. This was reported to the consultant the same day in the ward round. Similar symptoms were recorded on the 20 and 24 July 2010.
- 7.43 Mr C's case was considered by the Camden Funding Panel on 18 June 2010. The forensic link worker who had assessed him was not able to be at the meeting and his case was presented by his colleague. Funding was refused and a suggestion was made that Mr C should have a further period of rehabilitation on an open ward before transferring to a community setting.
- 7.44 During July there were a number of email exchanges between the two Trusts regarding Mr C's placement and the decision of the Camden Funding Panel. There was also an indication by the forensic treating team that they wished to discuss the possibility of a Community Treatment Order and they requested details of the consultant who would be taking over his care.
- 7.45 Following a discussion within the forensic service team, the forensic consultant psychiatrist sent an email to the chair of the Funding Panel apologising for the confusion in communication and clarifying that Mr C had improved considerably. The chair of the panel responded by authorising the funding for Mr C's community accommodation.
- 7.46 On 27 July 2010 a MHA administrator sent a memo stating that the outcome of the Managers Hearing of 26 July was that the Section 3 of the MHA was not renewed as had been recommended by the clinical team. This meant that a Community Treatment Order was not a possibility. (In fact the managers had not completed their hearing and so the Section 3 of the MHA, the renewal of which had been completed by the consultant psychiatrist, remained in place until the managers completed their hearing.)
- 7.47 Mr C's forensic care coordinator referred him to a Kings Cross CMHT care coordinator on 5 August 2010. The NLFS care coordinator subsequently sent copies of a risk assessment, and recent reports submitted to the Mental Health Act Managers Hearing. At the same time a letter was sent from the forensic specialist registrar to the CMHT consultant.
- 7.48 From 18 August 2010 Mr C began to have periods of overnight to leave to the CRP. This continued and increased in frequency over the next four weeks.

- 7.49 The Care Programme Approach (CPA) discharge meeting on 8 September 2010 was attended by the forensic link work on behalf of Camden and Islington, but no one from the community mental health team was present. The link worker asked that Mr C's discharge be delayed for two weeks in order that the CMHT care coordinator could have an opportunity to meet with him.
- 7.50 On 21 September 2010, Mr C was discharged to CRP following a further CPA meeting the same day, at which he met his CMHT care coordinator for the first time. Medication on discharge was:
- Clozapine 200mg twice daily
 - Semi sodium valproate 750mg twice daily
 - Senna tabs twice daily
 - Multivitaminsone tab daily
 - Lactulose 15mls
 - Beclomethazone 2 puffs twice daily
 - Salbutamol 2 puffs as required up to 4 times daily
 - Fybogel 1-2 sachets
 - Hyocine hydrobromine 100 µg three times daily
- 7.51 Mr C's CMHT care coordinator saw him at their base on 24 September 2010. Mr C said that he was settling in well at CRP, that his mental health was stable and that he hadn't taken any drugs or any alcohol.
- 7.52 Between September and December 2010 Mr C was seen on a fortnightly basis by his CMHT care coordinator. CRP staff recorded the visits in their notes but many of the visits were not recorded in the CMHT RiO record, or were recorded several weeks after they took place. During this period Mr C had three meetings with the forensic psychologist.
- 7.53 Mr C's first of 10 attendances at the Clozapine Clinic was on 20 October 2000. The entries in RiO are at regular monthly intervals except in November when he was seen on three occasions because of an amber blood result.
- 7.54 On 4 November 2010, an entry in RiO progress notes states that he denied any psychotic symptoms and was compliant with medication. He informed his care coordinator that he was drinking two cans of Stellar Artoirs lager per day and had smoked "weed" once.
- 7.55 A CPA meeting with Mr C, his CMHT care coordinator, his CMHT consultant psychiatrist and his housing project key worker was held on 16 November 2010 in the consultant's outpatient clinic.

2011

- 7.56 The last substantive entry in RiO before the date of the incident is 24 February 2011. The CMHT care coordinator noted that he met Mr C that day and that Mr C's mental health was stable and that he had not drunk any alcohol for a week. There was evidence provided by the CRP staff that Mr C was seen following this date by his care coordinator but these were not recorded in Mr C's RiO records.
- 7.57 A RiO entry was written on 13 May 2011, relating to events before the incident on 12 May 2011. The entry describes the meeting between Mr C and his CMHT care coordinator. Mr C was accompanied to the appointment by his key worker from the CRP. The CMHT consultant psychiatrist happened to see Mr C in the waiting room before his appointment and briefly spoke to him. It was reported that Mr C's mental health appeared to be stable that afternoon in that he demonstrated no psychotic symptoms: his eye contact was good and behaviour appropriate. Mr C reported that he had reduced his alcohol intake. He complained about some side effects from his antipsychotic medication and confirmed that he had an appointment with consultant psychiatrist the following week to discuss it.
- 7.58 On the evening of Thursday, 12 May 2011, an incident occurred on the premises of the CRP that resulted in the fatal stabbing of Mr D, a resident of the project who was also client of the local CANDI CMHT. A member of staff at the CRP witnessed Mr C attacking Mr D and holding a knife. After the incident Mr C was seen running from the hostel and his whereabouts were unknown until he was arrested by the police on the following evening of Friday 13 May 2011, and taken to Holborn Police Station.

Post Incident

- 7.59 Mr C was assessed in the police station by the consultant psychiatrist on duty at the request of the Forensic Medical Examiner, (FME), who had been asked to see Mr C by the police. The assessment by the consultant psychiatrist records that Mr C was exhibiting psychotic symptoms at the time he was assessed. The symptoms included auditory hallucinations and persecutory delusions. The record indicates that he told the FME he was hearing two voices and the psychiatrist, eight voices. Initially Mr C told the psychiatrist that he had been mentally well until the day of the alleged offence, but later said that he had been experiencing symptoms for nine months.
- 7.60 Mr C was charged with Murder and remanded in custody
- 7.61 Over the following weeks, as part of the criminal justice process, Mr C was seen by three different forensic psychiatrists for the purpose of providing psychiatric reports to the court.
- 7.62 All three psychiatrists were of the opinion that Mr C was psychotic at the time he attacked and killed Mr D and that his mental state was such that it substantially impaired

Mr C's ability to form a rational judgment and exercise self control and that his symptoms provided an explanation of his actions.

- 7.63 These opinions were largely based on Mr C's own account of the events that took place on the evening of 12 May 2011, his mental state following his arrest, and the possibility Mr C might have been masking symptoms and not taking his medication properly in the period leading up to the offence. In the case of the report prepared for the Crown Prosecution Service the "entirely unpredictable" nature of the offence is given as supporting evidence for Mr C's presumed abnormal mental state at the time.
- 7.64 In December 2011 Mr C pleaded guilty to manslaughter on the grounds of diminished responsibility.

Background – Mr D

- 7.65 Mr D was born in Iraq in 1976, where his family still live, his mother is a housewife and his father a retired teacher. He had three sisters and three brothers, all are reported to be well. There is no known family history of psychiatric illness. He had cousins and uncles who live in London and Liverpool. He left school at the age of 14 with no qualifications.
- 7.66 He left Iraq at the age of 16 or 17 years old when he first went to Jordan, then Holland and finally to the UK. When Mr D first arrived in Liverpool he stayed with his uncle for six months and obtained refugee status. He then stayed in London for three to five years living in a flat then moved to various cities in the UK living in hostels and flats.
- 7.67 Mr D appeared reluctant to reveal friends or family detail to the health service personnel. The records suggest he had a 3 ½ year old daughter with whom he has no contact and whose whereabouts are unknown.

Contact with Psychiatric Services

- 7.68 It is recorded that Mr D reported his first contact with psychiatric services was in 1999 in Birmingham. The notes indicate he gave no history of drug abuse although stated that he smoked 30 cigarettes a day. He also reported at that time he was apparently admitted to hospital in Germany, date and details unknown.

2002

- 7.69 In January 2002 Mr D was referred to the Focus Homeless Outreach Team by the Short Term Assessment and Recovery Team, (START) as he was living in a hostel in Euston. When seen for an assessment on 18 February 2002 Mr D was expressing ideas of grandiose nature including the belief that he was involved in a meeting with world presidents and Tony Blair. When Mr D was assessed he was described as talking to himself in Arabic, was elated, guarded, suspicious and reported hearing the voices of Victoria and David Beckham. He was sexually disinhibited touching his genitals in public. At that time Mr D reported that he wanted to return to Baghdad. The Focus team discussed his case in their allocation meeting with the team's Senior House Officer (SHO) two days later.
- 7.70 It was agreed that he was clearly ill and required a Mental Health Act assessment which was arranged for 25 February. He was placed under Section 2 of the MHA and admitted to the Florence Nightingale Hospital. His diagnosis was Schizoaffective disorder.
- 7.71 On 6 March 2002, Mr D was transferred to Tredgold ward, at St Luke's Woodside Hospital and placed on 15 minute observations. He was found to be calm and cooperative although had limited use of the English language. Mr D denied having delusions and hallucinations, but appeared to have poor insight into his illness and did not understand why he was in a psychiatric hospital. Following a ward round the next day Mr D was transferred to another ward under Section 3 of the MHA.

- 7.72 Mr D continued to respond to hallucinations in his native language, to self isolate and refused to go to occupational therapy and to have one-to-one sessions with staff. He was verbally aggressive to staff and as his mental state had not improved, haloperidol medication was increased from 15mg to 20mg at night.
- 7.73 Five weeks later whilst on escorted leave Mr D went absent without leave but was returned to the hospital the same evening by two policemen. On 8 May 2002, Mr D was referred to the NLFS for a forensic opinion. There is no evidence that this assessment took place.
- 7.74 At a Mental Health Review Tribunal that took place 9 May 2002, the decision was made for Mr D to remain in hospital. Seven days later a CPA took place and a plan was made for Mr D's care to be transferred from the Focus Homeless team to the local CMHT once he was settled in a residential home.
- 7.75 In July 2002 Mr D was aggressive on the ward, his auditory hallucinations still present, and Sodium Valproate was increased from 300mgs to 400mgs twice daily. In September the Hospital Managers, under the Mental Health Act reviewed his detention and decided he should to remain in hospital.
- 7.76 By October 2002 there was a continued improvement in Mr D's mental health. He was noted to not be responding to auditory hallucinations, his mood was reported as "okay" and he was seen to be interacting well with the other patients.
- 7.77 On 22 October 2002 Mr D was discharged from St Luke's Woodside hospital into a hostel, Euston Square Shelter, having had several successful leave periods there. A CPA review was undertaken two days later with the following plan to:
- Register with a GP
 - Monitor mental state
 - Remain engaged with services
 - Relapse indicators:
 - Sexually disinhibited in public
 - Responding to hallucinations
 - Self Isolating
 - Poor personal care
 - Guarded and suspicious
- 7.78 Mr D was to be discharged from his Section 117.

2004

- 7.79 During 2004 there was intermittent contact with the CMHT. In the latter part of November 2004 it was reported that Mr D had not collected his medication prescription

from his GP since August 2004. His care coordinator visited him on 7 December 2004 where Mr D reported that *"he had no complaints, he denied any problems and that he was taking his medication. He reported that he collected his prescription from his GP one week previously"*.

2005

- 7.80 Mr D moved to King's Terrace early in the year and when visited at home in February 2005 reported that he had no concerns, his mental state appeared stable but he remained socially withdrawn. No depressive symptoms were observed. The plan was that his care coordinator would maintain monthly contact.

2006

- 7.81 Monthly contact was continued throughout 2006 and in June Mr D moved to the Community Resettlement Project, where 4 years later Mr C came to live. Mr D was not happy about the move and refused to pack his belongings although he did finally hand over the keys to his flat in Kings Terrace.

2007-2009

- 7.82 Mr D continued to be maintained at the CRP with no issues reported until October 2009 when at a home visit by his care coordinator concerns were expressed by CRP staff that Mr D was self isolating, was dirty and malodorous and had heightened arousal when CRP staff proposed that his stash of porn magazines would need outside storage. Self-medication was suspended. When seen Mr D appeared relaxed, denied symptoms of depression or that there had been any deterioration of standards.
- 7.83 On 26 November 2009 a placement review took place, attended by CRP staff. It was found that Mr D was currently not suitable for the CRP and agreed that to stay there he had to stop buying 50 pornography magazines a month and to pay £57 monthly for suitable storage for his collection. Mr D agreed that he would maintain his room once it had been cleaned out.

2010

- 7.84 On 1 February 2010 the CRP enquired whether the CMHT would fund the storage of Mr D's pornography magazines. By June 2010, CRP staff were reporting that his room was deteriorating and his self-care was poor. Mr D had shaved off his long beard and cut his hair. His care coordinator was unable to assess him when he visited because Mr D did not wait to be seen, but the care coordinator did observe him in the street.
- 7.85 By the end of September 2010 there had been no significant change in his behaviour, he was no longer hoarding pornography but was grossly neglecting his personal space. He was still in bed at 12:30 hours when visited by his care coordinator on 23 September but did get up to see him. Mr D gave vague answers to questions about his mental state, he reported that *"he sometimes uses cannabis, cocaine and heroin. He does not use*

khat. No insights into his voices, not troubled, listens to music/TV as distraction. Is aware that the hostel is moving but not concerned what that means for him”.

7.86 On 21 September 2010 Mr C was discharged from hospital and moved to the CRP.

7.87 A CPA took place on 23 November 2010 without Mr D attending. CRP staff expressed concerns about his weight loss and neglecting to maintain his room. The consultant psychiatrist, who was present at the meeting, is recorded as expressing the view that a Mental Health Act Assessment might be necessary. In December a temporary care coordinator was appointed because his normal care coordinator was seconded to another team.

2011

7.88 On 2 February 2011 Mr D was seen in the outpatient clinic. CRP staff again expressed concerns about his general level of functioning, mental and physical health. It was noted that over the last 7 months he had lost 4-5 stones in weight. His personal hygiene had deteriorated and there were concerns about non-compliance with his medication. On examination Mr D was dishevelled, unkempt and malodorous. He appeared to be responding to auditory hallucinations. It was decided that he should be admitted to hospital but he refused an informal admission and it was recommended that he should be admitted under the Mental Health Act.

7.89 Two days later, 4 February 2011, the first medical recommendation for Section 3 of the MHA was completed. Mr D's care coordinator completed the police risk assessment and requested the CRP staff to investigate Mr D's nearest relative although the care coordinator understood that Mr D did not have any family in the UK. A date was to be set for the Mental Health Act assessment to take place. For a variety of reasons the MHA assessment did not take place until 16 February 2011 when Mr D was admitted to Solent Ward, Grove Centre under Section 2 of the MHA.

7.90 On admission Mr D admitted *“he had been lazy, not cleaning his room. He had started using drugs again over the last few months. He was spending his money on drugs and had no money for food. He had not cleaned his room or washed his clothes. He insisted that he had remained compliant with medication and admitted to having schizophrenia. He constantly heard voices”*

7.91 Over the next few days Mr D remained euthymic in mood but appeared unstable in mental state as was observed murmuring to himself. He was given Olanzapine 20mgs but refused Sodium Valproate. On 21 February 2011 Mr D was escorted to the shops, he was observed to be quiet and low in mood, but there was no mention of hearing voices or paranoia.

7.92 Two days later Mr D went back to CRP to try overnight leave with a plan that he should contact the ward on a daily basis until he was discharged. When he returned from leave on 25 February 2011 he tested positive for cocaine. However his mental state was

recorded as stable, he was described as not hearing voices, had good personal care, was calm and pleasant.

- 7.93 Mr D was discharged from the ward back to CRP on 2 March 2011. He contacted the ward to say he was fine, had arrived home safely and was reminded that he needed to collect his medication from the ward.
- 7.94 In April 2011 it was reported that Mr D was to be evicted from his CRP home as he was constantly ignoring house rules and leaving the front door open at night. CRP staff thought that he was probably taking illicit drugs again. Mr D was reported as not listening to staff, having visitors to his room and appeared to be high on drugs.
- 7.95 On 18 April 2011 the paperwork was completed for the eviction. The CRP housing management were looking to give him further notice to have moved on or before 26 April 2011. The main reason given for his eviction was that they were not prepared to compromise the safety of their other residents and staff as well as the continual elements of the breaches to his licence agreement.
- 7.96 On 11 May 2011 the imminent eviction was due. In addition Mr D's CMHT care coordinator sent an email to the CRP in response to an invitation received by the CMHT regarding a plan to deregister and relocate the hostel. Mr D continued to remain at the CRP. On 12 May 2011 Mr D died of multiple stab wounds. Another hostel resident was being sought in connection with the incident.

Section Two

Analysis of Evidence

8. Analysis of the Evidence

- 8.1 The following analysis has been compiled after an extensive examination of the written and oral evidence provided to the Investigation Panel.
- 8.2 The Investigation Panel were asked to undertake an examination of the mental health services provided to Mr C and the victim Mr D. Both men were residents in the same hostel when the incident happened and were both under the care of the same psychiatric team. The Investigation Panel have particularly focused on issues concerning Mr C which are equally relevant to Mr D or which highlight significant difficulties.
- 8.3 Mr C had a long history of contact with mental health services having been admitted 18 times to mental health hospitals, with psychiatric symptoms, and twice to general hospitals for attempted suicide. His last admission prior to the incident, lasted for a period of six years, initially two at Stockton Hall, Yorkshire and four years in Camlet Lodge, a medium secure unit managed by BEH.
- 8.4 Mr C had received inpatient treatment in a number of different hospitals in London and elsewhere, as well as community services in Camden and Islington before he was admitted to the forensic services.
- 8.5 Completed and partially completed risks records, care plans, and progress notes written following Mr C's transfer from forensic services to the Camden and Islington CMHT indicate that details about his past criminal behaviour, violence and psychiatric history recorded in his previous case notes were not included in more recent assessments and care planning. The Investigation Panel considered that these aspects of his history were significant and needed to be included in his care and care planning and that their omission did influence his care.

Care and Care Planning

- 8.6 The care and care planning that applied to both men raised significant areas of concern and is discussed further in this section.

Care Programme Approach

- 8.7 The Care Programme Approach was introduced in 1992 and is regarded as the cornerstone of care and care planning for individuals in receipt of mental health services. Both men were subject to CPA and reviews were undertaken by the services, some effective and others not so.
- 8.8 The written records of the way CPA meetings with Mr C operated, prior to 2009, appear to reflect the position of CPA as a major part of the care planning process. This relates to the initial period when Mr C was a patient in the medium secure unit at Camlet Lodge (NLFS) following his transfer from Stockton Hall.

- 8.9 Although there was a detailed and clear CPA record with short and medium term care planning, given the length of time he had been already been in a medium secure unit, it is of note that at this stage there was no significant long term discharge planning, even though he was having escorted and subsequently unescorted leave from the unit from July 2008. These periods of leave were largely uneventful.
- 8.10 In contrast the record of CPA meetings and the accompanying care plans immediately prior to Mr C's discharge from Camlet Lodge were much less detailed and did not provide the level of information that would have properly facilitated his discharge from a forensic unit into the community.
- 8.11 The Investigation Panel heard evidence that considerable work had been done in preparation for Mr C's discharge into the community. This included liaising with the CRP where he would be living, with the forensic link worker and attempting to establish contact with the CMHT care coordinator.

The work that was done was significantly compromised by the delays in identifying the CMHT care coordinator, the confusion over the role of the forensic link worker, the lack of any direct liaison between the forensic consultant psychiatrist and CMHT consultant psychiatrist, the lack of a medical discharge summary, and the lack of a timely record of the discharge CPA and resulting care plan

- 8.12 The evidence indicates that in 2010 the clinical teams involved in the care of Mr C and Mr D did not have a clear understanding of the CPA process at least in terms of how it should have formed the framework under which these men's care was planned and structured. This issue is also relevant to the section concerned with the transition of care from BEH forensic services to CANDI community services.
- 8.13 In the period leading up to Mr C's discharge from forensic services and following his move to the CRP, CPA meetings did not appear to provide the level of coordination and comprehensive care planning necessary to identify and address Mr C's most significant needs. Although the CMHT care coordinator did attend the final discharge CPA meeting on the 21 July 2010 this was the first time he had meet Mr C. Therefore he had not had any opportunity to participate in planning how best to facilitate Mr C's move back into the community after six years in forensic units or gain anything more than a superficial understanding of how to provide adequate support and monitoring once Mr C had been discharged.
- 8.14 The CPA Care Plan that should have been generated by the discharge CPA meeting was not circulated to the CMHT who were to carry it out, nor did the CMHT request it. The failure to circulate the plan may have been an unfortunate error but its absence was either not noticed or considered irrelevant to the work of the community team. A CPA took place in November 2010 and a care plan was generated by the CMHT care coordinator. This does outline some focused work on Mr C's activities and his drug and alcohol issues, however the plan has no mention of Mr C's psychotic illness, no mention of the signature psychotic symptoms in relapse indicators, and the only mention of

medication is in relation to medicine to stop hypersalivation. This suggests that the seriousness of Mr C's mental health problems and the needs arising out of those problems had not been recognised, and that the CPA process as operated in this case did not utilise the information available in previous CPA records or previous notes.

- 8.15 The basic principles of the Care Programme Approach as given in the CANDI Operational Policy on CPA from October 2012 are that CPA describes the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics. The CPA is central to a focus on personalisation, supporting individuals with severe mental illness to ensure that their needs and choices remain central in what are often complex systems of care. It emphasises the need for a focus on delivering person-centred mental health care and also emphasises that crisis, contingency and risk management are an integral part of the assessment and planning processes. Service user involvement and engagement will continue to be at the heart of the approach, as will a focus on reducing distress and promoting social inclusion and recovery.
- 8.16 While this edition of the policy was written after the homicide of **Mr D** the statement reflects principles fundamental to the CPA from its inception more than 20 years ago, and were reiterated in the Department of Health 'Refocusing the Care Programme Approach Policy and Positive Practice Guidance' March 2008.
- 8.17 This guidance also makes clear that: "Questions should be asked by suitably trained staff at assessment about the experience of physical, sexual or emotional abuse at any time in a service user's life. The response, with brief details, should be recorded in case records/care plans. If the specific question is not asked, the reason(s) for not doing so should be recorded". In **Mr C's** case there were clear reasons why his response to such enquiries would have been a significant indicator of his mental state.
- 8.18 A forensic outreach service is available for patients discharged from the NLFS who have a hospital order such as Section 37/41 of the MHA. Mr C, however did not have such an order and had been detained under Section 3 of the MHA and therefore did not meet the criteria for additional support from the forensic service following discharge. The Investigation Panel recognise that forensic outreach services would normally prioritise patients on court orders and restriction orders, but Mr C had been in forensic services for 6 years, and the discharge process had been disrupted by a number of events that had undermined the effectiveness of discharge planning. The Investigation Panel were pleased to hear that the system has been reviewed and that in the future all discharged patients from the NLFS will be supported as necessary by the Forensic Outreach Team.
- 8.19 The timing of Mr C's discharge from Camlet Lodge in 2010 appeared to be in part governed by the perceived change in Mr C's Mental Health Act status. This affected the possibility of using a Community Treatment Order and consequently limited the time available for the community team to involve themselves in the discharge planning.

- 8.20 Considering the presentation of Mr C's case to the Funding Panel raised a number of questions in the view of the Investigation Panel. Having reviewed the evidence available to the Investigation Panel the view is that Mr C's stated preference to live outside the Camden area and the inadequate presentation to the Funding Panel contributed a delay in identifying the appropriate CMHT. This diverted attention away from Mr C's mental health needs.
- 8.21 Although some members of the CMHT were reluctant to take on the care of Mr C the main reason for the limited presentation given to the Funding Panel was the absence of the Forensic Link Worker who had assessed Mr C in regard to his discharge.
- 8.22 There was confusion in the period leading up to Mr C's discharge. Firstly over the decision of the Mental Health Managers that resulted in Mr C's Community Treatment Order not being pursued. A memo was received by the forensic team social worker who was Mr C's care coordinator at the time, sent by a member of the Mental Health Act Administration stating that a CTO was not possible. In addition there were problems in obtaining funding for Mr C's community accommodation, or indeed agreeing where he was going to be placed, confusion (on the part of forensic services) about the role of the forensic link worker and a delay by the CMHT in appointing a community care coordinator. All of these factors contributed to an inadequate CPA process and less than optimum involvement of the CMHT following his discharge.
- 8.23 The Mental Health Managers' hearing (10 May 2010) was originally set up in order that the managers consider the recommendation for renewal of Mr C's Section 3 of the MHA 1983. The managers' decision note indicates that they became aware that Mr C had appealed his Section of the MHA, and having "taken advice" they decided to treat the meeting as an appeal meeting.
- 8.24 The MH Managers did not complete their review of Mr C's case and adjourned the meeting. This had the consequence that the renewal of Section 3 of the MHA completed by the consultant forensic psychiatrist remained in force until the Managers completed their deliberations. Previous statements by the Managers relating to the possibility of them being minded to discharge the Section of the MHA appear to have been interpreted in such a way as to contribute to the confusion about whether or not a Community Treatment Order (CTO) was available to the clinical team.
- 8.25 There is an indication that the care coordinator did attempt to clarify the situation, but there is no indication that this, quite possibly mistaken advice, was challenged.
- 8.26 The Community Resettlement Project (CRP) team appear to have utilised information regarding Mr C and his previous history from the forensic reports made available to them by the NLFS staff. This enabled them to develop care plans and risk documents. However there is no evidence to suggest that the CPA process, as operated by the CMHT, was used to coordinate the overall care planning for Mr C. It appears to have

been a parallel process that, as a result, did not take account of information available to the CRP team.

- 8.27 It was unclear as to whether the CMHT were able to access old records and whether they routinely accessed old records for patients transferred to their service. The Investigation Panel could find no evidence of a reference to previous risk assessments that were available in past records and the added information that would have therefore been provided about Mr C.
- 8.28 The Investigation Panel were informed that it was normal process to access old records as part of the response to a referral to the CMHT. The Investigation Panel were unable to find evidence that if this was done information from the records was used in formulating the response to the initial referral or to the CMHT's subsequent formulation of Mr C's needs and care plan.
- 8.29 In the case of **Mr D**, the CPA process appears to have been mainly followed and with the exception of the period, December 2010 to April 2011, when his care coordinator was seconded to another service, regular reviews were completed with one exception. However it is difficult to see whether this process created a structured proactive care plan. In November 2010 a CPA review made a recommendation that an admission to hospital would be advisable as Mr D's condition had deteriorated. No further action was taken until he was seen in outpatients in February 2011. The lack of properly completed paperwork means it was not possible to determine why Mr D did not get admitted at the time of the CPA or to ascertain who attended that CPA review.
- 8.30 The review team had concerns that after Mr D had been admitted under a Section of the MHA, there was no CPA review prior to discharge into the community, nor did there appear to be plans to hold one subsequently. This contributes to the review team's perception of a general lack of proactive care planning.

Care Coordination

- 8.31 The following three paragraphs are based on the CANDI CPA Policy document:
- 8.32 The main elements of a care coordinator's role are: to provide 'in-reach' to mental health service users and the inpatient teams, contributing to assessment and care planning when their patient is in hospital. In general it is to make an assessment and develop a care plan, for mental health service users referred directly to community teams. Although the care coordinator is the only professional able to sign off the agreed plan of care at CPA meetings, the consultant is responsible for ensuring that the clinical plan is appropriate to the level of care needed by the patient.
- 8.33 This role must be delegated to a senior member of the medical staff when the consultant is not available. Once the service user is in the community to keep in contact with them and monitor the package of care agreed in the care plan. Their role is to liaise with and keep in contact with other services involved in the mental health service user's care, including primary care services and accommodation placement team as

appropriate and to monitor the disclosure of information to other statutory agencies within the framework of the Information Sharing Protocol.

- 8.34 In working towards preventing re-admission the care coordinator will convene multidisciplinary CPA review meetings, and disseminate the care plan to all relevant people including the service user ensuring that they understand the care plan and the arrangements involved and are asked to sign the document. The care coordinator will ensure the carer's needs are assessed and in some cases agree a care plan for the carer, which is to be reviewed on an annual basis. Carers should be informed of their right to request an assessment.
- 8.35 The care coordinator needs to be familiar with the responsibilities of Section 117 aftercare as detailed in the MHA Code of Practice; where appropriate, to use or arrange specialist skills to provide particular types of therapy; and when several services are involved with the care of a service user the care coordinator take a lead organising cross service liaison meetings ensuring that there is integrated care and management of risk.
- 8.36 As indicated earlier, Mr D's care coordinator was seconded to another service for a period of three months in December 2010. It was prior to this period that Mr D's condition started to deteriorate (with concerns being expressed from October 2009 onwards) and by February 2011 he was reported to have lost four -five stone in weight. He also was displaying inappropriate behaviour at the residential home with self neglect, concerns about no-concordance with medication and was not eating properly.
- 8.37 It is unclear as to why the care coordinator was moved, or how his caseload, including Mr D, was handed over. It is not clear how the resulting need to reallocate his caseload was managed by the team but the impression from the notes of interviews with the internal investigation panel was that there was a degree of uncertainty and poor communication.
- 8.38 It was also during this period that Mr D was given an eviction notice. The Investigation Panel found that from the transcripts provided of the internal investigation interviews with CRP staff that they were not clear how long the care coordinator secondment was for or who would cover the case load.
- 8.39 The notes from the internal investigation also indicate that the care coordinator covering the secondment had a case load of 45, and the seconded care coordinator one of 23 cases. The Investigation Panel heard evidence that the numbers quoted did not represent accurate comparison.
- 8.40 Although these numbers may be subject to interpretation and not a direct comparator of workloads, the Investigation Panel were given the impression that the covering care coordinator appears to have carried some additional duties within the CMHT. It has to be questioned as to how he was able to care coordinate either Mr D or Mr C to the level

required. Once the seconded care coordinator returned to the CMHT he picked up some of his old cases which included Mr D.

- 8.41 The documents examined do not make clear how the decision was made for the covering team leader to become **Mr C's** care coordinator. There is no reference to a referrals meeting or allocation meeting. The Investigation Panel heard evidence that as a CMHT deputy manager, the care coordinator did in fact take on additional cases in order to facilitate case allocation. This appears to have been a matter of convention with the deputy manager taking on an extensive role to try and ensure that that CMHT covered its busy workload, but does not appear to have been tightly managed with possibly too much expected and taken on by this deputy manager/care coordinator.
- 8.42 The forensic service originally requested a community care coordinator on 5 August 2010. On 25 August 2010, the care coordinator (who was subsequently seconded to Islington) was invited, by his manager, to attend a CPA review for Mr C. Having put forward various objections to the CMHT taking on Mr MB's care, he declined the case. The CPA was attended by the forensic link worker without any direct representatives from the CMHT.
- 8.43 From the evidence seen it is unclear how the apparent resistance within the CMHT to accepting Mr C was positively managed. This may well have contributed to the limited level of psychiatric care planning at the CPA when Mr C moved into a community setting.
- 8.45 The Investigation Panel found it difficult to understand why **Mr D's** care coordinator did not ensure he had seen and assessed Mr D following his discharge from the inpatient unit in March 2011. On his return to the CMHT and resuming care coordinating duties for Mr D he was aware that Mr D had recently been admitted under Section 2 of the Mental Health Act 1983 and was causing sufficient concern to hostel staff for them to consider evicting him. Yet he did not appear to consider it necessary to make an assessment of his mental health or support him with the stress of eviction.
- 8.46 The information available to the Investigation Panel regarding the process of referral, the level of engagement by the CMHT with the Forensic Service, the allocation of care coordinators and caseload management raises concerns about the systems and management prevalent at the time within the CMHT.
- 8.47 The content of Mr C and Mr D's clinical notes supplemented by other evidence presented to the Investigation Panel indicates that, for both men, care coordination fell short of what would be expected from mental health services functioning in the way described in the three paragraphs taken from the policy document quoted at the beginning of this section.
- 8.48 In the case of both Trusts most of the shortcomings in care coordination only came to light following the homicide and as a result of the internal investigation process. Some omissions (such as the failure to send the discharge care plan) may have been isolated

lapses, but some (such as the failure to document proper risk assessments or to record contacts with the patient) were constantly repeated. This suggests that there were not processes in place to adequately monitor and support the clinicians functioning as care coordinators.

Risk Assessment and Management

- 8.49 In regard to risk assessment and management the Investigation Panel have further considered related issues such as care planning, proactive or reactive work with both men, as well as the admission and discharge of **Mr D** in February and March 2011.
- 8.50 In relation to **Mr C** there are several areas of concern regarding the identification, the recording, the sharing of information and risk management by the agencies involved.

Criminal record

- 8.51 Mr C had an extensive criminal record prior to him becoming unwell. There are 18 offences recorded between the ages of 17-20 years when there was no evidence of mental illness or referrals to the mental health services.

Aggression

- 8.52 There were several episodes of aggression and violence towards staff and other patients whilst Mr C was an inpatient. The level of violence does not appear to have been extreme, but they were significantly serious to merit referral to forensic services and in 2004 did include the threat with a flick knife and replica gun. These episodes appear to have been related to periods of increasing psychotic disturbance and some appear to have been precipitated by command hallucinations.

Risk to girlfriend and her son – Safeguarding Adults

- 8.53 During Mr C's periods of day, and overnight leave, from the forensic unit at a time when he was not displaying violence, but still had evidence of psychotic symptoms, he was spending time with his girlfriend and her son at their home. There appeared to be confusion over the age of her son who was thought to be either eight or eighteen years old. Examination of the notes indicates that the team were able to establish the son was eighteen. The issue was discussed in a CPA meeting on 3 March 2008 and at that time the view was that there was no need to involve the Children and Families Team as the son was then understood to be aged eighteen. Whatever the age of the son, there is no evidence that there was consideration of safeguarding the safety of the girlfriend and her son as vulnerable adults. This was particularly relevant because of Mr C's propensity for believing he was being sexually assaulted at night.

Risk history

- 8.56 The risk history for Mr C as recorded in his notes did not from 2010 onwards reflect a true picture of past behaviour. His past risk assessments were available in his forensic notes but only the most recent HCR20 was sent to the CMHT (it was filed in the CANDI CMHT notes). The earlier CANDI notes did contain several past risk assessments with much of Mr C's forensic history and history of violence, but it is not clear if the CMHT accessed his old notes. Following his discharge in 2010 the CMHT risk assessment did not contain any factors older than six months as that part of the form was left blank.
- 8.57 The Investigation Panel have made an assumption that the HCR20 was taken into consideration in Mr C's risk history and was included in the CPA review, but whether or not it was part of the information considered it did not appear to influence the management plan by recognising the need to include careful assessment of mental state as part of risk management.

Discharge/Transition Process Forensic Service

- 8.58 As indicated earlier an essential part of the care planning processes is to begin discharge planning as early as possible. Mr C was in a forensic setting for several years and there was sufficient opportunity to plan his discharge earlier. This may have enabled the forensic team to involve the appropriate community team at a much earlier point in the process with a resulting smoother transition from the forensic services to the community and from the services of one Trust to those of another Trust.
- 8.59 More importantly it would have enabled the community psychiatric services to actively contribute to the care planning process. The Investigation Panel heard evidence to suggest that the community services would have wished to consider the possibility of a period in an open ward before discharge into the community. Their involvement at an earlier stage would have facilitated such a discussion.
- 8.60 A further delay in the discharge process was in regard to obtaining funding for Mr C's accommodation. In interpreting the documentation and following the opportunity of discussing these issues with some of the personnel involved the Investigation Panel determined that the allocation of funding preceded the engagement of the responsible CMHT. This is counterproductive to facilitating a well managed discharge. If there is no alternative, such an arrangement necessitates a sufficient timeframe between obtaining funding and the involvement of the relevant CMHT to allow them to take a meaningful part in the discharge process.
- 8.61 The lack of clarity about the roles and responsibility of the forensic link worker, social worker/care coordinator and the CMHT care coordinator contributed to an apparent failure to present a coherent case for funding to the Funding Panel. This generated delay and a distraction from a proper consideration of the care needs of Mr C and engagement by the responsible CMHT. So that, for example, the forensic consultant communicated directly to the chair of the Funding Panel, but did not communicate directly with the CMHT consultant who was to take over responsibility for his patient.

- 8.62 The confusion about the role of the forensic link worker appeared to have added to the difficulty in engaging with appropriate clinicians in the relevant community team. This resulted in a poorly managed transition with neither service focussing on identifying Mr C's care needs in a community setting.
- 8.63 There was a lack of clarity in relation to the roles and responsibilities of those involved in the handover between the forensic link worker, Mr C's community care coordinator, CRP's key worker and his psychologist.

Community Resettlement Project

- 8.64 CRP staff assessed Mr C prior to accepting him and completed paperwork that seems to have taken account of the main point of his risk history and recognised the need for supervision of his medication. The Investigation Panel heard evidence that Mr C's CMHT care coordinator did work collaboratively with CRP, but this was not reflected in the CMHT RiO records of Mr C's care. There is no evidence that the CMHT did avail themselves of the information held by CRP or work in a fully collaborative way with the CRP staff.
- 8.65 The Investigation Panel heard evidence that a significant number of CRP residents receive services from CANDI. We have not seen the contractual documentation but it would be expected that such documentation would include clinical input, mutual expectation and a clear process of joint working.
- 8.66 There is a comprehensive contract that is jointly agreed by the resident and CRP. It identifies the responsibilities that the staff have towards the residents and equally those that the residents should have towards their fellow residents and the CRP staff.

Risk / relapse indicators

- 8.67 The written records and care plans do not demonstrate that risk and relapse indicators were discussed in meetings with Mr C's care coordinator or with his responsible consultant. This is concerning as it also appears that the CMHT consultant and the CMHT care coordinator were not involved in the discharge planning in any proactive way. The understanding of the Investigation Panel is that there was a consensus that the psychologist was the clinician best placed to understand risk factors and relapse indicators. However, the Investigation Panel could not see evidence that this was shared with, or sought by the CMHT care coordinator, consultant or within the CPA process.
- 8.68 When considering **Mr D's** presentation it was recognised that his relapse indicators were that he became unkempt, tended to eat less and displayed anti-social behaviour, flouting the house rules such as allowing strangers to access the accommodation late at night. This behaviour was described by CRP staff in the CPA meeting that took place in November 2010. The available notes indicate that Mr D did not attend the meeting and that the consultant psychiatrist expressed his opinion that an assessment under the

MHA was possibly needed. There is no evidence in the notes to suggest Mr D was seen by a member of the CMHT, and no action was taken by the CMHT staff until Mr D was seen by a Specialist Registrar in February 2011.

Clinical Responsibility

- 8.69 On the basis of the information given to the Investigation Panel it was not clear as to what part the CMHT consultant played in assessing **Mr C's** referral to his team or in the initial care planning when he became the responsibility of the CMHT. It would have been appropriate for the consultant to be directly involved in the process of managing clinical responsibility for Mr C following his discharge from the forensic service. The Investigation Panel was informed that the CMHT consultant was on leave from 15 August 2010 and may have missed the team meeting when Mr C's case was discussed. Adherence to a stronger allocation system within the team would have made him aware of Mr C as the referral was sent from the forensic service on 5 August 2010.
- 8.70 There was a clear reluctance to accept Mr C on the part of some members of the CMHT. This avoidance of accepting responsibility for Mr C was not managed by the senior members of the team and may have contributed to the unsatisfactory care coordination arrangements. From the evidence provided to the Investigation Panel it was not clear as to how the CMHT routinely handled referrals. The emails and document available to the Investigation Panel did not indicate that this referral was discussed at any CMHT referral meeting or that the consultant was actively involved in contributing to decisions as to how this transfer should be handled.
- 8.71 In his interview with the internal investigation panel the CMHT consultant said that in retrospect he didn't know Mr C very well but that the team had adequate documentation and at the time he thought "we knew him well". The Investigation Panel consider that without accessing Mr C's previous CANDI clinical notes and taking note of their contents at the time of the referral, or making direct contact with the referrers, it would not be possible to formulate an appropriate plan to manage the referral. It is also the case that the forensic consultant was not proactive in discussing the case with his counterpart in the community.
- 8.72 The Investigation Panel were able to establish that the CMHT would expect to receive no more than one or two referrals from the forensic team in the course of a year. The referral of Mr C, although not unique, was unusual in that Mr C was not subject to a Section 37 of the MHA with restrictions under Section 41 of the MHA, which would be more typical. As a result he came directly to the CMHT without passing through the forensic outreach service. If the forensic outreach service had been involved there would have been a period of joint working in the community between the CMHT and forensic services with the resulting extended handover period. The investigation Panel are reassured that the new working arrangements between BEH and CANDI services will now ensure there is joint working between forensic outreach and general community services for all patients discharged from forensic inpatient services.

Use of Mental Health Act

- 8.73 The Investigation Panel have already expressed concern with regard to Mr C and the application of the Mental Health Act. The actions of the Hospital Managers under the Mental Health Act and in particular the memo from a member of the Mental Health Act Administration Team led to confusion about Mr C's status under the Act and to the abandonment of plans to place Mr C under a Community Treatment Order (CTO). The memo sent to Mr C's care coordinator contained the following two paragraphs:

"The Hearing only lasted for approx 20 minutes whereby the Hospital Managers adjourned the Hearing for a period of six weeks (not setting any new date to reconvene) to allow time for (Mr C) to have some unescorted overnight leaves to his new placement, to allow time for the redecoration of the room in question and also to allow time for the Community RC to consider the use of a Community Treatment Order, therefore the Section was not renewed.

I advised the Hospital Managers that (Mr C) could not be placed on a CTO if the Section 3 had not been renewed and I informed them that I would be requesting you upon your return from annual leave to contact the Community Team and inform them that this was not an option....."

- 8.74 Although the memo is ambiguous the implication is that the Section 3 of the MHA was not renewed and therefore was not in force. As indicated earlier in this report in fact the Section 3 of the MHA was in force and would continue to be so until the Hospital Managers concluded the Hearing. As a consequence there continued to be a strong argument that a CTO was still a possibility. The forensic consultant did give evidence at the Managers' hearing but there was no evidence that the clinical team seriously challenged the views expressed in the administrator's memo or explicitly clarified Mr C's mental Health Act Status. On the RiO Mental Health Act Record the renewal of the Section 3 of the MHA by the forensic consultant was not recorded.
- 8.75 There are some issues in relation to **Mr D** and how the Mental Health Act was applied to his care and its appropriateness. There appeared to be a pattern whereby he would be admitted to hospital under Section 2 of the MHA and either quickly move to a Section 3 of the MHA or be discharged early from the Section of the MHA.
- 8.76 The Investigation Panel do have concerns in relation to the length of time that it took to complete a Mental Health Act assessment in February 2011. Mr D was finally fully assessed under the Mental Health Act fourteen days after the original request had been made by a consultant after seeing Mr D in outpatients. It was considered at the time that Mr D was clearly unwell, had lost appropriately five stones in weight and was thought to be showing a deterioration in his mental state.
- 8.77 The Investigation Panel heard evidence that this length of time delay was not and is not unusual. We were told that such delays more frequently arise in situations in which it is considered necessary to request a police presence.

Community Treatment Order (CTO)

- 8.78 Community Treatment Orders were introduced in November 2008, by new Sections 17A-G being inserted into the MHA 1983 by the MHA 2007. They give powers to the individual's consultant to recall the person to hospital if they breach a mandatory condition of their discharge from hospital.
- 8.79 The psychiatric team responsible for **Mr C's** care in the forensic services were considering the use of a Community Treatment Order for when he was discharged into the community. The forensic social worker (Mr C's care coordinator at the time) was clear why she supported a CTO as a possible tool for contributing to the management of Mr C's care in the community including as a way of addressing the potential for his non-concordance with medication. Quite reasonably they wished to discuss this with the team who would be taking over his care and would be operating the CTO. The teams were informed by the MHA administrator that it was no longer possible to consider a CTO. This advice was accepted without serious challenge.
- 8.80 One consequence of a CTO would have been to put the community consultant's responsibility for Mr C on a clear footing within the structure of the Mental Health Act. Communication lines and relapse indicators may have been more carefully documented, and Mr C would have been aware of the requirements of the order which may have made it easier to provide control over Mr C's care. It is not possible to predict what this would have meant in practice.
- 8.81 It is clear from documentary evidence and from discussing the issue with some staff that there was confusion in regard to the decision made by the Mental Health Managers and their understanding about the consequences of not making a decision about Mr C's Mental Health Act status. However it is not possible to say whether the absence of a CTO made any substantial difference to his care and the subsequent incident.

Medication

- 8.82 Mr C may be described as suffering from treatment resistant schizophrenia in that his psychotic symptoms did not appear to respond to a variety of standard antipsychotic drugs. In these circumstances clozapine is the drug of choice and Mr C was started on clozapine in December 1998. Clozapine can only be given orally and must be given regularly because the levels in the person's system fall rapidly. It can have unpleasant side effects such as weight gain and hyper-salivation causing dribbling of saliva. It can also have an effect on the person's white blood cells making them susceptible to infections that can prove fatal. As a consequence everyone taking clozapine must have regular blood test to monitor if their white blood cells are being affected.
- 8.83 Mr C comes from a racial group that may show a white cell count that is lower than is average for the general population and this can complicate the clozapine monitoring process for those individuals. Mr C had many 'amber' blood results (indicating his white count was falling) and as a result he was required to have extra blood tests. In December 1999 he had a red alert requiring the drug to be stopped, but it was later

reintroduced. In November 2004 the (independent) Clozapine Monitoring Service recommended that the clozapine be stopped because of Mr C's pattern of blood tests and this was done. It is possible to consider restarting clozapine in these circumstances following an assessment by a haematologist for an opinion on the cause of the patient's low white count, but there are a number of factors to be considered including the willingness of the patient to take the oral medication and the likelihood of continued concordance with the treatment. In Mr C's case he was reviewed by a haematologist in November 2009 and he restarted clozapine then.

- 8.84 In the four years following originally starting clozapine in 1998 Mr C relapsed seven times after stopping the drug indicating a firmly established pattern of non-concordance with treatment in the community.
- 8.85 Whilst Mr C was an inpatient at Stockton Hall there were attempts to try mood stabilising medication other than clozapine but these did not appear to have been successful.
- 8.86 During the period leading up to the homicide Mr C reported having hyper-salivation symptoms but the Investigation Panel did not see evidence of staff reporting their observation of the symptom which would have provided objective evidence of the side effects.
- 8.87 It was acknowledged that Mr C's clozapine medication dosage was written wrongly initially, but was corrected before he was given the wrong dose. The hyocine dose was written in the wrong units (milligrams rather than micrograms) but this is very unlikely to have affected the actual dose he was given.
- 8.89 In the case of both men the record of CPA meetings, and subsequent care plans, did not include a list of medication or details of treatment (including psychological treatment). This meant that the care plan omitted an essential component of their care and treatment. The CRP notes indicate that both Mr C and Mr D were receiving prescribed medication, but the CMHT care plans do not acknowledge the essential importance of medication in the men's treatment.

Supervision

- 8.90 The Investigation Panel were provided with evidence that there is a robust system of supervision in place within both Trusts. This was not the case in 2010/2011.
- 8.91 It is considered that Mr C had complex care needs so those caring for him would have required robust and reliable supervision. In his interview with the internal investigation panel the CMHT consultant spoke about his contribution to supervising the team. In practice this appeared to be largely restricted to the medical members of the team.
- 8.92 It was found that the Care Quality Commission (CRP) had concerns about the uptake of mandatory training within CRP services.

Community Resettlement Project

- 8.93 The internal investigation provided very little information regarding the CRP and how they operate with co-key workers and the division of responsibilities between the staff. It would have been helpful to have seen their staffing structure, supervision arrangements, qualifications and training programmes.
- 8.94 The notes of the Internal Investigation interviews with staff indicate that there was a division of labour between the two co-key workers at the CRP and some of the comments recorded suggested that the staff may have had a less than full understanding of Mr C's condition and relapse indicators.
- 8.95 The comments by the CQC that "not all staff have attended the necessary mandatory training" reinforce this concern about the depth of their training and support at that time.
- 8.96 It would seem that only one member of staff was on duty in the home when the incident occurred. The Investigation Panel have clarified that this was in keeping with the agreed staffing policy.
- 8.97 The Investigation Panel note that, remarkably the CQC inspection carried out in September 2011, barely three months after the incident, makes no reference to the homicide in its inspection report. This in turn raises the question about CQC's awareness or, assuming they were aware, the degree to which this was factored into their inspection. The home was deregistered in June 2012 as part of the plan to move the facility to another location.
- 8.98 The documentation examined suggests that CRP staff consider **Mr D** to have been discharged too early following his last admission to hospital. No CPA review took place, nor were the CRP staff involved in planning arrangements for his discharge.

Contract Monitoring

- 8.99 The Investigation Panel were not provided with any information about **Mr C's** placement at Stockton Hall, whether this was formally monitored and who was responsible for doing so.
- 8.100 The Investigation Panel were not provided with any information about the commissioning arrangements for the CRP resource.
- 8.101 The CRP was relocated and deregistered in June 2012. The Investigation panel understands that this was a planned change and was not caused by this incident, but had been in preparation for some time prior to the incident and subsequently completed. The CRP project relocated and was deregistered in June 2012. The Investigation Panel understands that this was a planned change and was not caused by this incident but had been in preparation for some time prior to the incident and subsequently completed.

Information Sharing

- 8.102 Examination of the documentation provided to the Investigation Panel showed that generally information sharing appeared poor, both between teams and within them. The care provided by the CMHT to Mr C appeared to run parallel to the care provided by CRP rather than being integrated and coordinated within the CPA process. The Investigation Panel heard evidence that there was collaborative working between members of the CMHT and CRP but this was not reflected in the CMHT care plans for either man, or in the care provided to Mr D following his discharge.
- 8.103 As indicated earlier some of the more well documented risk relapse indicators for Mr C were not recorded in the current relapse indicators. For example it was common knowledge that when relapsing Mr C started to wear a long coat and sunglasses. At such times he also appeared to use the name Marvin rather than Martin, the name more commonly used. Records suggest that some members of staff did not recognise this behaviour as a potential indication of psychotic thinking. It is also the case that when **Mr D** clearly demonstrated the full range of relapse indicators during the latter part of 2010, he was left without assessment by a member of the CMHT for more than two months until he was detained in hospital under a Section of the Mental Health Act.

RiO practice

- 8.104 Several issues arose out of the examination of the RiO records. The Investigation Panel found that they were not in keeping with CANDI's Clinical Records Management Policy, although the policy provided is dated July 2012 and therefore post incident. It was found that there were lengthy gaps in the record – ten weeks in one instance. Often entries were made several days after the contact and frequently contacts that had taken place were not recorded at all.
- 8.105 Mr C's care coordinator acknowledged in his interview with the Internal investigation that he had made (a rather fuller) RIO input after the incident relating to his contact on the day of the incident.
- 8.106 The Core Assessment sections in RiO do contain information for both Mr C and Mr D but do not fulfil the requirements of a core assessment on either man. The record on Mr C only contains information about his physical state and makes no mention of any mental health problem. The record on Mr D was completed in February 2011 and gives details of his admission to hospital at that time, but gives no information about his personal history or past psychiatric history.
- 8.107 The CMHT meeting notes were not recorded on RiO so it was not possible to ascertain whether Mr C's case was discussed, or if it was, the outcome from that discussion.
- 8.108 There were significant recording gaps in regard to Mr C and the Investigation Panel were unable to ascertain how widespread the habit was within the service of not

recording contacts with patients or postponing making entries regarding patients but did conclude that this was not an exceptional situation.

8.109 The Investigation Panel's experience in discussing record keeping in these two Trusts, (and also in discussing electronic record keeping with colleagues in a variety of other Trusts and settings) is that there may be many advantages to such systems but that clinical staff often find them cumbersome. While it is not within the Investigation Panel's remit to enter into any detailed examination of the electronic information systems used by BEH and CANDI they do wish to observe that there needs to be a realistic level of expectation as to the performance of care coordinators, doctors, nurses, social workers, and other clinical staff in fulfilling the requirements of record keeping policies. For example if the Core Assessment section of RiO is to provide the essential information needed to formulate an understanding of the patient's difficulties, diagnoses, and needs, it must contain comprehensive information under most if not all of the headings. When one considers that the same argument applies to the risk assessment, risk history, risk management, care planning, and many other sections it becomes clear that clinical staff have a significant burden of data entry and need sufficient time and other resources to fulfil their responsibilities.

Clinical Records

8.110 The internal investigation considered that the quality of records for both Mr D and Mr C were poor. The Investigation Panel concur with their comments. The documentation provided did not make it possible to follow the interventions and contacts made with either man, and as a result did not facilitate the level of care one would expect for patients under the CPA.

8.111 **Mr D's** care coordinator left the CMHT in December 2010 (on secondment to Islington for 3 months) without completing the CPA paperwork for the review held in November 2010, at a time when hostel staff were expressing concerns about Mr D's behaviour and weight loss. It was unclear as to how the handover of cases to colleagues at this time and the information provided to both the CRP and others in the CMHT was handled. The impression of the Investigation Panel from the document available to us and in the internal investigation's interview notes is that it was somewhat unmanaged.

8.112 From the evidence provided to the Investigation Panel it is unclear what the referral and case allocation system was within the CMHT, at the time of **Mr C's** discharge into the community or indeed if it was adhered to.

8.113 A forensic referral was made in May 2002 in regard to **Mr D** but no response was recorded in the records. Given Mr D's long history of schizophrenia and the ongoing problems with his substance misuse it would have been appropriate to have made a referral to dual diagnosis services. The paucity of CMHT notes, contact and CPA care planning might suggest there had been little active psychiatric review and planning within the CMHT. The Investigation Panel heard evidence that Mr D was being reviewed

by the team's Specialist Registrar under supervision of the CMHT consultant, but this had not been expedited as a consequence of the serious concerns of the CRP staff.

Housing Information Application

- 8.114 The CRP completed comprehensive application forms for both men, which contained details of their previous history and future care needs in regard to the suitability of the accommodation. However prior to **Mr D's** death when he was under an eviction notice, there did not appear to be evidence of any forward planning for the possible eviction of Mr D and presentation to the Homeless Persons Unit.
- 8.115 It appears from the information available to the Investigation Panel from the Internal Review that the care coordinator's intention was not to take proactive action in regard to the eviction, but to await its enactment. This was about a month after Mr D's discharge from hospital on Section 2 of the MHA and appears to be reflective of the attitude and approach of this care coordinator who, though in contact with the CRP by telephone and email, made no direct contact with Mr D despite his disturbed mental state, admission and discharge from hospital and the plan to evict him.

Primary Care

- 8.116 During **Mr C's** contact with mental health services and in particular whilst he was on clozapine medication there were concerns about his physical health. The Investigation Panel found no evidence of communication between the CMHT and a GP.
- 8.117 The CRP staff were instrumental in helping Mr C organise registering with a local GP although it might have been expected that the CMHT would have engaged with his GP, which would reflect a more general collaborative working relationship with primary care.
- 8.118 In regard to **Mr D**, his contact with primary care appears to have been for the purpose of receiving regular medication prescriptions.

Clinical Leadership

- 8.119 The forensic consultant was present in the ward round discussions, CPA meetings and Mental Health Act Managers Hearings. However the consultant was not aware that the medical discharge summary and CPA care plan had not been sent to the community mental health team until the internal investigation following the homicide. He did not take a lead in communicating with the community consultant or in clarifying the mental Health Act issues, or challenging the mental health act administrator's assertion about the Community Treatment Order. It was unclear as to how the CMHT consultant viewed his role within the team. He is quite clear in the internal investigation transcripts that he believes the consultant is the clinical leader of the team. The evidence presented to the Investigation Panel indicated that he supervised the medical psychiatric trainee meetings but did not help clarify what this means in practice in terms of leading the team.

8.120 The Investigation Panel were unable to meet the CMHT manager but some of the concerns identified in relation to the community consultant may also have relevance to the team manager.

Psychology Service– Mr C

8.121 Following Mr C's discharge from the forensic service he continued to see the forensic psychologist, who had begun to work with him on illness awareness and relapse prevention, in an informal supportive role. The staff at CRP were aware of his involvement with psychology but there was no reference to this in the CMHT records and psychology was not included in the CPA care plan prepared by the CMHT in November 2010, although Mr C continued to have psychology input for a further month.

8.122 Entries in the clinical record indicate the forensic team suggested that the psychologist would have the best understanding of Mr C's relapse indicators and there was a lost opportunity to understand these and involve the psychologist with his care by the CMHT.

Post Incident Assessment and Actions – Mr C

8.123 The records indicate that after the homicide Mr C's account was that he had not been taking his medication properly for some considerable time and had been experiencing psychotic symptoms. This account needs to be understood in context. The duty psychiatric consultant who assessed Mr C at the police station makes clear that in her view Mr C was exhibiting psychotic symptoms at the time he was assessed. The symptoms included auditory hallucinations and persecutory delusions. The assessment also makes clear some marked inconsistencies in Mr C's account of his symptoms. For example, he told the Forensic Medical Examiner (FME) he was hearing two voices, but told the psychiatrist he was hearing eight voices. He also told the psychiatrist initially that he had been mentally well until the day of the alleged offence, and then later that he had been experiencing symptoms for nine months.

8.124 In order to make some assessments of Mr C's mental state at the time of the incident it is necessary to take into account his presentation as soon after the events as possible, and place this in the context of all the other relevant information. The inconsistencies in Mr C's account as recorded by the FME and Duty Psychiatrist do not make Mr C's account irrelevant to the attempt to assess his mental state prior to the incident, but do emphasise the need to interpret his comments carefully in the context of his situation and mental state at the time he was giving his account to the doctors.

8.125 At the time of his assessment Mr C was in a police station, having been involved in a violent incident and having recently been apprehended by the police after 24 hours on the run. Prior to his arrest he had probably been without medication for 36 hours and by the time he was assessed may have been without medication for 60 hours, if he had not received medication in police custody.

- 8.126 **Mr D** was experiencing significant problems and had been admitted to hospital on 16 February 2011 and discharged two weeks later. He continued to present difficult behaviour at the hostel after his discharge from hospital. He was facing an eviction order from his accommodation and no plans had been put in place for an alternative placement. It does not appear that he was seen by a qualified mental health professional following his discharge and so it is difficult to judge what symptoms of mental ill health he was exhibiting leading up to his death.
- 8.127 The evidence contained in the clinical records up to the event suggested that **Mr C** was doing reasonably well, complying with his care plan, taking his medication and not showing any evidence of psychosis or exhibiting disturbed behaviour. Whilst it is possible that he was deceiving staff at the hostel, and CMHT; and was not actually taking medication, faking side effects, and masking psychotic symptoms this is not implied by the records we have seen or from the verbal evidence given to the Investigation Panel.

Section Three

Review of Internal Report

9. Internal Investigation

- 9.1 The following section sets out an analysis of the joint internal investigation that was completed on behalf of CANDI, BEH, One Housing Group (CRP) and the London Borough of Camden together with details of their recommendations and actions taken.
- 9.2 The Terms of Reference for the Independent Investigation Panel relating to the Trust's Internal Review had two specific areas to examine: -
- Review of the Trust's internal investigation to assess the adequacy of its findings, recommendations and action plans.
 - Reviewing the progress made by the Trust in implementing the action plan from the internal investigations.
- 9.3 The Trusts completed a notification of the incident form that was followed by an Initial Management Investigation report completed within 72 hours.

Initial Actions

- 9.4 The Trusts, immediately following the incident, informed all of the agencies as required including:
- NHS London's Patient Safety Team.
 - The Mental Health Act Commission.
 - The Care Quality Commission.
 - The Trusts' Commissioners.
- 9.5 Incident alert forms were completed and BEH followed this up with a 72 hour initial management investigation report. It is unclear as to whether CANDI completed a 72 hour report. There is no indication that a liaison meeting was held between the involved agencies and the police and they were not included on the list of individuals that had had involvement with both men. This does not mean that this meeting did not take place.
- 9.6 Although the internal investigation report does not specify that a senior manager was designated to be the contact person linking all agencies for the purpose of ensuring that communication was maintained, it does indicate that an Associate Director of Governance and Performance, (CANDI) provided support to the internal investigation.
- 9.7 The death of Mr D occurred on 12 May 2011 and the first panel meeting was held on 2 June 2011. The internal investigation was set up in accordance with the Department of Health Guidance HSG (94) 27 as amended in June 2005 in a timely manner.

The Internal Investigation Process

9.8 The joint internal investigation followed a clear set of Terms of Reference that were jointly agreed by both Trusts, One Housing Group and the London Borough of Camden. They also followed NHS London's Serious Incident Management Policy.

9.9 The internal review team comprised of:

Chair and Independent Convenor

Recently retired Medical Director of another London Trust

Panel Members

Medical Director, CANDI

Mental Health Director, One Housing Group

Head of Social Work, BEH

Assistant Director, Housing and Adult Social Care, London Borough of Camden

9.10 All of the agencies involved in the case were represented on the investigation panel and the chair was independent from these. Administrative support was provided by CANDI.

9.11 Not all panel members were present at all of the interviews of the thirteen witnesses over a period of four days in June and July 2011, but the independent chair and some of the panel did participate in all of the interviews. Notes were taken of each interview.

Family Support

9.12 The internal investigation did attempt to make contact with the families of both men. Mr D's family did not reply to their letter and there were apparently no contact details for Mr C's mother. (The Investigation Panel are aware the CRP had previously made contact with his mother and it is therefore unclear as to why there was any difficulty in contacting her).

Staff Support

9.13 The internal investigation made no mention of support being provided to the involved agencies' staff.

Internal Investigation Methodology

9.14 A Root Cause Analysis process was undertaken and the report included: -

- A list of documents obtained that only contained the case notes of Mr C and Mr D.
- Chronologies containing backgrounds and clinical contact for both men.
- Investigation of critical issues.
- Causal Factors and Service Delivery.
- Contributory Factors.
- Findings and recommendations.
- Good practice.

- 9.15 The internal investigation report makes thirteen recommendations in regard to:
- Forensic Service handover Processes.
 - Working arrangements between CANDI and the Forensic Link Workers.
 - Supervisory and Training arrangements
 - Arrangements for covering leave in the CMHT
 - Review of working arrangements with Supported Accommodation
 - The use of email as an inter-professional communication tool
 - Guidelines for caring for patients on clozapine medication.
 - Regular review of CMHT caseloads.
 - Care plan review
 - Regular review of individuals' placement in supported accommodation placement.
- 9.16 The recommendations are set out in tabular format with the Investigation Panel's comments later in this section. The report was presented to and accepted by the Trusts Boards together with an action plan to implement the recommendations provided.

Findings

- 9.17 The internal investigation's Terms of Reference specifically delineates the time frame to be the first contact with mental health services. In practice the internal investigation concerned themselves principally with the period following the transfer of Mr C into the community services from Camlet Lodge. The Investigation Panel found that the chronology did not give details of the circumstances leading to Mr C's admission to forensic services, and subsequent course of his presentation and management. This limits the understanding of his symptomatology and context of his treatment. His mental state and course of recovery are very relevant to assessing the adequacy of the care plans prepared for his discharge into the community (For example the particular significance of sexual delusions influencing Mr C's behaviour.)
- 9.18 The Investigation Panel consider that Mr C's actual and assessed risk of potential harm to others was not explored in sufficient detail to gain an understanding of how risk assessments were conducted and influenced clinical decisions within the CMHT's review process.
- 9.19 The internal investigation did not clarify if any action was taken to address the apparent significant shortcomings in the care provided by the care coordinator who was seconded.
- 9.20 Substance misuse was discussed in the main body of the report but it was unclear as to whether the services paid sufficient attention to this issue. This is a similar concern to the level of attention given to issues with Mr C's previous forensic history.
- 9.21 The internal investigation panel membership included an independent chair but did not include a psychiatric nurse. This role may have been undertaken by the Associate Director of Governance and Performance who may have had a nurse background.

9.22 The recommendations centred mainly on individual local services and did not provide a means of assuring the Trust Boards that the required changes in practice have taken place within the wider Trust services.

General Comments by the Independent Investigation Panel

9.23 The recommendations and therefore the action plans are generally not formulated in a way that would enable the Trust Boards to assure itself that the necessary changes have been made to the way in which clinicians are working and the functioning of teams in practice. For example, reviewing the supervision policy, or adapting training materials in themselves will not ensure that complex cases are discussed regularly and dealt with appropriately.

Tabular review of Internal Investigation Recommendations and Action Plan

Recommendation 1	Timescale	Progress
The protocol for transferring service users from BEH's is inpatient forensic service to local CMH fees should be reviewed, with particular reference to service users not on restriction orders. The revised protocol should ensure that in all cases a full CPA, incorporating a professionals' meeting, should take place before the case is closed to the Forensic Service, and allow for the option to hold such a meeting after the individual has been moved into the community, if this is in the service user's best interests. The arrangements for insuring handover of full documentation including a comprehensive handover care plan with a clear risk management and contingency plan, should be clear and subject to regular audit.	April 2012	Completed.
<p>Investigation Panel Comment</p> <p>The Investigation Panel endorses this recommendation with the caveat outlined in 9.23. The Trust Board need to satisfy themselves that the outcome of the audits do indicate the new protocol is ensuring that patients discharged from forensic services are handed over to local services with clear and agreed care plans and risk management plans.</p>		

Recommendation 2	Timescale	Progress
The working arrangements of CANDI's Forensic Link Worker Service should be reviewed, in particular its overall management and its links with the CMHT; an operational policy for the reviewed service should be developed and formally approved.	April 2012	Completed
<p>Investigation Panel Comment</p> <p>The Investigation Panel endorses this recommendation with the caveat outlined in 9.23.</p> <p>The Investigation Panel was provided with a draft operational policy. This needs to be ratified. The implementation needs to have particular emphasis on involving the allocated care coordinator in the process of planning discharge and providing appropriate care and treatment for the individual in the community. The Trust Board need to satisfy themselves that the implementation of this policy does result in the stated aim: <i>"the process of handover of Care Programme Approach</i></p>		

responsibility is managed effectively and that any issues with the process are resolved appropriately”.

Recommendation 3	Timescale	Progress
Supervisory and training arrangements within King's Cross CMHT to be reviewed to ensure that record-keeping, including care plans, risk assessments and RiO entries up to the required standards.	March 2012	Completed December 2011
Investigation Panel Comment		
The Investigation Panel endorses this recommendation with the caveat outlined in 9.23. The Trust Board need to satisfy themselves that systems are in place to monitor whether the changes brought about by this part of the action plan are translated into standards of performance that are adequate for acceptable patient care throughout the Trust.		

Recommendation 4	Timescale	Progress
The arrangements for leave and cover within the King's Cross CMHT should be reviewed.	March 2012	Completed December 2011
Investigation Panel Comment		
The Investigation Panel endorses this recommendation with the caveat outlined in 9.23. The problems with leave cover in 2010 /2011 appeared to be symptomatic of deficiencies in the management of the team (managing referrals, managing allocation of cases and workload, use of information systems, for example). It would therefore be necessary not to restrict the action to leave arrangements alone, nor to restrict any review to a single team.		

Recommendation 5	Timescale	Progress
King's Cross CMHT should review its working arrangements with the supported accommodation agencies with which it has professional relationships in order to establish a satisfactorily effective inter-agency working. A written agreement should be made between the CMHT's and the manager of each set of accommodation, which sets out the minimum standards for information sharing and communication about individual service users.	April 2012	Protocol in discussion with commissioners
Investigation Panel Comment		

The Investigation Panel endorses this recommendation with the caveat outlined in 9.23.

Recommendation 6	Timescale	Progress
Both CANDI and BEH to review a reissue guidance to staff on the use of e-mail as a clinical management and entire professional communication tool, in relation to protection of confidentiality, and proper recording of this material into the clinical and other records. Revised guidance must be approved by each Trust's Caldicott Guardian.	March 2012	Completed March 2012

Investigation Panel Comment
The Investigation Panel endorses this recommendation with the caveat outlined in 9.23.

Recommendation 7	Timescale	Progress
Guidelines should be prepared for all relevant staff working with service users prescribed clozapine clarifying that the nature and purpose, and limitations of the clozapine monitoring service.	April 2012	To be completed

Investigation Panel Comment
The Investigation Panel endorses this recommendation with the caveat outlined in 9.23. The Investigation Panel heard evidence that there has been a more extensive review of the practice of the clozapine clinic in CANDI to extend their clinical remit.

Recommendation 8	Timescale	Progress
King's Cross CMHT to develop and pilot an arrangement to ensure that CMHT's undertake regular review, by the team, of their caseload, to ensure that cases are probably brought to the attention of the senior clinical staff /consultant psychiatrist, and that a traffic-light or similar arrangements for prioritising cases for discussion is fully considered. Results from the pilot should be reported to the Trust's Quality Committee.	May 2012	Traffic light system introduced in July 2012

Investigation Panel Comment
The Investigation Panel endorses this recommendation with the caveat outlined in 9.23. If the results of the pilot indicate that this system is effective the Trust

Board needs to satisfy itself that these parts of the action plans are translated into standards of performance that are adequate for acceptable patient care throughout the Trust.		
Recommendation 9	Timescale	Progress
Training materials on care planning to be adapted to include information about service users whose historical risk and clinical profile includes factors that may be related to high risk behaviours, such as specific delusions or substance misuse, should include specific arrangements to ensure evaluation of such factors by the appropriate staff members on a regular basis, and whenever indicated by other observations or clinical change.	March 2012	to be completed
Investigation Panel Comment		
The Investigation Panel endorses this recommendation with the caveat outlined in 9.23. The Trust Board need to satisfy themselves that this part of the action plan is translated into standards of performance that are adequate for acceptable patient care throughout the Trust.		

Recommendation 10	Timescale	Progress
Trust CPA policy to be updated to put in place arrangements to ensure that care plans are signed off by consultant staff, or that this role is delegated, where appropriate, to an appropriately qualified and fully briefed senior member of staff.	May 2012	completed October 2012
Investigation Panel Comment		
The Investigation Panel endorses this recommendation with the caveat outlined in 9.23. The Trust Board need to satisfy themselves that this part of the action plan is translated into standards of performance that are adequate for acceptable patient care throughout the Trust.		

Recommendation 11	Timescale	Progress
One Housing Group to review their policy and procedures for reviewing at timely intervals the appropriateness of continuing an individual placement.	March 2012	policy updated April 2012
Investigation Panel Comment		
The Investigation Panel endorses this recommendation.		

Recommendation 12	Timescale	Progress
--------------------------	------------------	-----------------

To insure that the findings of this report are communicated to Mr D's next of kin in line with the Foundation Trust's "Being Open" Policy	February 2012	Completed
<p>Investigation Panel Comment</p> <p>The Investigation Panel endorses this recommendation.</p>		

Recommendation 13	Timescale	Progress
To insure that the findings of this report are communicated to the teams directly involved with the care and treatment of the service user, in line with the Foundation Trust's "Being Open" Policy.	March 2012	August 2012
<p>Investigation Panel Comment</p> <p>The Investigation Panel endorses this recommendation.</p>		

Section Four

Independent Investigation Findings and Recommendations

10. Findings and Recommendations

- 10.1 The following section sets out the Investigation Panel's findings and recommendations. These have been identified from a detailed analysis of the evidence, both oral and written, that has been presented to the Investigation Panel. The recommendations have been completed for the purpose of learning lessons and for the Trusts to put into progress any actions required to prevent a similar occurrence. It also sets out areas where the Investigation Panel have identified notable practice.
- 10.2 The Investigation Panel considers that this report identifies some serious shortcomings in the care and treatment of Mr C and Mr D, but has been encouraged by the response of the Trust Senior Management Teams from both Trusts to the investigation process. Considerable work has been undertaken to address the issues identified by the internal investigation processes and subsequent management processes.

Positive Practice

- 10.3 It is normal process in investigations into tragic circumstances such as the death of a patient to set out areas of notable practice. In this case there were several areas that the Investigation Panel found they specifically wished to single out as examples of good practice. These have been set out as follows: -

Trust Actions

- 10.4 The Investigation Panel would like to commend both Trusts for the prompt action that was taken to address the issues raised within the joint internal investigation. It was found that necessary actions were completed within a timely manner.

North London Forensic Service – Forensic Social Worker

- 10.5 The Investigation Panel would like to commend the Forensic Social Worker for their understanding of Mr C's care needs and the preparatory work with the staff at CRP.

North London Forensic Service – Forensic Psychologist

- 10.6 The Investigation Panel heard that Mr C's forensic psychologist maintained a short period of contact with him following his discharge as she considered he required some contact to be provided by the forensic service. This action is to be commended and the approach is seen as good practice, albeit it was an engagement that was not maximised because it was not incorporated adequately in the CPA.

Community Resettlement Project

- 10.7 The Investigation panel found that the CRP documented assessments in regard to both men were thorough and comprehensive.

Significant Changes - Camden and Islington NHS Foundation Trust

- 10.8 Since the incident in May 2011 the Trust has undertaken a major configuration of their teams. A transition period took place during 2012 in order for staff to ensure that the issues that required addressing within these changes were completed so that the patient pathway through the services was not disrupted. The Trust recognised that they have really high numbers of people with Personality Disorders, a lot people with very complex, untreatable or, difficult to treat, depression, trauma.
- 10.9 The main driver was to ensure that there was a rebalancing of services that are very much focussed on dealing with chronic psychosis. Training programmes are in place for managers across the Trust to enable them to have the skills to deal with the new way of working and identifies areas that require further input. This includes a new supervision policy which states that note keeping standards must be part of the process.
- 10.10 There is a central log held of appraisals, the percentages completed per team and Personal Development Plans that are part of the process.

Findings – General Comments

- 10.11 There were particular factors in **Mr C's** circumstances and difficulties which made his presentation and care arrangements unusual (although not exceptional). He had spent six years under the care of forensic services and yet was not detained under one of the more usual Sections of the Mental Health Act used in such circumstances. He was discharged directly into the community without a period under the supervision of the forensic outreach services. Both of these were unusual for patients referred to the local CMHT. Less unusual but nevertheless challenging was Mr C's tendency to use and be adversely affected by non prescribed drugs and his past history of non concordance with treatment.
- 10.12 Whether or not the circumstances of Mr C and Mr D were unusual many of the issues identified in this investigation are the same or similar to those identified in many other investigation reports from across the country. This suggests that this particular Investigation Panel's observations and concerns have some general applicability, and that the issues are ones that many organisations struggle to address effectively. In any case, the Investigation Panel was charged with examining the care and treatment of Mr C and Mr D, and in this regard we consider our findings and recommendations appropriate following our analysis of the evidence.
- 10.13 It is never a simple or straightforward matter to categorically link events in the care and treatment of an individual with causal factors producing a particular outcome. When incidents occur, there are usually many contributory factors interacting with many variables, and this is certainly the case in relation to Mr C and Mr D. It is therefore extremely difficult, if not impossible to precisely predict or anticipate events of this nature. Once one removes the benefits of hindsight from ones' understanding of such

incidents then the complexity of many factors combining to result in one particular outcome, out of many possible outcomes, becomes apparent.

- 10.14 When considering if this event could have been predicted or prevented, the Investigation Panel reviewed **Mr C's** history, his involvement with psychiatric services, and how he presented over the course of several years. Given his history of violence related to abnormalities in his mental state, his use of alcohol and drugs, and history of non concordance with treatment, it seems reasonable to expect that professionals involved with him needed to be alert to the possibility that he might at some point stop taking his medication as prescribed and or use non prescribed drugs with a resulting deterioration in his mental state with the risk that he may become violent.
- 10.15 The evidence presented to and seen by the Investigation Panel suggests that Mr C's behaviour had included levels of violence such as kicking or punching, but up to this point had not included the use of weapons during any actual assaults.
- 10.16 Mr C's account after the homicide is that he had not been taking his medication properly for some considerable time and had been experiencing psychotic symptoms. This account needs to be understood in context. The assessment by a consultant psychiatrist following the homicide makes clear that in her view Mr C was exhibiting psychotic symptoms at the time he was assessed. The symptoms included auditory hallucinations and persecutory delusions. The assessment also makes clear some marked inconsistencies in Mr C's account of his symptoms. For example he told the Forensic Medical Examiner (FME) he was hearing two voices, but told the psychiatrist he was hearing eight voices. He also told the psychiatrist initially that he had been mentally well until the day of the alleged offence, and then later that he had been experiencing symptoms for nine months.
- 10.17 These inconsistencies do not make Mr C's account irrelevant to the attempt to assess his mental state prior to the incident, but do emphasise the need to interpret his comments carefully in the context of his situation and mental state at the time he was giving his account to the doctors. The context is that at the time of his assessment Mr C was in a police station, having been involved in a violent incident and having recently been apprehended by the police after 24 hours on the run. Prior to his arrest he had probably been without medication for 36 hours and by the time he was assessed may have been without medication for 60 hours, if he had not received medication in police custody.
- 10.18 **Mr D** was experiencing significant problems and had been admitted to hospital on 16 February 2011 and discharged two weeks later. He continued to present difficult behaviour at the hostel after his discharge from hospital. He was facing an eviction order from his accommodation and no plans had been put in place for an alternative placement. It does not appear that he was seen by a qualified mental health professional following his discharge and so it is difficult to judge what symptoms of mental ill health he was exhibiting leading up to his death.

- 10.19 The evidence contained in the clinical records up to the event suggested that **Mr C** was doing reasonably well, complying with his care plan, taking his medication and not showing any evidence of psychosis or exhibiting disturbed behaviour. Whilst it is possible that he was deceiving staff at the hostel, and CMHT; and was not actually taking medication, faking side effects, and masking psychotic symptoms this is not implied by the records we have seen or from the verbal evidence given to the Investigation Panel.
- 10.20 The notes and verbal evidence did not contain anything to suggest there were reasons for any concerns in regard to the relationship between Mr C and Mr D, and nothing to predict there was likely to be violence between them.
- 10.21 The Investigation Panel have reviewed the written account of the contact made on the afternoon of the incident, and that was entered into RiO after the incident had taken place. These state that when Mr C was seen by the care coordinator with a member of the CRP staff Mr C had appeared well and there were no concerns about his mental state. He was compliant with his medication and no symptoms of mental illness were found.
- 10.22 The fact that these views were recorded and expressed after the event rather than contemporaneously with the meeting, places them in a less secure position as an accurate record of the facts. This said, however, having examined the CANDI RiO record, CRP progress notes, and testimony from the key worker at CRP, all are consistent with the account given by Mr C's care coordinator. There is no suggestion of observed symptoms of psychosis or concerns that Mr C was not taking his medication. While this does not rule out either possibility, this is the evidence that those looking after him would have based their judgement upon.
- 10.23 The analysis of evidence detailed in Section 8 has identified a number of issues, concerns and apparent shortcoming in the care and treatment of both Mr C and Mr D. There are some concerns about clinical practice within the CMHT in particular, but in relation to the homicide there was nothing to suggest this had a causal effect. The incident that led to Mr D's death did not appear to have been preceded by any change in behaviour or circumstance that would have alerted staff that Mr C was likely to be violent having appeared to be progressing well, or that there were any difficulties in the relationship between Mr C and Mr D likely to lead to a violent altercation.
- 10.24 **As a consequence the Investigation Panel consider that the incident was not predictable and therefore not preventable.**

Recommendations

Maintaining Clinical Standards

- 10.25 An underlying requirement for the effective care and treatment of patients is the need to integrate the collection of appropriate information with systematic recording and processing of that information, to enable the formulation of relevant care plans, which are then delivered effectively. This integration was lacking in a number of areas of the care and treatment of both Mr C and Mr D. All of these processes need to be based on sound and up-to-date clinical knowledge. The skills required to obtain the necessary information and formulate the patient's problems in an accurate and helpful way, the skills necessary to be able to collaboratively develop plans to address the problems, and the skills required to contribute to carrying the plans out, all require training but also need constant honing and development. Trying to ensure that all that needs to be done is done, may be best achieved by focusing on constantly reviewing the process in action (in clinical reviews or ward round handovers), and during clinical supervision (both individual and team supervision).
- 10.26 The investigation panel wish to make a recommendation to address this general issue and to suggest a potential for assuring subsequent recommendations are implemented in a way that results in the change in practice required to improve patient care. The full implementation of this recommendation requires a cultural shift in relation to supervision that cannot be achieved in a single manoeuvre, and is likely to require a phased plan, with a clear programme for implementation, and regularly reviewed at a senior level within both Trusts.

Recommendation One

It is recommended that: -

- ***Both Trusts further develop their supervision policies and procedure to facilitate supervision being used to provide assurance to the Trust Board that patient care is of the required standard.***
- ***The supervision process includes scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the requirements of the clinician's professional duties.***
- ***The supervision process includes scrutiny of current samples of actual care delivery at every level to ensure adherence to prescribed changes in practice such as those required by the recommendations in this report.***
- ***Regular audits take place to demonstrate that the supervision chain is identifying and addressing any deficiencies in the quality of care being delivered to patients.***

.....

Care Programme Approach (CPA)

- 10.27 The Investigation Panel found that CPA meetings and the accompanying record prior to **Mr C's** discharge from Camlet Lodge did not provide the level of information that would have properly facilitated his discharge from a forensic unit into the community. Furthermore subsequent CPA documentation for Mr C did not contain information about his diagnosis, psychotic symptomatology nor drug or psychological treatment.
- 10.28 Following **Mr D's** admission to hospital in February 2011 there was no CPA arrangements made or planned. Nor was there any evidence that the ward or CMHT staff had included CRP staff in Mr D's discharge planning. Mr D's previous CPA meeting in November 2010, did not lead to any action in regard to his care needs despite the voiced concerns of staff at CRP and the presence of virtually all of his relapse indicators and significant physical deterioration.
- 10.29 The Investigation Panel consider that the evidence provided to them indicates that the clinical teams' understanding of the CPA process in 2010 and its application was not clear for either man in regard to how it should form the framework under which care is planned and structured.

Recommendation Two

It is recommended that:-

- ***Both Trusts reinforce the position of clinical care management as the cornerstone of patient care in their psychiatric services. The essentials of this are contained within the Trusts' CPA policies and include the appropriate use and sharing of clinical information to inform clinical decision-making, and the management of risk.***
- ***The position of CPA be reflected and strengthened in the training programmes staff are required to attend, and the priorities identified in individual and group supervision.***
- ***Supervision facilitates the routine review of actual cases to ensure the appropriate application of the principles of CPA and to enable corrective action to be taken if required, as in Recommendation One.***
- ***The implementation of this Recommendation is monitored by periodic audit.***

.....

- 10.30 The content of Mr C and Mr D's clinical notes supplemented by other evidence presented to the Investigation Panel indicates that, for both men, care coordination fell short of what would be expected from mental health services functioning with the CPA as the underlying structure for coordinating clinical care.

Care Coordination

- 10.31 The position of the community CMHT as the team responsible for coordinating **Mr C's** care was undermined by the late allocation of a care coordinator, who's only direct contact with the forensic services and Mr C prior to discharge was at the CPA meeting on the day Mr C left the ward. The principle preparatory work prior to discharge was between the forensic service and the forensic link worker, and the forensic service and the staff of CRP. Despite considerable work in this area, the lack of involvement of the CMHT, and the fact that the discharge summary and CPC care plan were not sent to the CMHT in a timely way, suggests that the core role of care coordination within the framework of CPA was not recognised.
- 10.32 Mr D's care coordinator did not ensure he had seen and assessed him following Mr D's discharge from the inpatient unit in March 2011. This was despite the fact that Mr D had recently been admitted under Section 2 of the Mental Health Act and was causing sufficient concern to CRP staff for them to consider evicting him.
- 10.33 In the case of both Trusts most of the shortcomings in care coordination only came to light following the homicide and as a result of the internal investigation process. Some omissions (such as the failure to send the discharge care plan) may have been isolated lapses, but some (such as the failure to document proper risk assessments or to record contacts with the patient) were constantly repeated. This suggests that there were not processes in place to adequately monitor and support the clinicians functioning as care coordinators.

Recommendation Three

It is recommended that:-

- ***Both Trusts clarify explicit minimum standards for care coordinators and support these with documents to assist care coordinators in their role (for example the discharge check list produced by BEH in response to the findings of the internal investigation).***
- ***These standards form a benchmark within the supervision process which includes scrutiny of actual care delivery and records so as to enable corrective action to be taken if required, as in Recommendation One.***
- ***The implementation of this Recommendation is monitored by periodic audit.***

.....

Risk Management

- 10.34 From the documentation examined it was not clear that the CMHT had a properly managed process to routinely handle referrals. Such a process would have included appropriate information gathering and senior clinical scrutiny. The emails and

document available to the Investigation Panel do not indicate that the referral of Mr C was discussed at any CMHT referral meeting or that the consultant was actively involved in contributing to decisions as to how this transfer should be handled.

Recommendation Four

It is recommended that:

- **Meetings in which clinical decisions are made about an individual's care be organised so as to ensure that the necessary clinical records have been reviewed prior to the team making decisions about the care of the patient.**
- **The effective implementation of this recommendation be monitored within the Team Supervision Process as outlined above in Recommendation One.**
- **The standard practice of clinical teams in relation to this recommendation is monitored by periodic audit.**

.....

See also Recommendation Eight

10.35 The Investigation Panel found that in relation to Mr C there are several areas of concern regarding the identification of risk, the recording of relevant information, the sharing of information, and the management of risk by the agencies involved. Information in past clinical records was not utilised nor were standard risk forms completed properly. Evidence showed that written information was not shared between the CMHT and other agencies in relation to Mr C's risk management, and therefore relapse indicators were not responded to by the service.

Recommendation Five

It is recommended that:-

- **Within both Trusts risk assessments and management plans are completed within an agreed acceptable timeframe and that these are reviewed at significant points of clinical decision making for all patients, and shared with all professionals involved in their care to inform current risk management.**
- **Supervision facilitates the routine review of actual cases to ensure this is embedded as part of standard clinical practice, and to enable corrective action to be taken if required, as in Recommendation One.**
- **The implementation of this Recommendation is monitored by periodic audit.**

.....

Recommendation Six

It is recommended that:-

- ***Within both Trusts the Quality Assurance Programme is revised to ensure that Teams assessing and caring for psychiatric patients are producing Care Plans that reflect a comprehensive understanding of the current psychiatric, social, family circumstances and risk characteristics of the individual they are treating.***
- ***These audits form part of regular Clinical Governance Team Meetings.***

.....

Discharge and Transition Process

- 10.36 The discharge and transition process from inpatient forensic services to local community services was flawed. The Investigation Panel found that there was a poorly managed transition with both the discharging and receiving services diverted from focussing on identifying Mr C's care needs in a community setting by attending to practical obstacles, such as funding and Mental Health Act problems. Furthermore there was a lack of clarity in relation to handover between the forensic link worker, Mr C's community care coordinator, CRP's key worker and his psychologist and their respective roles and responsibilities in regard to Mr C's discharge.
- 10.37 From the documentation seen it was unclear whether the CMHT had a properly managed process to routinely handle referrals which would have included appropriate information gathering and senior clinical scrutiny. The emails and document available to the Investigation Panel do not indicate that the referral of Mr C was discussed at any CMHT referral meetings or that the consultant was actively involved in contributing to decisions as to how this transfer should be handled.

Recommendation Seven

It is recommended that:

- ***Within both Trusts all transfers and discharges of patients follow a comprehensive protocol that sets out a checklist. The Investigation Panel are aware that the North London Forensic Service have developed and are now using such a list. CANDI should consider developing a similar process for all external and internal transfers and discharges.***
- ***Supervision facilitates the routine review of actual cases to ensure this is embedded as part of standard clinical practice, and to enable corrective action to be taken if required, as in Recommendation One.***

- ***The implementation of this Recommendation is monitored by periodic audit.***

.....

Medication

- 10.39 Mr C's treatment resistant schizophrenic illness and his physical sensitivity to clozapine (tendency for his white blood cell count to drop) made the management of his psychotic symptoms more complex. Although this was recognised in earlier care plans these issues and the importance of monitoring of clozapine was not recognised in the documentation sent to, or sought by the CANDI CMHT.
- 10.40 In the case of both Mr C, following discharge, and Mr D, the record of CPA meetings, and subsequent care plans did not include a list of medication or details of treatment (including psychological treatment). The care plans therefore omitted an essential component of their care and treatment. The CRP notes indicate that both Mr C and Mr D were receiving prescribed medication, but the CMHT care plans do not acknowledge the essential importance of medication in the men's treatment.

Recommendation Eight

It is recommended that: -

- ***CANDI's Medical Director informs all doctors in the Trust's Psychiatric services that they have a duty to ensure participation in the multidisciplinary decisions made for patients for which they are responsible.***
- ***The Trust's Medical Director to inform all doctors in the Trust Psychiatric services that they have a duty to ensure that a patient's medication is appropriate, and being suitably managed within the CPA process.***
- ***The implementation of this Recommendation is monitored by including this issue in individual and group supervision at all levels, and by periodic audit.***

.....

Supervision

- 10.41 The poor execution of CPA processes, the omissions in risk assessment and recording, the routine failure to make contemporaneous progress note entries, the long gaps without seeing patients on CPA, the lack of management of care coordinator caseloads all suggest a lack of appropriate supervision and systems to address deficiencies if they are identified.

See Recommendation One

Clinical Leadership

- 10.42 The Investigation Panel found that the position of the forensic consultant as leader within the clinical team in regard to Mr C's transfer to the community was unclear. The consultant was present in the ward round discussions, CPA meetings and Mental Health Act Managers Hearings, but there were a number of ways in which the team's management of Mr C's discharge would have benefited from greater leadership from the consultant. He did not become aware that the two basic clinical documents, the medical discharge summary and CPA care plan had not been sent to the community mental health team until the internal investigation following the homicide. He did not take a lead in communicating with the community consultant or in clarifying the Mental Health Act issues, or challenging the Mental Health Act Administrator's assertion about the Community Treatment Order.
- 10.43 The Investigation Panel found that there was a lack of clarity in regard to the roles and responsibilities of the Community Team Manager and Consultant as leaders within the CMHT in regard to Mr C's transfer to the community. Mr C's referral to the CMHT and his initial management did not have medical input from the CMHT until November 2010, two months after his discharge into the community. There was no protocol for accepting cases from the forensic services and no expectation that the consultant psychiatrist or other experienced psychiatrist would be proactively involved in developing the community care plan for such a patient.

Recommendation Nine

It is recommended that:

- ***Both Trusts review their guidance to consultants ,managers and senior clinicians making explicit the Trust's expectations with regard to their role in leading the teams in which they work.***
- ***The effectiveness of implementing this guidance is monitored through normal appraisal processes.***

.....

Use of the Mental Health Act

- 10.45 The actions of the Hospital Managers under the Mental Health Act and in particular the memo from a member of the Mental Health Act Administration Team led to confusion about Mr C's status under the Act and to the abandonment of plans to place Mr C under a Community Treatment Order (CTO).

10.46 The clinical team at the time did not challenge the issue of the CTO which they would have been justified in doing, and the Managers under the Act did not appear to understand the consequences of their comments about being minded to consider discharging Mr C.

Recommendation Ten

It is recommended that:-

- ***BEH review the regular training for the Trust's Managers under the Mental Health Act and ensure that regular meetings occur between the Managers and clinicians involved in Managers' Hearings to facilitate effective working.***
- ***The implementation of this Recommendation is monitored by including this issue in individual and group supervision for those clinicians involved in such hearings, and by periodic audit of decisions recorded by Managers.***

.....

10.47 The Investigation Panel requests that both Trusts consider this report and its recommendations and sets out actions that will make a positive contribution to improving local mental health services.

Interview Letter

Appendix One

(The following is the basic text of the letter sent to all those invited to meet the investigation panel to give evidence. The list of areas for discussion, and other details varied according to the involvement of the individual to whom it was written.)

NHS London has set up an independent investigation into the care and treatment provided to Ms B prior to the tragic death of Mr under the auspices of HSG (94) 27. *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005

The panel consists of: -

On examination of the records provided to us, you have been identified as someone who might be able to provide us with information regarding the incident, or someone who may be able to assist us in understanding current systems and practice. Listed below are some of the areas that I and my colleagues would like to discuss with you, although there may be other questions that arise during the course of the meeting. If you wish to raise any other matters with us relating to this case please feel free to do so.

1. Your qualifications and experience.
2. Your role and responsibilities.

An appointment has been arranged for you to meet with my colleagues and myself at theon We expect the interview will be approximately an hour in length, but may be shorter or a little longer depending on the material we are discussing.

It would be helpful if you could provide a statement of your involvement with Ms B setting out responses to the questions within this letter. In order to ensure that the investigation panel has time to examine your statement please forward it to..... at the address on this letter.

Copies of the Terms of Reference and the agreed Procedure for the investigation are enclosed for your information. Please read them carefully as they are designed to ensure that the investigation is a constructive process and that the investigator acts fairly. I wish to draw your attention in particular to the fact that you may be accompanied to this meeting by a friend, relative, representative, or some other person of your choosing.

The meeting will be recorded and transcribed and a copy sent to you so that you can check its accuracy.

You should be able to access a copy of the case notes in order to prepare for the meeting and these can be obtained by contacting at the Trust. Complete copies of the documentation received by the panel will also be made available for your use at the meeting.

I wish to assure you that the members of the panel appreciate how stressful this can be and will do all we can to reduce that anxiety. We intend that this investigation will be a constructive

process that examines ways in which the delivery of some mental health services may be improved.

Thank you for your cooperation and assistance. Please do not hesitate to contact me if you require clarification or assistance on any point.

Yours sincerely,

Documentation Received

Appendix Two

BEH

Clinical Records – Forensic Service Mr C

Pre Incident

- RiO progress notes
- Care Plans
- Assessments and Discharge Summaries
- Correspondence
- CRP care plans
- CRP contact sheets
- E-mail Correspondence
- From BEH

Mental Health Act Hospital Managers Hearing Reports

Risk assessments – HCR20

Desktop review documentation

Post Incident – Mr C

RiO progress notes 2012/2013

Psychiatric Reports for the Court

Discharge pathway

Partnership working protocol

Discharge checklist

CANDI

Clinical Records – Mr D

- Care Plans and risk assessments
- Discharge Summaries
- Correspondence on RiO
- Physical health Information (RiO)
- CRP care plans
- CRP contact notes and Correspondence

Action Plans
Response to community consultation
Practice supervision framework
Joint supervision policy
Clozapine policy
Whistle blowing policy
Clinical risk policy
Pharmacy review and action plan
CPA policy

Joint Investigation Documentation

Investigation panel correspondence
Incident Background and investigation set up
Witnesses – interviews and correspondence
Contact with family members
Relevant policies and protocols
Mr C chronology
Mr D chronology
Final report drafts and correspondence
One Housing
Final Report
Action Plans – BEH and CANDI

Community Resettlement Project

Customer handbook
Service criteria
Contractual arrangements between residents and CRP
Contact notes – Mr C and Mr D

Investigation Procedure

Appendix Three

1. All meetings of the investigation will be held in private. The press and other media will not be invited to attend.
2. Staff to be interviewed will receive a letter in advance of appearing to give evidence informing them:
 - of the terms of reference and the procedure adopted by the Investigator;
 - of the areas and matters to be covered with them;
 - that when they give oral evidence they may raise any matter they wish which they feel might be relevant to the Investigator;
 - that they may bring a member of a defence organisation, a friend, relative, colleague or member of a trade union, provided no such person is also a witness to the Investigation;
 - that it is the witness who will be asked questions and who will be expected to answer;
 - that their evidence will be recorded and a copy sent to them.
3. The findings of the Investigation and any recommendations will be presented to the Trust.
4. The evidence which is submitted to the Investigator either orally or in writing will not be made public by the Investigator, except within the body of the final report.
5. Findings of fact will be made on the basis of the evidence received by the Investigator. Comments that appear within the narrative of the report and any recommendations will be based on these findings.

Glossary

Acuphase	A short acting depot antipsychotic drug used in periods of acute psychotic disturbance
Aripiprazole	A newer (atypical) antipsychotic drug used to treat psychosis in schizophrenia
A&E:	Accident and Emergency
ABH:	(Assault occasioning) actual bodily harm
AMHP:	Approved Mental Health Practitioner
Amisulpride:	A newer (atypical) antipsychotic drug used to treat psychosis in schizophrenia and episodes of mania in bipolar disorder
BD or bd:	From the Latin 'bis die' and used to indicate medicine to be taken twice daily
Carbamazepine:	An anticonvulsant and mood-stabilizing drug used primarily in the treatment of epilepsy and bipolar disorder .
Care coordinator:	a mental health professional specifically identified to coordinate and manage the package of care for a service user under the auspices of the CPA
Chlorpromazine:	An older (typical) antipsychotic drug
CMHT:	Community Mental Health Team
CPA:	Care Programme Approach (A system of delivering care to individuals with a mental illness, introduced in England in 1991)
CPN:	Community Psychiatric Nurse
CTO:	Community Treatment Orders were introduced in November 2008 and give powers to the individual's consultant to recall the person to hospital if they breach a mandatory condition of their discharge from hospital
Doxepin	An anti depressant drug
Duty Worker	A member of a team (often part of a larger team such as a CMHT) who deals with people newly referred to the team, usually making an initial assessment of the person's needs
Fluoxetine:	An antidepressant of the selective serotonin reuptake inhibitor (SSRI) class.

Flupentixol Decanoate	An older antipsychotic drug used in the treatment of psychosis and given orally or as an intramuscular depot
GBH:	(Assault occasioning) grievous bodily harm
GP:	General Practitioner
HMP:	Her Majesty's Prison
HCR-20:	The Historical, Clinical, Risk Management-20 is an assessment tool that helps mental health professionals estimate a person's probability of violence
HTT:	Home Treatment Team
MAPPA:	Multi Agency Public Protection Arrangements
MHA:	Mental Health Act 1983
MDT:	Multidisciplinary team
MHS:	Mental Health Services
NICE:	National Institute for Health and Clinical Excellence
Neutropenia	The presence of abnormally few neutrophils (a type of white blood cell) in the blood, leading to increased susceptibility to infection
Olanzapine	A newer (atypical) antipsychotic drug used to treat psychosis in schizophrenia and episodes of mania in bipolar disorder
OD or od:	From the Latin 'omne in die' and used to indicate medicine to be taken once daily
PDP:	Personal Development Planning or Personal Development Plan
Procyclidine:	A drug affecting a particular chemical system in the body (cholinergic system) used in mental health for the treatment of drug-induced parkinsonism.
Quetiapine:	An atypical antipsychotic drug used to treat psychosis in schizophrenia and episodes of mania in bipolar disorder
RAG:	Red/Amber/Green (A system for indicating levels of priority or levels of risk)
Responsible Authority:	In relation to a patient detained in a hospital under the Mental Health Act 1983 this usually means the responsible Primary Care Trust, Strategic Health Authority, Local Health Board, Special Health Authority, NHS Trust or Foundation Trust.
RiO:	Mental health electronic records

Risperidone	A newer (atypical) antipsychotic drug used to treat psychosis in schizophrenia
RMN:	Registered Mental Nurse
Salmon principles:	The six cardinal principles of fair procedure under the Tribunals and Inquiries Act 1921 devised by Lord Justice Salmon, who, in 1966, chaired a Royal Commission on Tribunals of Inquiry following dissatisfaction with procedural aspects of Lord Denning's inquiry into the Profumo affair.
Sodium valproate:	An anticonvulsant drug used in the treatment of epilepsy , and many psychiatric conditions requiring the administration of a mood stabilizer .
SOVA:	Safeguarding of Vulnerable Adults
SpR:	Specialist Registrar is a doctor in a higher training grade post and will have gained membership of the Royal College of their chosen specialism.
TDS or tds:	From the Latin 'ter die sumendus' and used to indicate medicine to be taken three times daily
Zuclopenthixol	An older antipsychotic drug used in the treatment of psychosis and given orally or as an intramuscular depot.