



Independent Investigation into the Care and Treatment of Mr DE

Commissioned by NHS England, London Regional Office

Prepared by

Mr Anthony R Thompson,
Lead Investigator, Caring Solutions (UK) Ltd

Dr Michael Rosenberg,
Independent Consultant Psychiatrist, Caring Solutions (UK) Ltd

Ms Maggie Clifton,
Investigations Manager, Caring Solutions (UK) Ltd

25 February 2014



Date of Publication: 14th July 2014

Contents

	Contents	3
	Acknowledgements	5
1.	Executive Summary	7
1.2	Introduction	7
1.2	Purpose	8
1.3	Terms of Reference	8
1.4	Methodology	9
1.5	Internal Investigation Report	9
1.6	Summary of Main Findings and Conclusions	10
1.7	Recommendations	12
	Main Report	
2	Terms of Reference	15
2.1	Commissioner	15
2.2	Terms of Reference	15
2.3	Approach	15
2.4	The Review Team	15
2.5	Principles of the Investigation	16
2.6	Procedure	17
2.7	Principles of Mental Health Services	17
3	Introduction	19
3.1	Summary of the Incident	21
3.2	Background and Context – The Victim	21
3.3	Background and Context – Mr DE	22
3.4	Methodology	24

4	Findings	29
4.1	Chronology of Events	29
4.2	Notable Practice	41
4.3	Patient Factors	42
4.4	Staff Factors (Care Delivery Issues)	44
4.5	Task Factors (Service Delivery Issues)	45
4.6	Examination of Risk Assessments	52
4.7	Examination of the Adequacy of Care Planning	54
4.8	The Trust’s Early Intervention Service	55
4.9	Contributory Factors	59
5	Lessons Learned	63
6	The Adequacy and Appropriateness of the Internal Investigation	67
6.1	Review of Internal Reports	67
6.2	Observations	70
7	Review of Progress Made by the Trust in Implementing the Action Plan from the Internal Investigation	81
8	Summary of Findings and Conclusions	91
9	Recommendations	93
	Appendices	95
Appendix 1	South London and Maudsley NHS Foundation Trust – Reports, Policies and Protocols Reviewed	97
Appendix 2	National Guidance and Research Reviewed	98
Appendix 3	The Independent Investigation Panel	99
Appendix 4	Abbreviations and Definitions	100
Appendix 5	Anonymisation Index	101
Appendix 6	National Guidance on the Early Intervention Service Model	102

Acknowledgements

The Independent Investigation Panel would like to thank all participants in this inquiry who assisted us in gaining a better understanding of the pertinent issues in this case. We interviewed staff of the South London and Maudsley NHS Foundation Trust. Our report is informed by their excellent contributions and we are most appreciative of their willingness to be interviewed and to express their views.

We wish to record our thanks to Michelle Davis who worked hard to ensure that effective liaison took place, that records and documents were made available to us, and that interviews were arranged.

We are grateful to the Internal Investigation Team and Board Level Inquiry from the Trust who compiled a most comprehensive report to which we were able to refer.

These contributions resulted in a comprehensive review of the issues raised in this case, which gave the Trust Board an understanding of the context of this homicide, and provided them with contemporary information with which to make additional recommendations.

Finally, we wish to thank Mr DE for agreeing to meet with us along with members of his clinical team and to provide us with a view.

Executive Summary

1.2 Introduction

- 1.1.1 Caring Solutions (UK) Ltd. was commissioned by NHS England (London) to undertake an Independent Investigation of the care and treatment provided to Mr DE by South London and Maudsely NHS Foundation Trust ('the Trust'). This is the report of the results of this investigation.
- 1.1.2 On 19 November 2011 Mr DE was arrested, charged with the murder of a young woman known to him and remanded in custody. Mr DE was being provided with mental health services by the Trust at the time of the offence. He had an initial admission to hospital in March 2011, detained under Section 2 of the MHA 1983, (amended in 2007), following an incident for which he was eventually convicted of a public disorder offence. He was discharged and continued to receive care and treatment from the Lewisham Early Intervention Service (EIS) at the time of the homicide. There is no evidence in his primary care records of any previous diagnosis of, or treatment for, mental health problems. Mr DE pleaded guilty to manslaughter by reason of diminished responsibility on 14 January 2013. Consequently there was no contested trial. On 22 February 2013 Mr DE was detained under Section 37 (41) of the MHA 1983 (amended 2007) and transferred from prison to a medium secure hospital.
- 1.1.3 The victim, Miss FG, was Mr DE's girlfriend. She had been a 'looked after' child in the care of the London Borough of Lewisham from the age of six to eighteen years, when she was looked after by foster carers. During her teenage years she was known to have frequented risky locations and had been found in the company of older men. Miss FG moved into independent accommodation when she was 19 years old, and was receiving support from the Lewisham Leaving Care Service. In 2011 Miss FG had spoken of having a boyfriend but his identity was not disclosed to any of the agencies concerned with her welfare. She had difficulties living in her own flat and stayed at the home of a 45 year old man (the perpetrator's uncle) for a few months before her death. It is believed that, whilst she was staying with this man, an intimate relationship evolved with the perpetrator Mr DE.
- 1.1.4 This report is informed by the Trust's Internal Investigation (Level Two) process, including a Board Level Inquiry (BLI, details in Appendix Four) and resulting report which was also compiled to meet the criteria of an Immediate Management Review as part of a Domestic Homicide Review (DHR). The Independent Investigation Panel have tried to avoid duplication of the process of the DHR and this was made possible by the clear Terms of Reference from NHS England. The investigation was further informed by interviews of key stakeholders, review of Mr DE's health records (for which he had provided his consent), and Trust policies and procedures. National guidance was also reviewed, as appropriate to Mr DE's care and treatment.

1.2 Purpose

- 1.2.1 NHS England (London) commissioned the independent investigation. An independent investigation has to be conducted when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the incident, including receiving care under the Care Programme Approach (CPA). The purpose is to examine all the circumstances surrounding the provision and delivery of the care and treatment, to identify any errors or shortfalls in the quality of the service, and to make recommendations for improvement as necessary.

An independent investigation should be undertaken in the following circumstances:

when it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death. There is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.

where NHS England (London) determines that an adverse event warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.

1.3 Terms of Reference

- 1.3.1 The Independent Investigation Panel was required to address the Terms of Reference agreed with NHS England (London).
- 1.3.2 The aim of the independent review is to evaluate the mental health care and treatment provided to Mr DE 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 investigation;
 - involving the families of both Mr DE and the victim as fully as is considered appropriate in liaison with the police;
 - 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 DE and a review of the relevant documents;
 - the appropriateness and quality of assessments and care planning;
 - the extent to which Mr DE's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies;
 - consider other such matters as the public interest may require; and

- complete an Independent review report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

Additional details are set out in Section 2 of this report.

1.4 Methodology

1.4.1 The independent investigation process was informed by:

- an interview with Mr DE (perpetrator);
- interviews with staff members from the Trust who were involved with Mr DE's care and treatment, or who were responsible for policy making and implementation of policy in the Trust;
- a review and analysis of Mr DE's health records including those from primary care and the Trust which provided in-patient and community-based care;
- a review and analysis of the Trust's key policies and procedures in place at the time of the homicide (November 2011) and currently;
- an audit and analysis of the Trust's internal serious untoward incident report and the Board Level Inquiry completed in May 2012 and
- a review of relevant national policy guidance.

1.4.2 The Panel used the Root Cause Analysis (RCA) framework to review and analyse the information collected.

1.4.3 The Independent Inquiry Panel attempted to interview the perpetrator's nearest relatives but despite several attempts they did not give permission for contact details to be forwarded to the panel. The victim's mother had not been in contact with her for some time and had not provided any useful information to the DHR so the panel decided not to try to trace her. The panel did attempt to trace the victim's foster carer but were informed that the foster carer had left employment with the agency contracted to provide care to the victim and could not be traced. In addition, we were informed that the relationship between the victim and perpetrator had commenced after the foster carer had ceased contact with the victim, so she would have been unlikely to add anything substantive to the report. However, it transpired from information to the Court that in fact this was not the case and that the foster carer was in contact with the victim the day before the homicide. The fact remains that the foster carer could not be contacted. The panel had wished to speak to someone who could have put the victim's point of view but this proved not to be possible.

1.5 Internal Investigation Report

1.5.1 The Independent Investigation Panel were impressed by the thoroughness of the internal investigation; the additional 'quality assurance' process of the Board Level Inquiry; by the efforts that had been made to complete actions arising from the action plan; and by the data the Trust was able to provide to demonstrate completed actions. The Trust Board clearly took a serious and measured approach to the opportunity to

learn lessons about its services. The Board Level Inquiry also identified that there was a wider problem in the functioning of CPA systems within the Lewisham EIS and in the wider service.

1.5.2 A number of recommendations were made by the Internal Investigation Team. These were recommendations regarding the importance of CPA processes and documentation, training needs in relation to CPA, clinical and operational systems within the Lewisham EIS, the structure of the Lewisham EIS care and discharge planning, carers' assessments and the involvement of families and carers to inform care and treatment decisions.

1.6 Summary of Main Findings and Conclusions

1.6.1 At the end of the investigation and after reviewing all the evidence, the Panel concluded that there were a number of items of notable practice in the overall care and treatment provided to Mr DE by the Trust. There were also a number of weaknesses, in both professional practice and the organisation of services.

1.6.2 Positive practices were identified as follows:

- appropriate diagnosis and treatment during Mr DE's in-patient treatment and on discharge;
- appropriate risk assessment and documentation when he was an in-patient;
- detailed risk assessment by the Assessment and Brief Treatment team (ABT) at the seven day follow-up after discharge;
- care plans recorded during the hospital admission;
- good practice by the Community Outreach Service (COS) Welfare/Vocational Specialist, appropriately recorded;
- inter-ward transfers were well-documented and appropriate documentation and care plans were handed over; and
- prompt and appropriate referral to the EIS.

1.6.3 Care delivery problems included:

- inadequate risk assessment, leading to a number of historical risk factors apparently not being taking into account;
- limited number of contacts made by Trust professionals with Mr DE after his discharge (13, of which five were by telephone) over a six month period, despite the fact that Mr DE was new to community mental health services and had a history of risk behaviours;
- care plans were not documented, so that the effectiveness of care against plans could not be evaluated; and
- the interpretation, application and implementation of the CPA was a fundamental weakness

1.6.4 Together, these represent failure to adhere strictly to both national and local policies. In addition, the Independent Investigation Panel noted the following:

- over-reliance on information provided by Mr DE to the care team;
- lack of monitoring closely his compliance with medication, including checking with his GP regarding Mr DE collecting his prescriptions – identifying that he was not collecting his prescriptions might have triggered a more assertive approach to Mr DE about compliance with medication;
- social circumstances report not updated;
- lack of a carer's needs assessment;
- four ward moves during his four week in-patient stay, the final one to a different hospital and discharge after taking his medication for less than one week - possibly indicative of pressures on in-patient beds in the Trust; and
- formal mental state examinations not carried out within Mr DE's community-setting, which might have elicited information indicative of recurring psychotic symptoms.

1.6.5 Service delivery problems included:

- heavy case-load of the Lewisham EIS at the time of Mr DE's referral;
- delay in allocating an EIS specialist consultant to oversee his care and treatment; and
- the geographical spread of the Lewisham EIS team across three locations, leading to difficulties for the team in acting as a specialist team and for the team manager in providing clinical supervision.

1.6.6 Together, these failings indicate that the Lewisham EIS did not comply with the 'gold standard' EIS model of a 'stand alone' team.

1.6.7 However, despite the above failings which were identified, the Panel concluded that nothing in Mr DE's presentation during his contacts with mental health professionals and services was predictive of the homicide and that the homicide would not have been prevented even if these weaknesses had not occurred.

1.6.8 The Independent Investigation Panel concluded that the Internal Investigation as supplemented by the BLI was thorough and comprehensive, that the recommendations followed on from the findings, and that an appropriate action plan had been agreed through the Trust processes.

1.6.9 The Trust has achieved progress towards full implementation of the actions identified, including those addressing the care delivery problems. Additional consultant time has been recruited to the Lewisham EIS. However, the difficulties of identifying a suitable single location for the team means that they are still not operating from the same base and a decision has been taken to defer this move until a more extensive restructure of the Adult Mental Health Services have been completed, expected in March/April 2014. The number of locations has, however, been reduced from three to two and 'zoning meetings' are now held three times a week (zoning meetings are explained in Appendix Four. The Trust reports that this increase in 'zoning meetings' appears to have led to 'more proactive management of the clinical risk and staff anxieties about the risk'. (Trust information, provided October 2013)

1.7 Recommendations

1.7.1 We have made a limited number of recommendations which are rooted in the actions already being taken as a result of the internal investigation. These are intended to encourage partnership, effective EIS outcomes and the dissemination of learning from good practice. These recommendations are:

1. That the implementation process of actions required to ensure compliance with Recommendation One of the internal investigation (risk assessment, care planning and performance management) is kept under regular review and an audit of progress is conducted before the end of 2013 to be considered by the Board.
2. That when changes are made to the organisation of the EIS, a specific audit of the quality of documentation is undertaken to measure fidelity with the Trust's policy standards and intended outcomes.
3. That the initiative being undertaken to acquire 'fit for purpose' accommodation for the Lewisham EIS to be subject to on-going evaluation of progress and quarterly reports be submitted to and considered by the Trust Board.
4. That the restructure of the Lewisham EIS aimed at producing a more integrated team, be subject to on-going evaluation of progress with bi-annual reports to the Trust Board.

1.7.2 In addition to supporting recommendations from the Trust's Comprehensive Level Two report, the Independent Investigation Panel would add:

1. That the Trust review how their EIS teams monitor compliance with medication, including checking that prescriptions have been collected and taking an assertive approach to medication compliance where there is reason to believe that this may be an issue.
2. The Trust stress the importance of a comprehensive social circumstances assessment which is updated and of the carer's needs assessment, to collect comprehensive information as one component of care planning and care provided. This is particularly relevant with a high risk, complex and sometimes transient population.

Terms of Reference

2 Terms of Reference

2.1 Commissioner

2.1.1 This independent review is commissioned by NHS England (London) 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.

2.2 Terms of Reference

2.2.1 The aim of the independent review is to evaluate the mental health care and treatment provided to Mr DE 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 investigation
- Involving the families of both Mr DE and the victim as fully as is considered appropriate in liaison with the police
- A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident:
- A examination of the mental health services provided to Mr DE and a review of the relevant documents
- The appropriateness and quality of assessments and care planning
- The extent to which Mr DE's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- Consider other such matters as the public interest may require
- Complete an Independent review report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

2.3 Approach

2.3.1 The review 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.

2.3.2 If the review team identify a serious cause for concern then this will immediately be notified to the Investigations Manager, NHS England (London).

2.4 The Review Team

2.4.1 The review team will consist of appropriate qualified senior professionals:

Consultant Psychiatrist
Project Manager from Caring Solutions

2.5 Principles of the Investigation

2.5.1 Approach

The investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations. Should the reviewers identify a serious cause for concern, this should be notified to NHS England and the Trust immediately.

2.5.2 Publication

The outcome of the review will be made public. NHS England will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the investigation panel, relatives and other interested parties.

2.5.3 Data Protection

The completed investigation reports contain details of the clinical care and treatment the service user received and is therefore subject to the Data Protection Act and if made public could also breach the Human Rights Act. It is the responsibility of NHS London to ensure that there is a balance within the report that would protect the rights of those individuals involved in the incident whilst also discharging its duty to publish what is deemed to be in the public interest.

2.5.4 Support to Victims, Perpetrator, Families and Carers

When an incident leading to death or serious harm occurs, the needs of those affected should be of primary concern to the Foundation Trust, NHS England and the Independent Investigation Panel. This should be reflected through the principles of the National Patient Safety Agency (NPSA) guidance, which are:

- the principle of acknowledgement;
- principles of truthfulness, timeliness and clarity of communication; and
- the principle of apology.

2.5.5 The family of the perpetrator was offered a meeting with the Independent Investigation Panel, unfortunately they did not respond. The foster carer of the victim could not be contacted.

2.5.6 In general families wish to:

- know what happened;
- know why it happened;
- know how it happened;
- know what can be done to stop it from happening to someone else; and
- tell their account of events.

2.5.7 It is important that the debate on the matters of public concern which may arise from this case are grounded on an accurate account of the facts.

2.6 Procedure

2.6.1 All inquiries have to consider what procedure is appropriate for the particular issues to be considered. The objectives must be to conduct an inquiry which as far as is practicable:

- investigates thoroughly the matters within the terms of reference;
- ensures objectivity;
- ensures all the relevant information is considered;
- is fair to those who are under scrutiny;
- recognises the position and interests of all those concerned with the events which led to the inquiry.

2.7 Principles of Mental Health Services

2.7.1 The Independent Investigation Panel believes that at the core of any mental health service delivered to people with a mental disorder there must be four principles:

- Clarity in current diagnosis, objectives, needs, changing the diagnosis, needs and risk assessment and the strategies to clarify and deal with them.
- Coordination of the delivery of service, sharing of information, and action.
- Checking on the outcome of service provision by regular review.
- Changes in the diagnosis needs and risk assessments, and service provision in light of the review.

Introduction

3 Introduction

3.1 Summary of the Incident

3.1.1 Limited information about the immediate circumstances leading to the killing of Miss FG is available. The only sources are Mr DE whose recollections are either partial or he is reluctant to provide the information; information from the Judge's Sentencing Remarks and from prosecution evidence. Although the timing and context of the first meeting between the victim and Mr DE is difficult to establish, police intelligence indicates that they probably knew each other for some six months prior to the incident.

3.1.2 No formal statutory records exist which link the victim to the perpetrator before the events of 19 November 2011. There are acknowledgements from the social care agencies that it was known that Miss FG had a boyfriend during this period but his identity was not disclosed.

- The homicide investigation conducted by the Metropolitan Police indicated that the victim's relationship with Mr DE had been established for approximately six months.
- On 19 November 2011 the uncle of Mr DE called the London Ambulance Service to his flat. He reported that a 22 year old woman in the flat had been stabbed. The ambulance service requested police assistance. On arrival at the scene of the incident the police were told that the man responsible for the attack was still inside the premises and he was armed with a knife. The police then entered the flat and arrested Mr DE.
- The victim, Miss FG, was found lying on a mattress in the front room suffering from multiple stab wounds. Helicopter Emergency Medical Services supported the ambulance service. Despite these efforts, Miss FG was pronounced dead at the scene of the incident.
- The Metropolitan Police Service undertook the homicide investigation. Post mortem examination on Miss FG recorded death being caused by haemorrhage and multiple stab wounds.
- Mr DE was charged with the murder of Miss FG and was remanded in custody. He pleaded guilty to manslaughter by reason of diminished responsibility at the beginning of his trial on 14 January 2013 and this plea was accepted by the prosecution. Consequently the case was not contested.
- On 22 February 2013 Mr DE was detained under Section 37 (41) of the MHA 1983 (amended 2007).

3.2 Background and Context – The Victim

3.2.1 The victim, Miss FG, had been a 'looked after' child in the care of the London Borough of Lewisham from the age of six to eighteen years, when she was looked after by foster carers. During her teenage years her apparent vulnerability increased. This manifested

in a breakdown of supportive foster care, she frequented risky locations and had been found in the company of older men.

- 3.2.2 Miss FG had been referred informally to the Croydon Child and Adolescent Mental Health Service (CAMHS) in 2009 by the Croydon Young Offenders Team. The referral was declined as she was 18 years of age and therefore did not meet the criteria for CAMHS engagement.
- 3.2.3 Miss FG moved into independent accommodation when she was 19 years old. At the time of her death Miss FG was receiving support from the Lewisham Leaving Care Service. Although Miss FG had her own flat there were a number of reports via social care agencies which indicated that from July 2010 she was not residing there on a regular or consistent basis.
- 3.2.4 In October 2010 she was defaulting on the rent and by the end of 2010 was at risk of eviction. Subsequently, there were concerns over her tenancy although it was not known precisely when she stopped occupying her flat. An eviction notice was finally issued on 26 September 2011.
- 3.2.5 During 2011 Miss FG had spoken of having a boyfriend but his identity was not disclosed to any of the agencies concerned with her welfare. It appears likely that she stayed at the home of a 45 year old man (the perpetrator's uncle) for a few months before her death. The nature of the relationship between the two parties was unknown to those agencies who contributed to the Domestic Homicide Review which reported in April 2013. However, whilst she was staying with this man it is believed that an intimate relationship evolved with the perpetrator Mr DE.

3.3 Background and Context – Mr DE

- 3.3.1 Mr DE was six years of age when, in 1997 he moved from Jamaica to the UK to stay with his mother and two sisters in Lewisham. No statutory agency involvement in his earlier life of particular note is recorded until 2011. Until this juncture he had not presented with any significant concerns to either primary health care or secondary mental health services.
- 3.3.2 He did have brief contact with the police when they were undertaking investigations into reported robberies. He was questioned by the police as a suspect on two occasions but he was not charged due to insufficient evidence. However, one of the investigations resulted in him being convicted of driving offences.
- 3.3.3 In February 2011 the police received a report that Mr DE had been seen in possession of a knife when at the Job Centre. It was some three days after the event that the report was made and the outcome was that the information was passed to the Police Intelligence Unit. This matter was not investigated further.
- 3.3.4 On 11 March 2011 Mr DE attempted to gain entry to a house, reports indicate that the home may have been that of a previous female acquaintance. This incident resulted in Mr DE being chased from the premises by the police. He climbed onto a roof in the

neighbourhood and a 14 hour 'stand-off' occurred. During this time he threw objects at the police. A specialist negotiator was at the scene and following Mr DE's descent from the roof he assaulted a police officer.

- 3.3.5 On 12 March 2011 Mr DE was referred to the court diversion service and they arranged an assessment of his mental health. The outcome of the assessment was that Mr DE required hospital admission. The subsequent admission was under Section 2 of the MHA 1983 (amended 2007) as he was unwilling to be admitted voluntarily. This incident led to the initial involvement of the Trust. Mr DE was detained on the Assessment Ward at the Mental Health Unit (Lewisham).
- 3.3.6 Mr DE was detained under Section 2 of the MHA 1983 (amended 2007) until 11 April 2011 when the section came to an end. During his time in hospital he was transferred from the Assessment Ward to an acute ward where he remained for some three weeks. During this time he was non-compliant with medication and tested positive for cannabis. He was transferred to the Psychiatric Intensive Care Unit (PICU) for five days after becoming threatening to staff and absconding. Whilst on this ward Mr DE was subject to a medical assessment which concluded that there were 'no signs of psychosis' which would have justified an application for further detention under Section 3 of the MHA, 1983 (amended 2007). From the PICU he was transferred to an acute ward at a different hospital for a further three days until his discharge on 13 April 2011. In all, he moved ward 4 times in 4 weeks. He was diagnosed with early psychosis, later described as first onset psychosis.
- 3.3.7 On 4 August 2011 he attended a hearing at Woolwich Crown Court, pleaded guilty to the public disorder offence and was sentenced to a Community Order for 12 months with Supervision (by the London Probation Trust) with a Mental Health Requirement.
- 3.3.8 Mr DE was referred to the Lewisham EIS for assessment. His care immediately on discharge was the responsibility of the ABT team whilst he was on the waiting list for assessment. On 5 May 2011 he was accepted by the EIS team, allocated a Care Co-ordinator and placed on the CPA. He was supported by a Consultant Psychiatrist (initially from the ABT until a dedicated EIS consultant became available) and a Vocational/Welfare Specialist from the COS. He was assisted to attend a job club, to access training (as a painter and decorator), and with an application for welfare benefits. He engaged well with the vocational and training support and seemed highly motivated. He presented as generally stable for most of this time, although there were concerns that he had not collected his anti-psychotic prescription from his GP in mid-September. At the end of October his care and treatment were transferred to a new part-time EIS Consultant at a formal handover meeting at which Mr DE was present and reported not taking his anti-psychotic medication. This was the final contact with mental health services prior to the homicide on 19 November 2011.
- 3.3.9 His mother and sisters were involved in his care both through visiting him in hospital and attending meetings with the Care Co-ordinator. His mother also accompanied him to court for a hearing in respect of the public disorder charge (which was adjourned). In

June 2011 his mother had a stroke – this was described as minor, although she was relatively young to have a stroke. There is no reference to Mr DE being given any additional support after his mother’s stroke.

3.4 Methodology

3.4.1 Consent was sought by NHS England and given by Mr DE to access relevant health and other records prior to the commencement of the investigation. The independent investigation was informed by:

- Interview with Mr DE;
- Interviews with key staff, specifically:
 - Consultant psychiatrist from the ABT, responsible for his care until shortly before the homicide (Dr KL);
 - EIS consultant who took over his care shortly before the homicide (Dr MN);
 - Mr DE’s Care Co-ordinator at the time of the homicide (Mr HJ);
 - Mr DE’s current Responsible Clinician;
 - Mr DE’s current primary nurse;
 - Service Director, the Psychosis Clinical Academic Group (CAG);
 - Associate Clinical Director, Early Intervention, Psychosis CAG);
 - The Internal Investigation Team - Consultant Psychiatrist, Clinical Services Leader and Investigations Facilitator;
 - Senior managers responsible for implementation of the action plan arising from the internal investigation and Board Level Inquiry - the Deputy Director, Clinical Service Delivery – Community and the Deputy Director for Early Intervention and Complex Care, Psychosis CAG, (Ms OP)
- A review and analysis of Mr DE’s health record including primary care records, records held by the Trust responsible for his care and treatment as both on in and out-patient, clinical records held by the Trust responsible for his current care, including reports to the Court, and the Judge’s Sentencing Remarks.
- A review and analysis of the Trust’s key policies and procedures in place at the time of the homicide(19 Nov.2011) and subsequently (listed in Appendix One)
- An audit and analysis of the Trusts internal report as revised by the Board Level Inquiry and agreed by the Psychosis Clinical Academic Group (CAG) Serious Incident Panel held on 29 June 2012 (including interview summaries).

- A review and analysis of the Domestic Homicide Review (instigated by the Community Safety Partnership, Lewisham) report.
- The Panel used the RCA framework to analyse the information collected, including the completion of a detailed time line for Mr DE's involvement with services up to the date of the homicide (19 November 2011)

3.4.2 Interviews were audio-recorded and transcripts sent to interviewees for amendment if required and confirmation of accuracy.

3.4.3 The panel undertook:

- a review of the treatment and care of Mr DE provided by the Trust;
- a Root Cause Analysis;
- a review of contributory factors leading up to the homicide; and
- arising from their analysis of the findings of the investigation, the panel made recommendations for consideration by the Trust and NHS England (London) to support further organisational learning from the homicide.

3.4.4 This Level 3 (Independent) investigation was commissioned by NHS England (London) from Caring Solutions (UK) Ltd. The investigation commenced in June 2013. The Independent Investigation Panel are required to present their report to NHS England (London) for consideration and implementation.

3.4.5 A draft of this report was submitted to the Trust for factual accuracy checks, and necessary amendments made in the light of their feedback.

3.4.6 The Independent Investigation Panel was comprised of Mr Anthony Thompson, Dr Michael Rosenberg and Ms Maggie Clifton (see Appendix Three for further details). An additional member on the Panel was included by Caring Solutions UK Ltd to support the investigation process.

Findings

4 Findings

4.1 Chronology of Events

- 4.1.1 Mr DE was only known to the mental health service for ten months prior to the homicide and the chronology reflects this period. The chronology is based on the clinical records – information provided was validated and clarified by the interviews but no substantive new information was provided in this respect. It is included as required by the Terms of Reference and it reinforces the reconstruction of events, identifies any differences from the accounts presented in the internal inquiry reports and the Domestic Homicide Review report. It also helped identify areas of specific concern or consideration by the Independent Investigation Panel when they interviewed key staff and cross referenced information. Additional information was identified from psychiatric reports provided to the Court, and from interview with Mr DE. This information was not known to Trust staff at the time they were providing him with care and treatment.
- 4.1.2 On assessment by the court diversion CPN, it was recorded that his family reported that he had been smoking skunk (a strong form of cannabis).
- 4.1.3 Mr DE was admitted to an assessment ward in Lewisham on 15 March 2011. Copious notes and recorded entries in clinical files were produced during the in-patient stay, some of which add little to our understanding of the event in November 2011. The pertinent elements of these clinical notes record that, on 16 March 2011 he was reviewed in a ward round and described as “distractable, guarded and suspicious”. He denied experiencing any abnormal perceptions and ideas of reference and he did not understand why he was in the hospital. A decision was made to transfer him to an acute ward for more comprehensive assessment the following day.
- 4.1.4 During the assessment on 21 March 2011, whilst he was on the acute ward, Mr DE stated that things had gone wrong from the New Year. The impression of the ward Doctor making the assessment was that this was a first episode of psychosis and there was a link to known cannabis use. His risk to others was considered ‘low’ and he was not thought to be suicidal. The treatment plan was for continuing assessment without medication and referral to the Lewisham EIS. Home weekend leave was given on 26 March 2011.
- 4.1.5 During this time Mr DE had regular support and visits from family members. His consultant informed Mr DE on 28 March 2011 that he may have been suffering from psychosis and was prescribed anti-psychotic medication Aripiprazole. Mr DE refused this and walked out of the consultation.
- 4.1.6 The refusal to comply with medication was maintained by Mr DE over the following week and on 5 April 2011 he was restrained and medication was administered under the auspice of the Mental Health Act (MHA) 1983 (amended 2007). Shortly afterwards Mr DE became threatening towards staff. He kicked his way out of the acute ward door and absconded. He was returned by the police later that day.

- 4.1.7 The level of risk he presented together with his non-compliance with treatment resulted in a decision to admit him to a Psychiatric Intensive Care Unit (PICU). On 7 April 2011, shortly before his detention under Section 2 of the MHA 1983 (amended 2007) was due to lapse, he was assessed for detention under Section 3 of the MHA, 1983 (amended 2007), but this was not considered to be justified as there were no signs of psychosis. Mr DE remained on the PICU for five days, during which time he was described as being reasonably settled and complied with medication.
- 4.1.8 On 11 April 2011 Mr DE was transferred to another acute mental health ward at the Maudsley Hospital, as an informal patient. He remained stable and two days later at a ward round the decision was taken to discharge him.
- 4.1.9 Mr DE was then discharged that day (13 April 21011). After discharge a seven-day follow-up was planned. This was to be provided by a local ABT team while Mr DE remained on a waiting list for assessment by the EIS.
- 4.1.10 Mr DE was seen by a nurse from the ABT team for the seven day follow up, on 18 April 2011, following an ansaphone message left by the team on his mother's phone. At this point his risk to others was assessed as 'low'. This is the last documented risk assessment which has been identified.
- 4.1.11 He was then assessed for acceptance by the EIS team on 4 May 2011, although no record of the assessment was completed on the Electronic Patient Record System (ePJS). He was accepted for EIS intervention at a team meeting on 5 May 2011, allocated a Care Co-ordinator (Mr HJ) and placed on CPA. There is no record of the team meeting or of any formulation, risk assessment or any planning for care, crisis or contingency. The Board Level Inquiry noted that a risk assessment was completed at this time, but there is no record of the type or findings of this risk assessment.
- 4.1.12 A joint visit between Mr HJ and a Vocational/Welfare Specialist from the voluntary service COS was arranged and took place on 9 May 2011. Mr DE was referred to COS for employment and vocation support (he was unemployed with no day-time activities), and support with applications for welfare benefits (he was not in receipt of any benefits). Over the next three weeks, Mr DE engaged well with the COS, submitting application forms for benefits, attending a vocational assessment and job club, and showing an interest in training as a carpenter
- 4.1.13 Mr HJ visited him at home on 7 June 2011: they discussed issues, including his being stressed, which led to his hospital admission, but he did not say what the issues were. He said he was taking his medication but was not sure it was helping.
- 4.1.14 It became evident from the court reports and interview with Mr DE that he had not in fact been taking his medication most of the time he was in the community; and that for five to six months he had not resided with his mother but with an uncle. This information was not known to the Trust at the time.

- 4.1.15 On 21 June 2011 Mr HJ visited him at home again. Mr HJ reported as being low in mood, this being related to his mother's recent stroke and the court appearance the following day for the public order offence of March 2011. Mr HJ had written a letter to the court the previous day, explaining the Mr DE was under the care of the EIS team and was accepting medical and other appropriate treatment, and was intending to accompany Mr DE to the hearing. There is no reference to this hearing taking place, although interview evidence indicated that the case had been adjourned. The next reference is to a court hearing set for 20 July 2011.
- 4.1.16 From 24 June 2011 until the homicide Mr DE continued to engage with the COS worker, attended job club meetings and commenced a one-year Painting and Decorating NVQ course, attending for 3 days per week as required. His attendance was exemplary, only missing one week when he went on holiday.
- 4.1.17 On 8 July 2011 he attended job club where his vocational worker noticed a wound on his face. Mr DE reported that he had been in a fight triggered by an argument. He had attended A&E for treatment of the wound but had not reported the incident to the police.
- 4.1.18 Mr HJ telephoned Mr DE on 14 July 2011 and documented that Mr DE's mental state was 'stable and he is complying with medication'.
- 4.1.19 There is again no record of a court hearing taking place on 20 July 2011. The Independent Investigation Panel learnt from interview that the case had again been adjourned.
- 4.1.20 On 29 July 2011 Mr DE met his vocational worker at the job club and expressed interest in taking up leisure activities to meet 'positive' people and was offered a Lewisham Card Plus for him to apply for discounted membership. There is no record as to whether or not he made the application or engaged in any leisure activities.
- 4.1.21 On 1 August 2011 Mr DE was seen for a medical review with the ABT Consultant who also was treating EIS clients at that time. Mr HJ accompanied Mr DE. His behaviour leading to the charge of public disorder was discussed, but he reported feeling strange but with limited memory of it. At this review Mr DE complained of low mood, some loss of appetite and insomnia. Dr KL concluded that Mr DE was suffering a post-psychotic depression and prescribed an anti-depressant, which he did not take.
- 4.1.22 On 4 August 2011 Mr DE did appear in Crown Court, where he pleaded guilty to causing a public disorder.
- 4.1.23 He was sentenced on 31 August 2011 to a 12 month Community Order with a requirement to report to a probation officer on a weekly basis with a mental health treatment requirement. Mr HJ did not attend court with Mr DE but did telephone Mr DE to ascertain the outcome of the court appearance. Mr DE reported that he had been 'put on probation' for 12 months. He did not mention the mental health treatment requirement and no one from the Trust was informed about the mental health treatment

requirement by the probation service. (There is no evidence that a psychiatric report had been prepared for the court nor that a mental health professional had recommended or offered to provide mental health supervision as a requirement of the sentence.)

- 4.1.24 On 7 September Mr DE informed his GP that he had run out of his anti-psychotic medication three weeks previously.
- 4.1.25 On 8 September 2011 Mr HJ visited Mr DE at home and found him to be 'generally stable' and 'did not present with any psychotic symptoms'.
- 4.1.26 On 12 September Mr DE was seen for his second medical review with the ABT Consultant. The Consultant, Dr KL, recorded that Mr DE had not collected the prescription for anti-depressants and that Mr DE reported that his mood was unchanged, re-inforcing the Consultant's opinion that a trial of these drugs would 'be worthwhile'. Dr KL informed his GP.
- 4.1.27 On 17 October 2011 the ABT consultant saw Mr DE again when he reported that his mood had improved, although he had not taken the anti-depressant medication. Dr KL then recorded that the anti-depressant was probably not needed, and informed the GP.
- 4.1.28 On 31 October 2011 Mr DE attended a consultant handover meeting with both the ABT and EIS consultant (the latter recently appointed to the Lewisham team on a part-time basis). The Trust clinical record of this meeting indicates that Mr DE reported that he had not been collecting his repeat prescription and had not taken his anti-psychotic medication for a week.. Mr DE reported he was happy to take the medication and to continue to engage with EIS. His GP was informed of the situation regarding non-compliance with anti-psychotic medication. The EIS consultant also recorded that Mr DE 'seems not to be' using street drugs at this time. This was the final consultation before the homicide took place.
- 4.1.29 The Judge's Sentencing Remarks indicate that the use of skunk by Mr DE contributed to the psychotic condition evident when he stabbed Ms FG. Ms FG had also been using skunk in the period leading to the homicide. The Judge commented on the association between use of skunk (a 'very dangerous substance'), psychosis and violence in 'psychiatrically fragile' people.
- 4.1.30 On 19 November 2011 the Custody Sergeant at Lewisham Police Station contacted the Trust to request information about Mr DE's involvement with mental health services. Staff were informed that Mr DE had been arrested for the murder of a female known to him. Support was offered to staff and to Mr DE's mother. There was no further contact from the police until Mr DE was on remand in prison.
- 4.1.31 On 2 December 2011 Mr HJ and the vocational worker visited Mr DE in prison where he presented with psychotic symptoms similar to those he presented prior to his in-patient

admission in March 2011. He had refused his medication since being detained, and reported that he had not been taking his medication for four months prior to the incident.

Timeline of events

Date	Event	Source of information
11–12/03/2011	<p>Mr DE involved in a public order offence (street fight). Mr DE ran from the police and eventually climbed on a roof top after running through gardens. The situation was resolved following the intervention of a specialist negotiator</p> <p>After descending from the roof, Mr DE assaulted a police officer. He was arrested and taken into custody.</p>	Electronic Patient Journey Records (ePJS)
15/03/2011	<p>Mr DE was assessed by Court Diversion Service at Greenwich Magistrates' Court.</p> <p>The assessment concluded that Mr DE required hospital admission. This admission was under Section 2 of the MHA 1983 as he was unwilling to be admitted voluntarily</p> <p>Mr DE was admitted to Assessment Ward at the Mental Health Unit (Lewisham).</p>	ePJS
16/03/2011	<p>Mr DE was reviewed in the ward round and described as 'distractible, guarded and suspicious'. Mr DE denied any abnormal perceptions and did not understand why he was in hospital. Mr DE's speech revealed lack of spontaneity.</p> <p>Decision was made to transfer Mr DE to an acute ward for further assessment to rule out psychotic episode, drug induced psychosis or acute stress reaction.</p>	ePJS
17/03/2011	Transfer to acute ward.	ePJS
21/03/2011	<p>Mr DE was assessed by the ward junior doctor, who considered Mr DE was suffering from an episode psychosis, possibly due to cannabis use. The result of a urine test showed positive for cannabis. Mr DE stated that things had begun to go wrong since New Year 2011 – things had been confusing and had a feeling that as if he was on a film set.</p> <p>The risks identified included:</p> <ul style="list-style-type: none"> • no other risk of violence except that demonstration upon arrest; • currently presents a low risk to others; • greater risk to self through social isolation/withdrawal; and • not suicidal and no history of self harm. <p>The management plan included:</p> <ul style="list-style-type: none"> • repeat thyroid function tests in one month; • urine drug screen; • period of assessment without medication – drug free 	ePJS

	<p>period;</p> <ul style="list-style-type: none"> • referral to the Early Intervention Service (EIS); • escorted leave; • ECG; and • review. 	
24/03/2011	<p>Nursing report from Powell ward round commented that</p> <ul style="list-style-type: none"> • Mr DE was very isolated; • family visit each afternoon and return in the evening following dinner; • denies receiving messages form TV/radio at that point; • mother confirmed family stress as Mr DE was due to return to Jamaica and meet father; and • family invited to ward round. <p>Mental health state examination included the following observations:</p> <ul style="list-style-type: none"> • good self care; • laughter at times inappropriate; • reports good concentration; • believes there is something wrong with him; • no reported hallucinations. 	ePJS
26/03/2011	Mr DE on home leave for the weekend. It is reported that the visit went 'OK'.	ePJS
28–29/ 03/2011	<p>Mr DE seen in ward round. Medication was discussed with Mr DE. Aripiprazole (anti-psychotic) was suggested by the ward consultant. Mr DE refused and walked out of the meeting.</p> <p>Consultant felt that the diagnosis was of early psychosis.</p> <p>Report from Mr DE's mother that he does not want to take medication as his cousin had been an in-patient and gained significant amount of weight. She also stated that she felt her son was depressed.</p>	ePJS
30/03/2011	Social worker tried to engage with Mr DE for a social needs assessment. Mr DE refused. Assessment was to be rearranged.	ePJS
03/04/2011	Mr DE on home leave for Mother's Day.	ePJS
04/04/2011	<p>Ward round. Noted that in the preceding week, Mr DE continued to refuse to take the medication.</p> <p>The plan was for staff to continue to encourage Mr DE to take oral medication. However, if he refused, Mr DE would be given intra-muscular (IM) injection, under restraint if required. Reports that Mr DE lacks insight, that he spends significant time in his room. Mental state examination observed that Mr DE appeared</p>	ePJS

	<p>perplexed, with mood changeable.</p> <p>Plan also included</p> <ul style="list-style-type: none"> • referral to psychologist (Mr DE declined); • encourage oral medication; • referral to EIS; and • room to be locked to encourage participation in ward activities. 	
05/04/2011	<p>Mr DE continued to refuse medication. He was restrained and given the IM injection as discussed in ward round.</p> <p>He became threatening to staff (with his belt), kicked his way out of the unit and absconded. Mr DE was returned by the police at 18.00 on 5 April. The risk Mr DE posed and non compliant behaviour resulted in Mr DE being admitted to the PICU.</p> <p>It is noted that he remained on the PICU for five days and was settled and complied with medication. Section 2 expired on 11 April. Further assessment for Section 3 found that it was not justified.</p>	ePJS
11/04/2011	<p>Admitted to an acute ward at the Maudsley Hospital. It is stated that he remained stable.</p> <p>Consultant believed that Mr DE was presenting with first onset psychosis.</p> <p>Management plan included:</p> <ul style="list-style-type: none"> • general observations; • refer to CMHT for seven day follow up; • discharge on the Wednesday 13 April; and • medication Aripiprazole 10mg. 	ePJS
12/04/2011	<p>Mr DE attended court hearing (re public order offence) with mother.</p> <p>Case was adjourned,</p>	ePJS Interview
13/04/2011	<p>Mr DE was seen in ward round. Mr DE was discharged home with a seven day follow up. This was to be provided by the local ABT team. Mr DE remained on the waiting list for assessment by the EIS team.</p>	ePJS
13–20/04/2011	<p>Mr DE seen by a nurse from Northover CMHT on 18 April. Risk assessment stated:</p> <p>Risk to self and others – low:</p> <ul style="list-style-type: none"> • no aggressive behaviour; and • denial of substance misuse/alcohol. <p>Information about his prescription was faxed to Mr DE's GP.</p>	ePJS

	Reported by Mr DE that he was going on holiday with family and would contact EIS on return.	
04/05/2011	Mr DE was assessed for acceptance by EIS . While it was unclear when Mr DE contacted EIS, an arrangement was made for assessment on 9 May. Recorded that 'paperwork, details and outcome of assessment to be completed on ePJS'. No such records were found by the internal investigation.	ePJS
05/05/2011	Case presented and discussed by EIS clinical/business meeting. Mr DE was allocated a care co-ordinator and placed on CPA. There is no record of a discussion of: <ul style="list-style-type: none"> • risk; • formulation; and • care/crisis/contingency planning. 	ePJS
09/05/2011	Joint home visit to Mr DE between the care co-ordinator and the Vocational/Welfare Specialist from the Community Outreach Service (COS). Social circumstances were discussed at the home visit: at the time of the visit, Mr DE was: <ul style="list-style-type: none"> • unemployed; • no day time activities; and • no benefits received. Mr DE was referred to COS for vocational and employment activities in addition to support with applications for Employment and Support Allowance (ESA) and Disability Living Allowance (DLA). The plan further stated: <ul style="list-style-type: none"> • consultant to be confirmed by Care Co-ordinator; and • Mr DE to attend a job search club on 10 June. 	ePJS
17/05/2011	Telephone call from Mr DE to COS worker regarding benefits application. Appointment arranged for Mr DE to attend COS North on 24 May 2011 to discuss further COS/vocational support.	ePJS
24/05/2011	Vocational assessment by COS. It is noted that he showed an interest in participating in a plumbing or carpentry course. Carpentry and Joinery course assessment offered for 8 June 2011. Mother also present at this meeting.	ePJS
02/06/2011	Care Co-ordinator telephoned to arrange a home visit. Mr DE was not at home. The Care Co-ordinator spoke to Mr DE's mother, who stated that he was doing 'relatively well'. Mr DE awaiting benefit. Mr DE had been seen and supported by COS benefit specialist.	ePJS
07/06/2011	Care Co-ordinator visited Mr DE at home. Discussion occurred	ePJS

	<p>around the events that led to Mr DE admission to hospital.</p> <p>Mr DE confirmed that he was taking his medication but unclear as to whether it helped. He denied any abnormal thoughts, sleep and appetite were noted as normal. Mr DE had received benefit payment (including backdated payment).</p> <p>Sister was present during the meeting, who confirmed that mother had a minor stroke and had been hospitalised.</p>	
10/06/2011	Mr DE attended COS for job search. He agreed to attend assessment for Carpentry course.	ePJS
15/06/2011	COS volunteer support telephoned Mr DE to remind him of assessment. He arrived 45 minutes late so assessment was rearranged for 22 June. However, this was also rearranged due to court appearance.	ePJS
20/06/2011	Letter from Care Co-ordinator to Woolwich Crown Court confirming that Mr DE is under the care of the EIS team and 'is accepting medical treatment and other relevant treatment as necessary under the Care Programme Approach (CPA) with our specialist team'.	ePJS
21/06/2011	<p>Care co-ordinator visited Mr DE at home. Mother was present and presented as ill following a minor stroke.</p> <p>It was noted that Mr DE was 'low in mood' which was related to his mother's illness and to the imminent court appearance for the public disorder offence of March 2011.</p> <p>The Care Co-ordinator noted that:</p> <ul style="list-style-type: none"> • Mr DE has made good progress and currently asymptomatic; • happy to continue with the current medication; and • is highly motivated and engaging well with support services, including COS. <p>It was recorded that the Care Co-ordinator provided a supporting letter to the court. The Care Co-ordinator was also intending to accompany Mr DE at the hearing. However, there is no record that he attended.</p> <p>The case was adjourned till July 2011.</p>	ePJS
24/06/2011	Mr DE attended COS job club. Mr DE was still planning to attend Carpentry course assessment.	ePJS
01/07/2011	Mr DE attended COS job club. Meeting to be arranged with voluntary work organisation.	ePJS
06/07/2011	Mr DE reported to have attended course assessment and had registered for a NVQ in Painting and Decorating.	ePJS

08/07/2011	<p>Mr DE attended the job club. He reported that he had been registered for an NVQ Painting and Decorating course in Brixton, for a year with three days a week attendance.</p> <p>The vocational worker noted that Mr DE had a wound above his eye. When questioned, he informed the worker that he had been involved in a fight with 3 others. Mr DE had attended A&E department but had not involved the police.</p>	ePJS
14/07/2011	<p>Care Co-ordinator telephoned Mr DE. He informed the care co-ordinator of the NVQ course and the date of his court appearance (20th July). Outcome unclear.</p> <p>The Care Co-ordinator documented that Mr DE's 'mental state is stable and he's complying with medication'.</p>	ePJS
15/07/2011	<p>Mr DE attended COS job search. He continues to look for voluntary work opportunities, has registered with Next Step (career guidance) and commenced with the NVQ course. He stated it was going well.</p>	ePJS
20/07/2011	<p>Court appearance at Woolwich Crown Court as scheduled.</p> <p>Case adjourned</p>	ePJS Interview
22/07/2011	<p>Mr DE unable to attend COS job search due to NVQ course</p>	ePJS
29/07/2011	<p>Mr DE attended job club and spoke to the vocational worker. He informed her that he often experienced low mood, withdrawing from his family and friends and isolating himself. Mr DE also went on to discuss period of feeling very 'high', exhibiting lots of energy and 'being on the go all the time'.</p> <p>He showed insight into the social dynamics of his personal relationships, wishing to engage with 'positive' people.</p>	ePJS
01/08/2011	<p>Mr DE was accompanied by his Care Co-ordinator for the medical review by the ABT team consultant. This consultant also was allocated EIS clients at that time. The diagnosis was psychotic episode. Mr DE stated that he felt medication had helped.</p> <p>The events leading to Mr DE's arrest were discussed. Mr DE reported that he had little recollection of the events at the time. He felt 'strange and out of place'. Mr DE complained of low mood, some insomnia and low appetite. The consultant prescribed Citalopram (anti depressant) following his impression of Mr DE suffering a post psychotic episode depression.</p>	ePJS
16/08/2011	<p>Letter sent to Mr DE by COS, offering a place with 'bouncin trax'. His application for DLA was completed and sent.</p>	ePJS
31/08/2011	<p>Mr DE's Care Co-ordinator telephoned Mr DE regarding the</p>	ePJS

	outcome of the court hearing. Mr DE reported that the sentence was 12 months probation.	
7/09/2011	Mr RH informed his GP that he had run out of the anti-psychotic medication 3 weeks previously.	GP records
08/09/2011	<p>Mr DE's Care Co-ordinator visited him at home to look at the details of the sentence and provide support. He states that he found Mr DE to be 'generally stable in his mental state, his mood was fine and he did not present with any psychotic phenomena'.</p> <p>Mr DE appeared highly motivated to continue course and expressed that he would like to do plumbing or bricklaying next. Mr DE had 'good insight' into his illness. No report of any side effects.</p> <p>Mother was present during the visit.</p> <p>Further home visit was planned but no record indicates whether this took place.</p>	ePJS
12/09/2011	<p>Mr DE was seen for second medical review by the ABT consultant. Diagnosis was stated as psychotic episode with medication remaining as Aripiprazole 10mg in addition to planned trial of Citalopram 20mg</p> <p>It was noted that Mr DE had not collected his prescription for Citalopram until 10 September 2013. Mr DE reported that his mood was stable but low. Functioning well.</p>	ePJS
17/10/2011	<p>Mr DE was seen by ABT consultant. He reported an improvement in mood despite not taking anti-depressant medication. Consultant recorded that therefore the anti-depressants were probably not needed.</p> <p>Planned handover to EIS consultant on 31 October 2011</p>	ePJS
31/10/2011	<p>Consultant handover from ABT consultant to new part time EIS consultant. One of the main points was that Mr DE disclosed that he had not collected his anti-psychotic medication from his GP and had not taken the medication for a week.</p> <p>Dr MN noted that made a good recovery on Aripiprazole. No reported concerns regarding his mental health and that he had changed his lifestyle since admission. He reported that he was happy to continue to take the medication and engage with EIS.</p>	ePJS
19/11/2011	<p>Mr DE arrested and charged with the murder of a female known to him.</p> <p>Lewisham police requested information concerning Mr DE's history and involvement with mental health services.</p>	ePJS

	Mr DE remanded into police custody until 21 November, pending court appearance.	
--	---	--

4.2 Notable Practice

4.2.1 Mr DE was presented to mental health services as an in-patient who needed to be detained during a crisis when he displayed psychotic symptoms. There were also criminal justice factors to be considered together with likely substance misuse. Such patients are likely to be considered to be 'an unknown quantity' when admitted and accurate diagnosis together with initial treatment planning is essential.

4.2.3 The Independent Investigation Panel felt able to reinforce some of the positive findings of the internal investigation process. These included:

- that any diagnostic uncertainty was handled well and that diagnosis was consistent with the clinical presentation of Mr DE and appropriate treatment was commenced. This pertained to Mr DE's first admission and post discharge in April 2011;
- informative Brief Risk Screening was undertaken during in-patient admission, a Risk Event was properly completed after he absconded from the ward and an effective plan was designed within the MHA, 1983 (amended 2007) detention framework;
- there was evidence that, in-patient care plans were designed based on the screening of risks and appropriate documentation of risk events;
- a post-discharge seven day follow-up by the ABT was arranged. On discharge the ABT team conducted a detailed assessment including assessment of recent historical risks together with risk features at the point of discharge within the required seven day period;
- the care plans formulated during first admission and recorded on the ePJS reflected both physical and mental health issues;
- good practice standards were attained by the Vocational/Welfare Specialist (COS) and this aspect of intervention was well recorded and clearly documented;
- there was prompt and appropriate referral to the Lewisham EIS;
- inter-ward transfers were handled well, including information, communication and documentation of care plans.

- the holding of Mr DE's care by the ABT team to compensate for delayed assessment by the EIS due to the waiting list was good practice.

4.3 Patient Factors

- 4.3.1 When Mr DE was compulsorily detained under Section 2 of the MHA 1983 (amended in 2007) for a period of assessment in March 2011, the nature and degree of his mental illness required medication. His subsequent refusal to consider taking oral anti-psychotic medication resulted in the need for this to be administered intra-muscularly whilst being restrained. Such was his resistance to taking medication that after being injected he threatened staff, kicked his way out of the ward and absconded from the unit.
- 4.3.2 This behaviour associated with the unwillingness to receive medication was to prove to be an indication of his future non-compliance with prescribed medication.
- 4.3.3 The recognised risk posed by Mr DE necessitated transfer to the PICU. When he complied with his prescribed medication he settled and could be treated in an acute ward, in another hospital. Later that week he was considered fit for discharge by the care team at the Maudsley Hospital. The detaining section had expired two days previously.
- 4.3.4 Whilst only a short time had elapsed since his crisis, the 48 hour period on the acute ward saw him being compliant with treatment and amenable to a seven day follow-up by the local ABT team. The therapeutic intention relied on his willingness to engage in the process and maintain compliance with the proposed treatment regime.
- 4.3.5 The mental state examination undertaken by the ABT team on the 18 April 2011 confirmed such concordance. They also recorded that Mr DE was to take a holiday with his family during the Easter period and would return for his court appearance for the public order offence. On his return he would contact the EIS. Information about his prescription for his medication was faxed to his GP. Inspection of the GP records evidence that this request was actioned on 20 April 2011.

Panel Consideration

Only a short time had elapsed between his psychotic crisis, a display of violent behaviour, medication non-compliance and discharge from detention under the MHA, 1983 (amended 2007). Mr DE had poor memory or recall regarding any precursor to his psychotic episode and was not a reliable informant when contributing to any assessment of risk. The risk assessment undertaken by the ABT team indicated a low risk and few risk factors. The Internal Investigation Team were rightly concerned in their view that insufficient notice had been taken of the prior high risk events. This included high risk behaviour leading to the court appearance, the subsequent need to utilise detention under the MHA, 1983 (amended 2007) in order to enable assessment and treatment, his aggressive response to staff and forceful absconding from the ward, the requirement for a period in a PICU and most importantly less than one month previously Mr DE was unknown to the mental health services.

- 4.3.6 Patient motivation to engage with services and their attitude to medication is an important determinant of how they will satisfactorily return to life in their local community.
- 4.3.7 No social circumstances assessment had identified that contact with, and possible influence of, an uncle was likely to have on Mr DE. It was only after the catastrophic incident in November that information came to light which identified to mental health services the connections between Mr DE, the uncle and the victim Miss FG. Similarly, the fact that he had left his mother's home to live with Miss FG at his uncle's house was not identified until after the homicide. This move was reported to have happened some five to six months before the incident. No carer's needs assessment was undertaken – again this might have drawn out information from his mother that he was not living with her; or from his uncle that his behaviour was becoming strange.
- 4.3.8 After the event it also became evident that Mr DE had not been taking his medication for some time prior to the homicide (reports vary, but at worst he only took the anti-psychotic medication a couple of times between his discharge in April 2011 and the homicide the following November). Efforts to monitor his compliance with medication were taken (asking him, checking that tablets had been taken from the pack, observation by his mother), but clearly had not been effective. His reluctance to take medication by mouth was known from his in-patient stay, when he was given medication by injection whilst under restraint. There was no check to see if he was collecting his prescriptions from his GP – if this had been identified it might have triggered a more assertive approach to his care in this respect.
- 4.3.9 If previous risk behaviour is accepted as a fair indicator of future risk then the importance of comprehensive assessment after a first episode psychotic episode as presented by Mr DE was reinforced in November 2011.
- 4.3.10 The DHR was able to establish that by summer 2011 Mr DE was under court legal supervision and assessed as being of 'medium risk' to the public and known adults and that it was highly likely that Mr DE was associating with the victim Miss FG at this time. This essential information was not known to the providers of the mental health care for Mr DE.
- 4.3.11 Overall, the panel have concluded that there was a significant shortcoming in the risk assessment of Mr DE after the 7-day follow-up following his discharge from hospital.

Panel Consideration

The Independent Inquiry Panel are of the opinion that, whilst Mr DE could have been invited to remain in hospital as an informal patient for a longer period based on the nature and degree of his presenting psychosis, the likelihood of him accepting this invitation or remaining voluntarily was low. If he had agreed to stay, he could then have benefitted from the regular medication regime. Aspects of his social circumstances and exposure to cannabis may have been explored further through more accurate risk assessments, prior to discharge into the community.

The Trust did not consider that the known pressure on acute bed availability was an issue in relation to the rapid transition between admission, PICU, acute ward transfers and then discharge.

4.4 Staff Factors (Care Delivery Issues)

- 4.4.1 Mr DE was allocated a Care Co-ordinator (Mr HJ). The professional background of Mr HJ was social work. He had been in post with the EIS for over seven years. Mr HJ was a practitioner who was undertaking his role whilst under a considerable degree of work pressure due to an inordinately heavy caseload. Whilst the Independent Inquiry Panel recognises that similar workload pressures existed for other care co-ordinators with the Trust and national early intervention services, the Panel consider that this heavy workload did contribute to a number of errors by Mr DE's Care Co-ordinator associated with the delivery of the CPA.
- 4.4.2 The Internal Investigation Team established that during the totality of Mr DE's care under CPA between May and November 2011, only 13 contacts were made. Apart from five home visits by the Mr HJ, (one of which was undertaken jointly with a vocational specialist from the community outreach service), there were only four medical reviews, including the handover to the EIS consultant 19 days before the incident. The remaining contacts were by four telephone calls.
- 4.4.3 The Internal Investigation Team pointed out that, since no Care Plans had been designed as a basis of any interventions, they had no yardstick with which to measure the effectiveness of the Care Co-ordinator's input. The Independent Investigation Panel concurs with their view regarding the lack of care plans, and also agree that more intensive contacts should have been made with someone who was previously unknown to the service.

Panel Consideration

The interpretation, application, and the administration of CPA was a fundamental weakness in care delivery to Mr DE. Whilst much of the anomaly could be focussed on the Care Co-ordinator it is likely that a more systemic problem existed at the time, as reported by the internal investigation.

The internal investigation made accurate and detailed comments, together with recommendations with regard to these areas of concern. All of their views were evidenced during examination or documentation and interviews with relevant staff by the Independent Investigation Panel. Corrective action has been taken including contemporary training, supervision and developments and will be considered later in this report.

Effective CPA including risk management emerges from the interaction of the components of the process. This does not reside in a single person and the case of Mr DE reinforces the need for whole system learning. It appears that this has been the approach that was taken by the Trust on receipt of the Internal Investigation report incorporating the Board Level Inquiry recommendations.

- 4.4.4 A more fundamental weakness in the care delivery was the task of note-keeping and documentation. The internal investigation considered this important aspect of role and function and exposed deficiencies in the records of Mr DE.
- 4.4.5 Whilst the above weaknesses begged questions about the performance of the Care Co-ordinator it also highlighted the way in which the paucity of recorded information could have acted as a barrier in communication between other services.
- 4.4.6 When the Independent Investigation Panel interviewed the Care Co-ordinator it became clear that he recognised gaps in his practice which had been recorded by the internal investigation. He expressed appreciation for having the opportunity to attend further staff development and experience an increase in supervision. He also felt that the issues had been presented with limited background and understanding of his work context.
- 4.4.7 The Independent Investigation Panel did not share his view, since the internal report and recommendations clearly acknowledged there were wider difficulties in the functioning of CPA and Lewisham EIS at that time.

Panel Consideration

The Care Co-ordinator had received support, supervision and training as part of implementing the recommendations of the internal investigation, it was clear that he still feels disenchanted with the level of support being offered to him in the aftermath of the incident.

The Trust policy which pertains to providing support for staff during investigations is robust and the Independent Investigation Panel felt that it requires to be applied with regard to offering further Counselling and advice due to latent stress experienced by the Care Co-ordinator.

Whilst in an environment with the highest adherence to procedure there are times when flexibility and adaptation to circumstances will occur, we do however concur with the internal investigation finding that there was a departure from proper procedures, policy and guidelines relating to the CPA Process.

4.5 Task Factors (Service Delivery Issues)

- 4.5.1 The Independent Investigation Panel were able to consider the task factors as part of the concept of classifying the organisational conditions at the time of the serious untoward incident. The RCA framework allowed the panel to consider any influencing or contributory factors which may have produced errors in either the systems in use within the service or in the work of practitioners. This approach assisted the panel to examine the mental health services provided to Mr DE and to review the relevant documents, policies and procedures. This element formed an important part of our Terms of Reference.
- 4.5.2 The process of admission to in-patient services is subject to a detailed series of policies, procedures and protocols. These are reinforced when a patient is to be compulsorily detained under the MHA 1983 (amended 2007) by clear Trust wide procedures which

reflect national guidance and statutory requirements. Mr DE was subject to these measures when he was admitted to the Mental Health Unit (Lewisham Hospital). On discharge the ABT team implemented the Trust's CPA policy. Task and organisational factors became apparent regarding the operation of the EIS which were to affect the process of care delivery and implementation of Trust policy. Plans for care and treatment were recorded on a number of occasions, albeit in the incorrect section of the ePJS. No formal 'Care Plan' exists on the record between his seven day follow-up and after the incident. No subsequent risk assessments or risk events were recorded on the ePJS until after the reporting of the serious incident on 19 November 2011.

4.5.3 The manner and means by which Mr DE was accepted onto the EIS and his placement on CPA pointed to errors in the construction of care plans together with failures to adhere to the Trust's policy on CPA.

4.5.4 Those errors exposed gaps in the service provided to Mr DE by the EIS as a result of poor implementation of CPA.

4.5.5 Several factors which may have lessened any negative effects of poor implementation of CPA existed and they were put into context by the internal investigation. These included the facts that:

- Mr DE had not expressed thoughts of either self-harm or harm to others during risk assessments;
- he appeared to value the contact with the vocational specialist and was reported to be engaged positively with the vocational course in the training centre;
- he was seen on a regular basis by a consultant psychiatrist and during those sessions his mental state appeared stable; and
- importantly, he had family support and appeared to be responsive to the Care Co-ordinator.

4.5.6 The discharging ward had simultaneously made referrals to the EIS and to the ABT team. The ABT team referral was for two reasons – to provide interim care and treatment whilst Mr DE was on the waiting list to be assessed for acceptance into the EIS; and to allocate a medical practitioner until such time as additional medical resources were made available to the EIS. At the time of referral, some EIS patients were linked with ABT consultants, some were linked with continuing care consultants and some EIS patients were with an EIS consultant. Hence the discharge process was based on the understanding that if referrals to both were made the patient would be followed up within the required week, the EIS would engage as soon as the caseload permitted and a consultant (whether EIS or ABT) would be responsible for his care.

- 4.5.7 So, at the time of Mr DE's discharge there were about 185 patients on the EIS case load, some 33 percent more than were funded by the Primary Care Trust. Whilst the Care Co-ordinator came from the EIS the Consultant was from a different service.
- 4.5.8 The consultant confirmed to the Board Level Inquiry that at that time the ABT team were themselves receiving about 800 new referrals a year.
- 4.5.9 One result of this situation was that Mr DE was discharged into an organisation of mental health care where, as succinctly described to the panel by a consultant, "with ABT its very much a non-CPA approach and people who needed a CPA would be moved on to what was called the continuing care team who would have CPA". The consultant went on to describe how the ABT team made a formulation quickly, informed by risk assessment and making a plan, implementing the plan and discharging from the service within six months to a year.
- 4.5.10 Such rationale, custom and practice meant that the CPA policy of the Trust and National Guidance for patients who had been detained under the MHA, 1983 (amended 2007) (as Mr DE had been) was not being correctly implemented. This fact was properly considered by both the internal investigation and the Board Level Inquiry.
- 4.5.11 It was against this background that any limited discussion with Mr DE regarding compliance with prescribed medication was taking place. Reliance was made on Mr DE stating that he was happy to take medication and the subject was not flagged as a possible problem, and that his presentation and behaviour as known to the mental health professionals did not raise concerns. The EIS consultant accepted that Mr DE had not collected his prescription from his GP and did not interpret that event as a problem associated with non-compliance. In fact, she felt that in an EIS it could well be 'the norm'.
- 4.5.12 Another consultant psychiatrist associated with ABT care of Mr DE acknowledged to the BLI that had he been faced with Mr DE being more abusive in his reluctance to take medication, then further and more stringent monitoring would have taken place.
- 4.5.13 It appeared that he was correct in that view as later, when interviewed by the Independent Investigators, Mr DE admitted that he did not take medication during most of the period since his discharge, and that most of that time he took steps to convince his mother and others that he was taking them when he was not. Even when he collected his prescriptions and took tablets from the blister pack he was not actually taking his anti-psychotic medication.

Panel Consideration

The fact that a formal CPA process based on both national guidance and the correct implementation of local CPA policy did not take place at this stage was a weakness in the risk management of Mr DE during this phase of his contact with the service. Both consultants interviewed by the BLI acknowledged that, if Mr DE had been more obviously resistant to taking medication, more stringent monitoring would have been necessary. They also

recognised that, had the EIS been involved in a similar situation, then a more lengthy discussion would have taken place around the associated risks. The Independent Investigation Panel felt that, regardless whether the risks were accurately documented or not, there was not enough emphasis on the actual mechanism and process of correct CPA implementation. Had there been so, the treatment team may have been more aware of relapse indicators.

4.5.14 The Independent Investigation Panel considers the above points to be important as the two senior consultants acknowledged to the internal investigation team that the differing clinical approaches between the ABT and EIS led to a “slightly messy situation”.

4.5.15 This view was reinforced when considering that a few weeks prior to his ABT contact, Mr DE had to be compulsorily detained, he required restraint in order to be given medication, he was prepared to demonstrate hostility to staff authority, and he caused damage in order to abscond. On discharge he was visiting an uncle who was a substance mis-user, Mr DE was known to take illicit substances, the vocational worker had advised Mr DE with regard to contact with the uncle and the potential pressure to use cannabis. None of this information formed part of a documented care plan based on cumulative risk and relapse potential.

4.5.16 It appeared that even if the above factors had been considered the core process and outcome would have been the same due to the role and function of the EIS at that time, together with its location and obvious staff pressures.

4.5.17 It was within the above context that the Internal Investigation recognised that the Care Co-ordinator’s approach to clinical documentation and CPA appeared to be symptomatic of an absence of an understanding of its importance. It also formed part of their recommendations which are considered later in this report.

4.5.18 The Internal Investigation Team was able to establish that after Mr DE had committed the offence on 19 November 2011, he was remanded to Belmarsh Prison and that he had not taken medication for some four months. It was thought that by this time he was psychotic. This view was reinforced by a team leader in Mr DE’s current location. This team leader had witnessed the disturbed state that Mr DE was in when he was remanded in custody after the offence.

4.5.19 In some respects the period of care provided to Mr DE up to the day of the incident acted as a ‘window’ on the EIS system in place at that time. Analysis of the events has revealed systemic weaknesses which in turn allowed all levels of investigation to reflect and consider lessons learned. These are considered later in this report.

4.5.20 The Internal Investigation Team captured the essence of problems within Lewisham EIS at the time when they placed the system in conjunction with the presentation of Mr DE during his time in the care of the service. They recognised that Mr DE was adept at telling people what he felt they wanted to know. It was commented that he did this in order to avoid any interference with his life at that time.

4.5.21 Mr DE was selectively engaging with those parts of the service which appealed to him, such as pursuing a vocational course. He was in a position to be disingenuous and not reveal information to the clinical team. The absence of longitudinal risk assessment implied a low level of risk. In fact care plans and management were weakened because they were based on this assumption.

4.5.22 The Independent Investigation Panel concluded that clinical judgements were reasonably based on Mr DE's presentation at the time (positive feedback from the Vocational Worker, his self-reported stable mental state and no observed evidence of psychosis). However, this was in the context of incomplete, independently corroborated, information (where he was living, the contact with his uncle, frequency of cannabis/skunk use, relationship with the victim and non-compliance with medication).

Panel Consideration

Mr DE was typical of many such patients who are complex and do not engage. Attempts to visit them or to assess rigorously prove difficult for treatment teams. Typically, when asked they will confirm they are taking medication, they will indicate an address that may be untrue. Assessors then acquire risk information which may be difficult to corroborate.

Since Mr DE had experienced previous psychotic episodes, and also had periods of remission, it is understandable that the information he provided appeared plausible to care providers.

4.5.23 It is clear that on his entry to the EIS that it could be reasonably expected and good practice would suggest Mr DE should have been subjected to a more active approach to engagement and face-to-face contact with the specialist team.

4.5.24 His relationship with a very competent vocational specialist was relied upon by the Care Co-ordinator to maintain Mr DE's engagement.

4.5.25 During her contact with Mr DE the vocational specialist worker was the recipient of information around the life-style of Mr DE. This was not capitalised upon and the COS information could have been used to contribute to a better designed care plan. This, in turn could have been accurately recorded and the evidence of the implementation of such a plan could have been maintained.

4.5.26 These factors associated with the task of providing a relevant service revolved around how the EIS was structured and delivered within Lewisham. The Internal Investigation identified the negative effect that such a service design had on the care delivery to Mr DE. The design is one based on a 'hub and spoke' model for EIS. Practicalities at that time meant that the EIS team were not based in one building and were scattered around the Borough in three different team bases.

4.5.27 One significant effect of this for the manager of the service was that she had to manage clinical supervision of an overloaded case-load.

Panel Consideration

The Internal Investigation Team recognised that the overload of cases on the EIS meant that the model would probably be prevented from being properly implemented. In turn, the internal investigation acknowledged that the case-load ratio meant that the service was really more of a generic service in the way it functioned. Any weaknesses were likely to be exacerbated because the typical EIS patient was represented by Mr DE i.e. young, in transition, probably a substance mis-user and disenchanted with any level of control in their life-style. The drive to develop the EIS model was reinforced by the Kings College London, Institute of Psychiatry paper (McCrone et al. 2006), commissioned by the Department of Health. This briefing which was noted by most EIS in the UK highlighted the economic impact of Early Intervention's Services. The key messages were that EIS appeared to have the potential to offer significant savings when compared to Standard Care. Findings were based on EIS modelled over one and three year periods.

- EI would save £16K per patient over one year and £46K over three years.
- This saving was largely insensitive to changes in the cost of the actual EI team.
- The savings were mainly due to lower re-admission rates for EI services

These and similar initiatives were derived from theoretical models. Time has moved on in the nature of care pathways and the work undertaken in the Trust. As the Trust takes action in response to cases such as Mr DE may well inform contemporary service configurations, treatment modes and policy initiatives beyond South London.

A critique of the 'hub and spoke' service as it was applied in Lewisham will appear when the Independent Investigation Panel considers and comments on the actions taken on the Recommendations from the Internal Investigation.

4.5.28 The above issues appear to have vexed the EIS team when interviewed as part of the BLI process. This resulted in an informed dialogue regarding the application of the 'hub and spoke' model in use at the time of the offence committed by Mr DE.

4.5.29 Not least, the fact that the team were split across three sites rather than being housed in a single building, created operational difficulties. Of course it is most difficult to identify, acquire, and equip a building with the capacity in this locality.

4.5.30 Fundamentally, when interviewed by the BLI, the EIS team reinforced their view that the 'hub and spoke' model was not one they would have chosen. They were frustrated because, at the time of Mr DE's treatment, none of the other boroughs followed that approach.

4.5.31 The team appreciated that 'hub and spoke' arrangement was under review by the Trust. They described action taking place that assisted them in their endeavours to increase their sense of functioning as an EIS. This included quarterly meetings with all the teams from other boroughs, increased supervision and invitations to be part of working groups set up to evaluate and reflect on what a modified contemporary EIS may look like.

- 4.5.32 Whilst the view was taken by the EIS team that good examples of EIS outcomes could be identified and they cautioned against generalising from single incidents, they appreciated that any lessons learnt meant that the future improvements were likely to create greater fidelity to the EIS model.
- 4.5.33 Since the initial planning and design of the EIS model contemporary national guidance and local critique including that of the Psychosis CAG will help inform service changes within the Trust.
- 4.5.34 The overall services provided to service users in South London are organised on a functional, rather than geographical, basis. The structure though in Lewisham at the time of the incident was atypical. Any weakness in the structure of services was exacerbated due to the demographic profile of the local population. This is diverse, complex and sometimes transient.
- 4.5.35 The EIS model is, on the whole, flexible and is multi-disciplinary in composition and function. Further, it is capable of offering assessment and treatment in a wide range of community settings. These include primary care settings such as GP surgeries, educational and vocational venues.

Panel Consideration

The organisation of the EIS is based on a rational planning concept, that is following an initial assessment a care plan based on recovery is designed. The recovery plan is constructed in collaboration with the service user. The type of input and level of care is agreed, together with any available support required. The process is completed by regular review and evaluation by the team. It can be deduced that such a process does require the commitment and motivation to compliance by the service user, particularly the need for concordance with prescribed medication.

- 4.5.36 The Independent Investigation Panel does not wish to suggest that compliance and better engagement with EIS by Mr DE would have resulted in avoidance of the index offence. However, it may have provided him with a better understanding of his care plan and its aims.

Panel Consideration

The discharge plan from Acute In-patient Services and the ABT assessment were appropriate and acceptable. It seems that the point between these and the subsequent EIS assessments represented a 'tipping point' when the assessment and planning which might have been effective in supporting Mr DE and his maintenance in the local community failed to meet recognised standards of good practice.

4.6 Examination of Risk Assessments

- 4.6.1 The Independent Investigation Panel was able to examine the Trust's policies and procedures which were pertinent to the identification of risk. The particular policies of reference were *CPA – Refocusing the Care Programme Approach, 2008, Discharge and Transfer Policy, (2011)* (this sets out the arrangements for managing the risks associated with discharge and transfer of service users) and the *Risk Management and Assurance Strategy (2011, 2012)* (this supports compliance with the NHS Litigation Authority (NHSLA) Risk Management Standards for Mental Health and Learning Disability Trusts).
- 4.6.2 The comments and details contained in both the internal investigation report, incorporating the Board Level Inquiry, relating to these areas were the result of careful scrutiny of the application of risk assessment, together with risk formulation and documentation.
- 4.6.3 The internal reviewers identified that a systematic and consistent approach to the risk assessment process was taken whilst Mr DE was an in-patient. However, after his discharge and the seven day follow up when he was seen by the ABT team, when historic and current risks were identified, no further risk assessments or risk events were documented on ePJS until after the offence on 19 November 2011.
- 4.6.4 The above view was reinforced during the Independent Investigation when we conducted an analysis of documented history and clinical records.

Panel Consideration

Whilst the assessments conducted in the acute units were undertaken in line with policy, any improvement in Mr DE's presentation and lowering of any risk, particularly whilst on the PICU may have been indicative of the positive effects of medication. The effectiveness of this together with clinical interventions may therefore have been short term. The fact that Mr DE confirmed during the interview by the Independent Investigation Panel that he had been either erratic or non-compliant with taking medication when discharged would seem to reinforce our view.

- 4.6.5 The Trust utilises the ePJS and when the Independent Investigation Panel examined this, it was found that the Risk Information Sections of the system were fit for purpose. The form and content allowed for a recovery based care plan to have been formulated and this would have informed other agencies as well as internal practitioners had the guidance in the Trust Risk Policy been adhered to.

Panel Consideration

The ePJS facilitates overall risk formulation being documented and recorded in sufficient detail, but the system was not fully followed when Mr DE was under the care of the EIS. As a result improved in-service training in the Trust has been provided. Further, the nature of risk assessment and competence in risk management is included in the revised CPA training.

- 4.6.6 The on-going monitoring and improvement of the ePJS takes place regularly and the system has been reviewed and modified by the Trust. This includes action taken in response to Serious Untoward Incidents (SUI) that had a link to the quality of record keeping.
- 4.6.7 The managers of the Trust scrutinise all serious untoward incidents and collate them for emerging themes. The Independent Investigation Panel understands that any aspect of the risk assessment failures would appear as part of action to be taken from audit. In turn they would appear on the Corporate Governance agenda and be reflected in the risk register.
- 4.6.8 The Internal Review of the incident did not reveal any significant aspects of service delivery problems based on risk management, other than those highlighted earlier with regard to the process not being undertaken and recorded after the seven day follow up by ABT. Of course the Internal Investigation Team were unaware of the risk status placed on Mr DE by the probation service. This aspect was criticised by the DHR.
- 4.6.9 The Independent Investigation Panel concurs with the view of the internal review, in that the type of offence committed by Mr DE could not have been predicted. Scrutiny by the Independent Investigation Panel of the clinical pathway followed by Mr DE in his relatively short contact time with the Trust did not reveal any missed clues that Mr DE would act as he did on 19 November 2011
- 4.6.10 The Independent Investigation Panel concludes that the catastrophic incident which transpired was not foreseeable. The Team acknowledges that, whilst rectifying the failings identified would have improved his care and treatment, this does not necessarily imply that the homicide could have been averted.
- 4.6.11 Regardless of his level of risk the chances of success of any well formulated care plan depended on his meaningful engagement including compliance with psychotropic medication.
- 4.6.12 The local policies of risk assessment appear to comply with national guidance in use during 2011. This was mainly on the work published by the Department of Health *Best Practice in Managing Risk; Principles and Guidance for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*.
- 4.6.13 The above guidance emphasised that the recording of risk assessment is not an end in itself. It is simply a tool to inform the handling of risk. Had Mr DE had the benefit of a longer and more frequent planned intervention, together with high concordance with medication, he may have been better prepared to see the need to avoid specific risk situations. This would have been particularly relevant regarding his personal relationships, his drug use, and his reactions during any relapse of psychotic symptoms.

4.7 Examination of the Adequacy of Care Planning

- 4.7.1 The Independent Investigation Panel was able to consider the aspects of care planning and the involvement of Mr DE and his family in this process, against practice guidelines.
- 4.7.2 Initially, the local policies were grounded in the application of care planning based on earlier statutory obligations. Such guidance was issued in 1990 as a Health Circular. The Department of Health Guidance relating to discharge was that issued in Health Service Guidance in 1994. Whilst these documents provided a template for use by the forerunner of the South London and Maudsley Trust, they have been superseded and local procedures and policies have been adapted based on periodic reviews to reflect contemporary practice standards with reference to the *National Service Framework: Modern Standards and Service Models*, (1999); *Modernising the Care Programme Approach* (2008) and later the *No Health Without Mental Health, A cross-Government mental health outcomes strategy for people of all ages* (2011).
- 4.7.3 Within the above context the internal investigation, incorporating the BLI, sought to examine the extent to which the treatment and care plans for Mr DE were:
- documented;
 - agreed with him;
 - communicated with and between appropriate agencies and his family;
 - implemented; and
 - complied with by Mr DE.
- 4.7.4 The key components of the CPA which continue to inform the policies of the Trust are those in the refocused guidance continued in a national review of CPA and the Department of Health issuing guidance relating to CPA policy and practice in March 2008. The Guidance consists of:
- systematic arrangements to be put in place for assessing the health and social care needs of people accepted by specialist mental health services;
 - the formulation of a care plan to address the identified health and social care needs;
 - the appointment of a care co-ordinator to continuously monitor the care plan; and
 - undertaking regular reviews and implementing agreed changes to the care plan if required.
- 4.7.5 Subsequently in common with all other NHS Trusts the Trust has featured CPA as part of performance management. It also forms a standard by which the Care Quality Commission reviews a mental health service as part of its regulatory framework

4.7.6 Whilst the policies and procedures of the Trust were written in accordance with national policy and guidelines, the implementation of the CPA systems and processes by the service responsible for the care and treatment of Mr DE fell short of the required standards. (details in Section 4.5)

4.8 The Trust's Early Intervention Service

4.8.1 It was the view of the Internal Investigation Team as part of any lessons learned from the homicide that the 'hub and spoke' structure of the EIS team was a key contributory factor in the difficulties of maintaining and monitoring such systems effectively

4.8.2 The BLI recommended that a review should be implemented of the clinical and operational systems within the Early Intervention Service. They also recommended that the Psychosis CAG executive should conduct a review of the structure of the Lewisham EIS as an effective service model, with a view to developing a more integrated team in Lewisham that was to be properly resourced to ensure fidelity to the Early Intervention model.

4.8.3 The intention was to bring the Lewisham EIS into line as a stand alone service alongside others provided by the Trust.

4.8.4 Action was taken to commence the preparatory work to implement this complex reconfiguration of role and function. The Independent Investigation Panel is able to confirm the progress in achievement and this is recorded in Section 8 of this report. The development had to be phased and a series of working groups were set up in 2012 to facilitate an interim solution to moving both the EIS and Forensic services within Lewisham.

4.8.5 In order to progress these developments it was the intention that eventually the Lewisham EIS would operate daily 'zoning meetings' from a single team base. Initially, the team were to meet three times a week when the members had moved from three to two bases. These meetings would focus on risk management plans and enable more robust and proactive management of risk, for those service users considered to be at high risk, who may be contacted on a daily basis. This system was also to allow the weekly team meetings have more time to be available to discuss the progress of service users who were not in current crisis.

Panel Consideration

The Lewisham EIS was set up in 2004. This was in response to central policy to develop new kinds of teams under the *National Service Framework for Mental Health* (1999). At that time, mental health services in Lewisham were organised as locality bases. This meant that each locality had assessment and longer term treatment teams with assertive outreach and home treatment teams working from the same bases. It was within that context that the Lewisham EIS was developed – with team members spread across three localities (Speedwell, Northover and Southbrook Rd.) This configuration worked for a time but as the systems around Lewisham EIS changed any advantages of the locality arrangement were weakened.

- 4.8.6 The Trust has undertaken a process of reconfiguring its services. The objective is to align clinical services, research and education. The CAGs move away from a generic, locality-based approach to adult mental health services, to one of 'specialisms' for specific problems.
- 4.8.7 The care is delivered through care pathways, these reflect contemporary national policy for mental health. There is a resonance in this approach for Lewisham as it relates to the standards that people can expect in relation to assessment, care planning, interventions, reviews, and discharge from services.
- 4.8.8 The time frames for such a major restructuring of the service in Lewisham have been accelerated due to the Lewisham EIS being the subject of two serious untoward incident investigations, including this one. The Independent Investigation Panel has been supplied with the option appraisal for re-location of the team and this includes identification of estate to house a specialist team within Lewisham. This remains to be completed, pending a wider restructuring of Trust services.
- 4.8.9 The nature of any Early Intervention in Psychosis (EIP) service means that it is likely to be a riskier setting to work in. It involves a younger, more volatile age profile; people who are at the first presentation of their illness and where diagnosis may be uncertain; involve larger numbers of people who are difficult to keep engaged and who can be resistant to traditional approaches; and a group whose peers are likely to be active in misusing legal and illegal substances.
- 4.8.10 Working with such a group of factors across its boroughs, can mean that compromises are reached and arrangements entered into to keep people engaged in treatment; not to enter into flexible arrangements could be even riskier practice and lead to total disengagement or lack of disclosure on behalf of the client.

Panel Consideration

The Trust has a regular audit programme which relate to the CPA process. The Independent Investigation Panel notes that the CPA policy identified all the contemporary guidance required by an EIP service to function. Of course, successful implementation relies on the competence and skill of the care co-ordinator and other team members. A comprehensive training and development plan is in use and the Lewisham team have been participants on this programme as a result of the finding of the internal investigation report pertaining to Mr DE's care and treatment.

- 4.8.11 The Independent Investigation Panel is able to identify concerns around critical inter-agency collaboration. It seemed to be appreciated by staff and senior managers that if the CPA policy on which the EIS relies is to be implemented to best effect, there has to be an increase in collaboration with the contributing agencies - not least the probation service when a client is under legal community supervision.

4.8.12 Lack of inter-agency communication is a common stumbling block which occurs nationally in EIP services. One negative result is that of undue caution to share client information of relevance to treatment. This is often explained as being due to the need for confidentiality, although there is no evidence that this was the reason the probation service did not share the information on the mental health treatment requirement.

Panel Consideration

The Independent Investigation Panel believes that this aspect needs further consideration at a senior level and it should include the Caldicott Guardian and Safeguarding Leads. A number of high profile cases in the UK have identified poor information sharing as contributing to a breakdown in the programme of care. This feature needs to be considered in the light of the Domestic Homicide Review of Miss FG and Mr DE and the criticisms of the probation service associated with supervision of Mr DE whilst he was engaging with the EIS in Lewisham.

4.8.13 The panel interviews with managers and staff concerned with EIS, together with the impact on information sharing and inter-agency factors, highlighted some areas that cause concern throughout similar early intervention services in the UK. These mainly revolve around occasional tension in team dynamics. Typical elements that senior managers and policy makers in the Trust will have to continue to consider as they roll out changes to the EIS will include:

- status and hierarchies;
- language specific to the group or profession;
- clarity of roles and information sharing;
- personal relationships;
- nature of working relationships;
- group dynamics;
- communication cultures across boundaries;
- inter-agency cultures and custom and practice; and
- culture of dealing with both overt and covert conflict.

4.8.14 Of course the above elements are set against the backcloth of the Trust's organisation of all the mental health service it provides.

4.8.15 Contemporary delivery of EIP services within the UK is described in Appendix Six. Any of the reconfiguration and service transition with the CAG and Trust framework as a whole will need to consider:

- resource allocation;
- Clinical Commissioning Group (CCG) expectations and contract requirement;
- financial constraints in light of coalition changes to the NHS;
- organisational priorities;
- disparity in local/geographic policy;

- safety culture and priorities;
- gaps in generic mental health services provision;
- clarity and adequacy of the commissioning processes; and
- information management and technology systems currently in use with EIS.

Panel Consideration

The Independent Investigation Panel in discussion with practitioners and managers of the EIS demonstrated the point that the EIS did not claim to hold special skills other than working in a specific context. We felt this was an important point, as the methods and system they have developed should facilitate the Trust's planners to consider the above elements in a rational, systematic way. In other words if planners use the history and development of the EIS as a yardstick it may assist future plans for the transition to a different service provision around community care in Lewisham.

4.8.16 A number of models for providing the EIS were considered by Department of Health (2001), including the 'standalone' model, a 'hub and spoke' model and enhanced community mental health teams. The 'stand alone' service was advocated as the gold standard, by the Department of Health, although benefits of both have been identified.

(Details in Appendix Six).

Panel Consideration

The way in which the 'hub and spoke' model has developed and is operationalised within Lewisham has been criticised and points to the action being taken to re-organise this service. Caution may be required. In a number of ways the 'hub and spoke' design might have had much to commend it during the time of the homicide, if it had been correctly implemented. Any future configuration should benefit from scrutinising its effectiveness in delivering competent care to a high risk and complex population.

4.8.17 One apparent weakness of the Lewisham service at the time of the homicide was the absence of dedicated psychiatrist cover for all EIS service users. This is reflected within other services nationally and the progress made by the Trust since the recommendations of the Internal Investigation has corrected this anomaly.

4.8.18 This point is reinforced by the areas of the EIS which centres on care delivery via comprehensive bio-psycho-social interventions.

4.8.19 A number of weaknesses were identified by the internal investigation and accepted by the Independent Investigation Panel, in the location, structure and functioning in the Lewisham EIS (details in Section 4.7), and in implementation of the CPA (details in Section 4.6). Other than these factors, the Independent Investigation Panel was able to agree that the care delivered to Mr DE was provided in accordance with statutory obligations, relevant national guidelines from the Department of Health and local policies.

4.8.20 Early intervention services have an increasingly strong evidence base in terms of effectiveness. There remains however a degree of scepticism about the implementation of the services nationally.

4.8.21 The Trust's early intervention services are not unique in experiencing tensions and practitioner mistakes which weaken the process on occasion. These can be related to staff supervision, development, performance targets, and, as linked with the case of Mr DE, heavy case-loads.

4.8.22 From an examination of the recommendations of the internal investigation and subsequent actions to be taken by the Trust it can be seen that consistent funding that recognises the importance of developmental as well as case-load work is required to ensure effective EIS.

4.8.23 If the revision of the service to Lewisham is successful it will at the least lift morale amongst the team. It will also improve client care, including the oxymoron of the Trust having a waiting list for a service defined as '*Early Intervention*'.

4.9 Contributory Factors

4.9.1 We have identified weaknesses in the process of Mr DE's assessment, care and treatment that were not undertaken in accordance with good practice and local procedures in professional practice, case formulation and organisation of the Lewisham EIS. These factors contribute to the shortfalls in the service. In addition we have identified factors relating to Mr DE in the weeks immediately leading up to the incident, whilst he was in the care of the Lewisham EIS. These factors were not known to those working with him. In summary, these are:

- recurrence of Mr DE's psychotic symptoms;
- Mr DE's use of 'skunk'; and
- his non-compliance with medication.

4.9.2 These factors were exacerbated by poor adherence to CPA and risk management policies, including:

- inadequate social circumstances assessment, including no carer's needs assessment;
- inadequate care planning, risk assessment and management;
- inadequate record-keeping and documentation; and
- inadequate monitoring of compliance with medication.

4.9.3 Contributing to these failings were:

- high case-load for the Lewisham EIS;

- geographical dispersal of the Lewisham EIS team in three locations; and
- the EIS model was not strictly adhered to.

4.9.4 These failings represent services which do not adequately reflect the standards of practice set out in the Trust's policies and procedures. Correction of these weaknesses would have improved the care and treatment offered to Mr DE, but would not have improved the likelihood that professionals could have predicted the risk of the homicide or prevented it from happening.

Lessons Learned

5 Lessons learned

- 5.1 The Independent Investigation Panel reviewed the internal *Comprehensive Level Two Report and Immediate Management Review* (incorporating the internal investigation and BLI) which identified a number of lessons learned. After carrying out interviews of key stakeholders and reviewing further local and national documentation, the Independent Investigation Panel accepts the lessons learned identified in the *Comprehensive Level Two Report*. These are listed in para. 6.1.11
- 5.2 The Independent Investigation Panel also adds the following two items:
- The need to monitor compliance with medication more closely, particularly where there is evidence of previous resistance to medication, including by checking that prescriptions have been collected from the GP. Failure to collect prescriptions can be a trigger to more assertive work on this subject.
 - The need to complete a comprehensive social circumstances assessment and to keep this up-to-date; and the need to complete a carer's needs assessment, to which carers are entitled. Understanding the service user's family and social circumstances 'in the round' can assist in identifying areas where care and treatment can be focussed.

The Adequacy and Appropriateness of the Internal Investigation

6 The Adequacy and Appropriateness of the Internal Investigation

6.1 Review of Internal Reports

6.1.1 The Independent Investigation Panel reviewed three internal reports:

- The Trust's Notice of a Serious Incident.
- The Trust's *Comprehensive Level Two Report* which incorporated the Immediate Management View and recommendations from the Board Level Inquiry.
- Executive Summary of The Trust's Board Level Inquiry report.

6.1.2 The review of reports was supplemented by review of notes of interviews as part of the comprehensive level two investigation and the Board Level Inquiry.

6.1.3 In addition, the Independent Investigation Panel had pre-publication access to the report of the Domestic Homicide Review, set up by the Lewisham Community Safety Partnership. The Trust's Immediate Management Review contributed to the DHR, which is intended to review how well different agencies worked independently and together, and to examine lessons to be learnt. The DHR panel consisted of representatives of the Trust, London Probation Trust, Metropolitan Police Service, Lewisham Council, Lewisham Health Care Trust and a GP.

6.1.4 The 'Notification of A Serious Incident' was completed by the Assistant Director for Patient Safety in a timely manner on 21 November 2011. The report provides basic information about the alleged perpetrator and victim; information about the nature of the Trust service provided to the alleged perpetrator and his last contact with the service before the incident. The incident is described and the fact that staff had offered support to his family. The report was appropriately completed and complied with the Trust's incident policy.

6.1.5 The Internal Investigation Team included a consultant psychiatrist, a clinical services leader and an investigation facilitator. The clinical members of the panel were drawn from services not involved in the provision of care and treatment of Mr DE. The report, incorporating the BLI findings and recommendations, is dated 14 May 2012, and agreed through the Trust structure on 28 May 2012 and 29 June 2012. This process complied with the Trust's incident policy at the time; but the timescale for completion of the report did not comply with the policy, taking about twice the length of time specified.

6.1.6 The investigation used RCA tools (including timeline, Human Error Classification Framework, fishbone diagram and the NPSA decision tree) and Trust's structured investigation methods. It was informed by interviews of relevant staff involved in Mr DE's care as both in-patient and EIS service user and by review of documents including Mr DE's clinical records, and relevant policies and procedures. The investigators approached his mother offering to meet her but received no response. The team were advised against approaching the family of the victim.

6.1.7. The report contains an Executive Summary and Main Report, providing a brief chronological history and background, findings related to diagnosis and treatment, risk

management and assessment, care plans and interventions offered, discharge and transfer planning and a discussion regarding referral of the victim to CAMHS. Appropriate positive feedback was provided and areas of concern were reported. In their conclusions, the Internal Investigation Team identified lessons learned and made recommendations.

6.1.8 Positive feedback includes the following points.

- The diagnosis was consistent with Mr DE's presentation and he was treated appropriately.
- The service provided by the COS vocational/welfare specialist was commended, including the level of contacts, which were well documented in the clinical records.
- There was prompt referral to the EIS whilst Mr DE was an in-patient.
- Plans made on one ward were carried out on another which evidenced effective documentation of plans and handover of information.
- Provision of care and treatment to Mr DE by the ABT team until he could be assessed by the EIS (which had a waiting list at that time) was good practice.

6.1.9 Areas of concern were identified.

- The team could not find any CPA documentation (e.g. risk screens, risk assessment or formulation for crisis, contingency or care plans) relating to Mr DE after he was accepted onto the caseload of the EIS, despite understanding that he had become subject to CPA on acceptance.
- The investigation team interviewed members of the EIS who reported that they had considered Mr DE to have few risk factors. The Internal Investigation Team did not agree that this was an accurate assessment, given his previous history of, amongst other things, admission under the MHA, 1983 (amended 2007), the high risk events preceding the admission, the violent incident and absconding during the admission. They felt that the EIS team might have a lack of understanding of risk assessment as a 'dynamic and longitudinal' process'.
- There was no record of documented risk and needs assessment, or of care plans by the EIS.
- There was no evidence of a person-centred care.
- There was no evidence of a systematic approach to CPA reviews.
- The investigation team would have expected more intensive contact by Mr HJ, as Mr DE was new to mental health services, under the care of an EIS and on CPA.
- As there were no care plans there was a lack of structure to the interventions and the interventions could not be properly evaluated.
- There appeared to be no forum for discussion of care plans and interventions outside the weekly team meetings.
- There did not appear to be a systematic approach to clinical supervision, and reports and clinical records were not utilised in supervision.

6.1.10 The report also identified the difficulties posed by the excess caseload carried by the EIS at the time of the incident; the shortage of consultant input to the EIS, leading to care co-ordinators having to relate to a number of consultants; and the 'hub and spoke' structure of the Lewisham EIS leading to the limited forum for communication outside weekly meetings and mitigating against the provision of an integrated service including daily zoning meetings.

6.1.11 This report incorporated findings and recommendations of the Board Level Inquiry. This inquiry involves a further internal inquiry intended to establish facts relating to the incident provided by the structured investigation and is intended to identify recommendations which can improve the service the Trust provides. The BLI panel also assures the quality of the structured investigation. The panel includes a non-executive director, the Medical Director or representative and the Nursing Director or representative. The panel reviews the structured investigation report and other documentation, meets and interviews the staff involved and invites relatives and carers to contribute. In relation to this incident, three additional recommendations were incorporated into the final internal investigation report, reviewed in this and the following section.

6.1.12 'Lessons learned' were identified by the BLI. The Trust Board clearly took a serious and measured approach to the opportunity to learn lessons about its service. They identified that there was a wider problem in the functioning of CPA systems within the Early Intervention Service. Key lessons were learnt.

1. While the internal investigation process identified that the EIS team was under pressure and the working structures were not ideal, it was concluded that the Care Co-ordinator's approach to clinical documentation and CPA appeared to be symptomatic of a lack of understanding of its importance.
2. The Board also formed the judgement that there were standards of documentation required of all staff and that all staff should be reminded of these standards.
3. It was recognised by the internal investigation that the 'hub and spoke' structure of the team was a key contributory factor in difficulties of maintaining and monitoring systems effectively.
4. Having established important gaps in the nature of service delivery provided to Mr DE by the EIS, particularly those aspects which focussed on the CPA status, the internal investigation considered the context of his care 'in the round'.

6.1.13 The *Comprehensive Level Two Investigation Report*, including input from the BLI, concluded that there were gaps in the service provided to Mr DE. However, these gaps in service should be seen in the context of his engagement with services, the lack of any reference to harming himself or others, his reporting that he was compliant with medication and had ceased using cannabis. His mental state appeared stable to all health and social care professionals he was in contact with. In this context, the Internal Investigation Team was unable to make any attributable or causal link between the care and service delivery problems and the offence committed by Mr DE.

- 6.1.14 The totality of recommendations made in the *Comprehensive Level Two Structured Investigation Report* (which incorporated those in the BLI), the action plan and progress towards completion are detailed in Section 7 below.
- 6.1.15 The recommendations were intended to reinforce the lessons learned from the investigations. Whilst the 'lessons learned' focussed on specific events within the Lewisham service, they feature aspects of care provision that are also relevant across other such contemporary services.

6.2 Observations

- 6.2.1 The Independent Investigation Panel audited the *Comprehensive Level Two Structured Investigation Report*, which incorporated an Immediate Management Review and recommendations from the Board Level Inquiry, using an audit tool developed for this purpose. As a result of this audit and information provided at interview, the Panel made a number of observations.
- 6.2.2 The Internal Investigation Team reviewed an appropriate range of documentation and interviewed five relevant members of staff involved in Mr DE's care and treatment (Care Co-ordinator, EIS Consultant Psychiatrist, Team Manager, ABT Consultant Psychiatrist, and the Vocational/Welfare Specialist). They did not interview his GP.
- 6.2.3 The date of the incident is clearly stated; a summary of the incident is provided at the beginning of the report but there was limited information available to the team about the circumstances leading up to the incident such as precipitating factors, mental state or substance misuse.
- 6.2.4 Clear and appropriate Terms of Reference were established for the internal investigation, including the scope of the investigation and its methodology but there is no overview of the team members.
- 6.2.5 The brief history and background included a social background, a detailed record of his in-patient care, referral to EIS, discharge from hospital, follow-up by the ABT team, and chronology of contacts and interventions from the EIS.
- 6.2.6 Efforts were made to involve the family of Mr DE, although this was not pursued further because of his mother's ill-health. On advice from the Domestic Homicide Review, the Internal Investigation Team did not approach the victim's family.
- 6.2.7 The report outlines the process by which it was to be disseminated to key professionals, there is a list of the internal and external agencies who should see the report. A summary was sent to the EIS team in May 2012. Minutes of a meeting in which the report was presented to and discussed by the CAG were provided to us as evidence that this had taken place.
- 6.2.8 The report provides a relevant and appropriate history of Mr DE's care and treatment prior to the homicide. The report outlines the following:

- social/family background;
- previous forensic history;
- diagnosis of mental disorder /psychotic episode;
- history of in-patient care (under section 2 MHA, 1983 (amended 2007));
- incidents whilst an in-patient, including his absconding and transfer to the acute ward and the Trust's PICU;
- referral to the EIS;
- discharge from hospital and follow up by the ABT team whilst the patient was awaiting assessment by the EIS;
- Mr DE's history of compliance with medication including episodes of non compliance;
- reference is made to the risk assessments of Mr DE as in-patient and issues concerning the lack of documentary evidence of risk assessments/management plans following discharge to the EIS team; and
- reference to his use of cannabis/skunk from age 17 years, with reference to possible relationship to psychotic symptoms in January 2011; and at assessment by the ward doctor when he was an in-patient after the public order offence.

6.2.9 The report noted previous incidents of violence – public order offence in March 2011 and threats to ward staff in April 2011 – and their relevance to risk assessment. The possibility that the public disorder offence included a domestic violence component was noted but also that the police had discounted this possibility.

6.2.10 Risk assessment and management were examined for each stage of the patient's involvement in mental health services. This included risk assessment and management on admission; risk assessment and management of Mr DE following incidents such as non compliance with medication; threats to staff and absconding from the ward in April 2011; and the lack of a documented, up to date, risk assessment when Mr DE was under the care of the EIS team. The report makes reference to a brief risk assessment screen (on admission), a risk event (following absconding), and the risk assessment made by the ABT team following discharge. However, the lack of use of a specific standardised risk assessment tool (e.g. HCR-20) is not mentioned.

6.2.11 Mr DE's care and treatment were examined in depth by the report. The report also highlights the issue of care plans, the required process of CPA and risk assessments/plans following discharge. Additionally, an extensive chronology of events is included at Appendix One of the investigation report.

6.2.12 In relation to the appropriateness of his care and treatment, the Internal Investigation Team noted and examined:

- the appropriateness of the diagnosis Mr DE was given;
- the appropriateness of the treatment following diagnosis;

- the treatment of Mr DE following discharge, including lack of CPA formalities, action plans and reviews;
- the type and scope of interventions adopted with Mr DE at admission and on discharge; and
- areas of good practice in the care and treatment of Mr DE.

6.2.13 The report highlights the Trust's policy and procedure regarding CPA and Clinical Risk Assessment and Management of Harm, local systems and standards, with reference to clinical documentation. Non compliance with Trust policies in relation to CPA, Clinical Risk Assessment and Management of Harm are noted. There was no particular reference to national guidance within the report other than the guidance on domestic homicide reviews as referred to in the terms of reference.

6.2.14 The report examined professional judgement and clinical decision making in relation to:

- clinical diagnosis and treatment, including medication regime as an in-patient and when discharged;
- the understanding of the EIS team as to the CPA process, risk assessment and management plans, care planning, documentation and level of engagement with Mr DE;
- positive feedback is provided regarding his diagnosis and treatment as an in-patient; and regarding the detailed assessment recorded at his seven day follow-up after discharge. Appropriate care plans during his in-patient stay were documented; and
- areas for concern were noted in relation to the lack of CPA documentation such as risk assessment, risk screens, formulation of crisis or care plans, carers' needs assessment. The Internal Investigation Team disagreed with the EIS team (the latter's view being that he had few risk factors) given his risk history of section 2 of the MHA, 1983 (amended 2007) admission, high risk events preceding that admission, violence and absconding during that admission leading to a period of intensive care: the internal investigation were concerned that 'this might demonstrate a lack of understanding of risk assessment as a dynamic and longitudinal process'. They also noted that 'there was no evidence of person-centred care' or of a 'systematic approach to CPA reviews'.

6.2.15 The Internal Investigation Team examined and highlighted:

- the handover of plans and information between in-patient wards after the transfer of Mr DE, concluding this was reasonable;
- the referral to the EIS team prior to discharge;

- the role of the ABT team in maintaining the care of Mr DE prior to the EIS team's assessment; positive feedback on the quality of risk assessment by the ABT at this time;
- the operational structures of the EIS team and the pressures of workload when the team was operating at 33 percent above their funded capacity and the involvement of multiple consultants from different services using different approaches to the EIS. However, concerns regarding documentation and implementation of CPA processes were noted and the team concluded that, despite the working conditions not being ideal, there was a lack of understanding of the role of clinical documentation and the CPA process on the part of the Care Co-ordinator and the team as a whole; and
- positive feedback was provided about the role of the Vocational/Welfare Specialist and her input into his care and treatment.

6.2.16 The issues regarding Mr DE's engagement with services were examined in the report, with specific comment on:

- engagement with the COS Vocational/Welfare Specialist;
- engagement with his Care Co-ordinator (EIS team);
- involvement with the ABT team following discharge before activation of the EIS referral;
- his reluctance to accept the need for medication and concerns about side effects were noted and discussed.

6.2.17 There was limited discussion of the services' involvement with Mr DE's family, other than noting contact to offer support after the incident, the family circumstances as highlighted in the historical section of the report, and their responsiveness to the Care Co-ordinator.

6.2.18 There is evidence outlined in the report that the Internal Investigation Team examined the completion of risk assessments of the ward staff and the documented awareness of risk factors, such as harm to self, and risk to others. Significant reference was made to the EIS team and their understanding of the risk factors, and level of Mr DE's medication compliance and engagement. The Internal Investigation Team additionally noted the system of clinical supervision for the EIS team. There seems to have been no consideration specifically of precipitating factors (or in fact their absence) in the clinical record after his care was taken on by the EIS. The report does comment in detail on the lack of recorded risk assessment by the EIS; disagrees with the team view that his risk was low; and comments on a possible lack of understanding of risk as a 'dynamic & longitudinal process'.

6.2.19 No MHA, 1983 (amended 2007) assessments were examined. The team noted the detention under section 2, which led to Mr DE's admission to the Mental Health Unit, Lewisham Hospital.

6.2.20 As part of their investigation, the Team examined Mr DE's clinical record and noted the following:

- the limited nature of documentation whilst Mr DE was under the care of the EIS team Care Co-ordinator;
- the absence of understanding by the EIS team of the importance of documentation (CPA), risk assessments and care plans;
- the standards of clinical documentation; and
- the quality of care plans whilst Mr DE was an in-patient was commended.

6.2.21 The report examined preparation by staff for the transfer and discharge of Mr DE, including his referral to the EIS, his discharge in April 2011 with 7-day follow up arranged, his assessment by the EIS team in May 2011, the lack of documentation, the involvement of the ABT and involvement of the ABT consultant until October 2011. Mr DE was referred to the COS service when his needs for employment and benefits support were identified. However, there is limited discussion of the extent to which either Mr DE or his family were prepared for his discharge or transfer between services.

6.2.22 Follow-up after discharge formed a significant component of the report and in particular the role of the EIS team. The report made note of:

- frequency and level of contact with his Care Co-ordinator, the consultant psychiatrist (ABT), the GP and with the COS specialist;
- documentation of care plans and risk assessments, including those by the ABT team and the EIS;
- issues relevant to the EIS team and the care provided to Mr DE, including the structure of the team and staffing factors; and
- the engagement of Mr DE with the services outlined above.

6.2.23 The report clearly states the roles of each service/professional when required, explaining their responsibilities and reasons for involvement in the care and treatment of Mr DE. For example, the reason for the involvement of the ABT consultant psychiatrist is explained as is the nature of the COS and the COS worker who assisted Mr DE in respect of claiming benefits, looking for work and accessing training.

6.2.24 Adequacy of staff training was examined in relation to the EIS team, with one recommendation (from the BLI) suggesting that a training needs analysis be undertaken with the EIS in areas of CPA and risk assessment and management particularly highlighting the possible lack of understanding of risk assessment process; and of the importance of documentation in CPA.

6.2.25 In relation to clinical supervision, team leadership, management support, staffing levels and skill mix a number of issues were examined during the investigation.

- Clinical supervision: the report stated that there did not appear to be a 'systematic' approach to clinical supervision.
- Team leadership: the team noted there did not appear to be a mechanism for discussion of care plans and interventions outside of the EIS weekly team meetings.
- Management support: performance management recommendation was made in terms of adherence to policies and procedures.
- Staffing levels at EIS: the report noted that there were issues of staff turnover and long term sick leave.
- Activity of EIS: the number of cases was noted at 33 percent above funded capacity.
- Team structure: the possible consequences of being based and working with local community teams in 3 bases, rather than being centralised; the report also commented on the use of multiple consultants from different services used by the EIS team.

6.2.26 The Root Cause Analysis approach to the investigation is outlined in the report, noting that a tabular time-line was completed and a cause and effect analysis leading to establishing root causes was carried out.

6.2.27 The report demonstrates a clear accurate and precise narrative with regard to the facts of the case. There is a sound analysis of the discrepancy between some aspects of the service actually delivered and that which should have been delivered, in particular the CPA process and the management of Mr DE in the community following discharge, including the apparent lack of care plans and risk management/assessment, as required by the Trust's CPA policy. Conclusions are clearly derived from the evidence presented particularly in reference to risk assessments, diagnosis and treatment and the issues identified within the CPA process following discharge. There is evidence that, in conclusion, the Internal Investigation Team considered all features of the patient's care pathway, with reference when required to Trust policy and procedure.

6.2.28 There is a clear correlation between the findings of the investigation, the lessons learned and recommendations made. This was demonstrated by the following points:

- CPA process and recommendations for performance management within the EIS team;
- structure of the team and the recommendation for a review of the structure;
- clinical documentation and the recommendation for a Trust wide minimum standard;
- Training and the recommendation for a Training Needs Analysis in relation to CPA and Risk policies and procedures; and

- operational and clinical systems and the recommendation for review.

6.2.29 An action plan was included with the *Comprehensive Level Two Investigation Report*, a updated plan was provided to the Independent Investigation Panel in June 2013, and further progress information provided by email in October 2013. The initial action plan documented recommendations but no stated actions, clear timescales/completion dates or identified person responsible were detailed. The up-to-dated action plan did however include timescales and indication of who was responsible for implementation of the actions.

6.2.30 The second version of the action plan provides evidence of review, progress towards completion of actions with evidence of actions completed and reasons for delay in completing actions.

6.2.31 A distinction between individual and system issues is made. Reference is made not only to policies and procedures but also practice (as highlighted in the findings and lessons learnt sections of the report). Individual issues are identified, namely documentation of assessment, care plans and risk assessment/management and the overall CPA process, and the frequency and level of contact between the Care Co-ordinator and Mr DE. System issues highlighted include performance management within the EIS team, training, operational and clinical systems, service design and the geographical dispersal of the team across three bases.

6.2.32 Recommendations are made for performance management in relation to a particular postholder and comments are made with regard to generic team training.

6.2.33 Clear recommendations regarding system issues are made, including recommendations for:

- a review of the structure of the Lewisham EIS team to bring about a more integrated team, with closer fidelity to the EIS model of care and treatment;
- a Trust wide reminder of the minimum standards for clinical documentation;
- a training needs analysis in relation to CPA and Risk policies and procedures for the Lewisham EIS team; and
- review of operational and clinical systems in the EIS more widely.

6.2.34 The report is well structured and written with an Executive Summary. Assumptions and beliefs are distinguished from factual information - statements made throughout the report are based on the evidence provided by the review of documentation and the views and understanding of the staff interviewed as to the circumstances of the care and treatment of Mr DE. Suppositions are indicated as such by the use of the terms 'appears to be' and 'may'.

6.2.35 The report is divided into sections which follow a logical and systematic approach.

6.2.36 Information is clearly presented in the report pages and sections are numbered. Numbering of paragraphs in each section aid cross referencing and provide a clear demarcation of sections.

6.2.37 The report is written to a good standard with regard to grammar, punctuation and consistency. It is clear, avoids jargon and explains abbreviations.

Review of Progress Made by the Trust in Implementing the Action Plan from the Internal Investigation

7 Review of progress made by the Trust in implementing the action plan from the internal investigation

- 7.1 Both the internal investigation and the Board Level Inquiry examined the homicide to defined Terms of Reference and both appeared mindful of the limitations of retrospective review of clinical records. Both supported the investigation process by interviewing key participants and policy shapers whose work had influence on the care delivery for Mr DE. The validity of the Trust investigation was enhanced by the later production of the Domestic Homicide Review and its findings which helped identify the context in which the young life of Miss FG was ended by the actions taken by Mr DE in November 2011.
- 7.2 Whilst the internal investigation process concluded that this catastrophic incident could not have been predicted, it did extract valuable information on future actions which could be taken to assist in the reduction of errors in the delivery of care and treatment either systemic or individual.
- 7.3 A known weakness within such investigations is that the situation faced by practitioners is inevitably simplified when reviewed with hindsight. An investigation cannot capture the logic of all decisions made in the unfolding events of a clinical encounter. Still less can it depict the pressures and distractions of everyday mental health care in all its complexity.
- 7.4 Against the above backcloth the Independent Investigation Panel was able to review the progress of action taken by the Trust as part of its response to recommendations by the Internal Investigation.
- 7.5 This level 3 Independent Investigation report reinforces the findings of the Internal Investigation. Our deliberations have benefitted from the passage of time, access to contemporary policies and procedures, more recent records, interviewing key parties and discussion with Mr DE and his current clinical team.
- 7.6 The lessons learned from the examination of this tragic event were identified in the internal investigation findings.
- 7.7 These lessons do not appear to be of a type or nature that lend to being transferable or of specific value to the wider or generic services of the NHS.
- 7.8 The lessons learned are reflected in our panel considerations when we examined the contact, care delivery, risks and documentation of CPA pertaining to Mr DE.
- 7.9 We were able to record the progress that the Trust had made when implementing the five recommendations arising from the Internal Investigation, including the Board Level Inquiry, which were grounded in the lessons learned. For each recommendation a number of specific actions were identified, with a named individual responsible for implementing those actions and a timescale for implementation. The Trust provided the

Independent Investigation Panel with detailed documentary evidence of actions and activity linked to the recommendations made by the internal investigation.

7.10 The recommendations and actions to implement them are identified in the table below, along with the evidence provided to show the Trust's progress implementing the actions arising from each recommendation.

Recommendations and Actions	Evidence provided
<p>Recommendation 1. The Lewisham Early Intervention Service (EIS) management address the absence of understanding of the importance of CPA (Care Programme Approach) documentation, risk assessment and formulation of care plans through performance management structures.</p>	
<p>1.1 Performance management of specific individual whose poor practice (CPA documentation, risk assessment, formulation of care plans) was highlighted through both the report and audit of his work undertaken by the team manager: performance management</p>	<p>Audit of the individual's ePJS recording; records of supervision of Ms OP by Ms QR re. Mr HJ; Attendance at an Early Intervention course and application for funding. Ms OP's supervision of Mr HJ's recording, monitoring his documentation, risk assessment, CPA documentation, care planning, event recording. Ms OP attended course on 'managing for high performance' to improve her skills. Correspondence setting up the performance review, learning contract; Ms OP's notes of performance monitoring, her assessment of his improved practice. Team performance data for May 2013.</p>
<p>1.2 Team to undertake Clinical Risk training and CPA training</p>	<p>Ms OP supervision 24 May 2012 refers to Clinical Risk training; two emails to trainer refer to organisation of Clinical Risk and CPA training for whole team.</p>
<p>1.3 Team manager to monitor documentation for completions and quality for all team members</p>	<p>Ms OP to use ePJS in supervision to monitor documentation; Supervision records – examples of Ms OP with different team members demonstrating monitoring of documentation; risk assessment, CPA documentation, care planning, event recording.</p>
<p>Recommendation 2. A Blue Light Bulletin (explained in Appendix Four) outlining the minimum standards for clinical documentation within the Trust will be circulated to senior staff for cascade to local services across the Trust</p>	
<p>2. Blue Light Bulletin to be issued, outlining minimum standards for clinical documentation in the Trust circulated to senior staff for cascade to local services</p>	<p>Copy of the Blue Light Bulletin provided, dated and circulated January 2011.</p>
<p>Recommendation 3. An analysis of training needs of Lewisham Early Intervention Service in relation to 'Making CPA Relevant' and 'Clinical Risk Assessment and Management'</p>	
<p>3.1 Whole team training to be undertaken in Clinical Risk Assessment and Management</p>	<p>Ms OP supervision 24 May 2012 refers to Clinical Risk training; emails to trainer organising Clinical Risk training for the whole team</p>

3.2 To ensure team receive training in CPA, individually or as a team	Emails to trainer setting up CPA training for the whole team
3.3 To ensure training is kept up to date	Verified during interviews with relevant staff
Recommendation 4. That there is review of the clinical and operational systems within the Early Intervention Service.	
4.1 Review of team meeting structure, including zoning	Document with the red zone criteria. Setting out the arrangements to commence zoning 3 times per week.
4.2 To consolidate a referrals duty system to ensure swift response to referrals as per the EI model	Proposals for a duty rota; and the proposed rota
4.3 Team to work towards daily 'zoning' meeting to ensure more robust risk management. To be fully implemented when the team are in one base: Weekly zoning meetings initially; 3 times per week when team in two bases; daily meetings when team in a single base.	Document with the red zone criteria. Setting out the arrangements to commence zoning 3 times per week. Notes from meetings provided as examples of zoning in practice.
Recommendation 5. The CAG executive should conduct a review of the structure of the Lewisham Early Intervention Service as an effective service model with a view to developing a more integrated team in Lewisham that is properly resourced to ensure fidelity to the Early Intervention model. This should be a 'stand alone' Early Intervention for Psychosis Service in Lewisham to bring it in line with the Early Intervention Team structures in Lambeth, Croydon and Southwark.	
5.1 Team to move into one team base: <ul style="list-style-type: none"> interim move into two team bases to enable closer team working and more robust zoning system for risk management eventual move into one team base allowing team to become fully standalone team 	Briefing note on proposed relocation to two bases (undated): date not fixed for the move when paper written but decision has been made. Option appraisal for one base (August 2012); proposal for restructure of services to a single EIS team located in one base. (May 2013).
5.2 Following the move to one base, team to restructure to allow for more robust risk management; and to develop close team working practices to allow closer fidelity to EI model.	Red zone/zoning meetings, see 4.3 above.

7.11 In order to facilitate this analysis we adapted a framework of measurement similar to that utilised by the NHSLA. This uses a set of risk management standards within health care organisations. There are three, defined below, and the principle applied to each level can be aligned with the action plan progress.

- Level 1: Policy: evidence has been described and documented.
- Level 2: Practice: evidence has been described, documented and is in use.
- Level 3: Performance: evidence has been described, documented and is working across the organisation(s) as appropriate.

7.12 When we examined the initial documentary evidence of actions taken we classified progress made using this framework, incorporating information provided in October 2013.

7.13 Recommendation One:

- The documents submitted to the Independent Investigation Panel describe the efforts being made to address Recommendation One which focussed on the lack of understanding of CPA and the need to manage practitioner performance. Documents included detailed supervision records between the Lewisham EIS team leader and different team members. They describe both the process and the product of the actions taken including certification of the supervision in managing for high performance. The evidence for Recommendation One compliance depicts professionals working together to undertake management and planning tasks which both benefit the EIS clients and contribute to the running and planning of the Trust's service.
- For Recommendation One, this would suggest Level 2 compliance of our framework. We would recommend therefore that the implementation is kept under regular review and that an audit of progress is conducted before end of 2013.

7.14 Recommendation Two:

- The origin of Recommendation Two was the BLI and highlighted the need for all staff to be reminded of the required Trust minimum standards for clinical documentation. The message was to be cascaded to local services across the Trust by senior managers using a Blue Light Bulletin to staff in January 2012. The document emphasised the key points relating to care planning and the identification of risk and the need for accurate documentation. The Bulletin was clear and succinct, and guides staff to relevant supporting policies. The process is reinforced by an Annual Trust Clinical Records Audit, which examines overall clinical records including documentation.
- This would suggest Level 2 compliance in our framework as change is taking place relating to the EIS structures and organisation which will impact on the integration of documentation and will require further review as such changes take place. We therefore recommend that when amendments are made to the organisation of EIS that a specific audit of the quality of documentation is undertaken in order to measure the fidelity with the Trust's standards and intended outcomes.

7.15 Recommendation 3:

- The BLI recommended a training needs analysis of the Lewisham EIS team. This was specifically aimed at two programmes *Making CPA Relevant* and *Clinical Risk Assessment and Management*.
- The Independent Investigation Panel were able to evidence from the documentation supplied to us that a detailed training programme record was being maintained by the Trust and this was documented on a spread- sheet containing dates of attendance at specific training events. Email evidence was submitted to us which depicted the request to the training department for further courses on risk management and this was responded to positively by the learning and development advisor. Individual team members across disciplines confirmed to us that they had either attended a programme or were due to commence one when next available.
- This would suggest Level 3 compliance and we would suggest that in order to reflect the importance of these topics the process is kept under continuing review.

7.16 Recommendations Four and Five.

- A major objective of recommendations Four and Five was to produce a 'standalone' EIS in Lewisham and therefore bring it into line with Lambeth, Croydon and Southwark. (An overview of national EIS guidance is provided in Appendix Six with comments on the Trust's implementation in Section 4.10 above.) The Independent Investigation Panel recognised that such changes are difficult to attain quickly and demand clear communication with all affected parties in the process. However, we also acknowledge the necessity for this to take place in order to help overcome some of the more systemic problems identified by the internal investigation when they examined the challenges faced by Lewisham EIS when delivering care to Mr DE.
- We received documented and oral evidence of progress being made to comply with recommendations Four and Five. We do not underestimate the nature and complexity of the challenges faced by the Trust to attain these goals but the need to do so was very well described by the Medical Director in his supporting paper proposing the required changes in May 2013.

- The evidence describes a clear and compelling rationale for changes to NHS adult mental health services in Lewisham. Of particular relevance is the stress placed on a unified and integrated delivery of health and social care, this has resonance with criticisms made in the DHR and the need for more effective communication with agencies such as the probation service.
- The main feature of the proposal is to facilitate the alignment with primary care neighbourhoods. This would bring a greater coherence between primary and secondary care teams. It would also hope to support the evolving relationships between secondary care and the CCG.
- The intended outcome is to ensure that the Early Intervention Teams would operate as a single team based in the same building. This is augmented with plans to acquire accommodation for the re-aligned teams. There is also a degree of 'future proofing' depicted in the proposals as they recognise the need for implementing flexible working practices and better utilisation of mobile technology.
- The Independent Investigation Panel welcome these proposals and simultaneous actions to develop them but recommend that this initiative is subject to on-going evaluation as it progresses.
- The evidence for actions taken to meet recommendations four and five clearly demonstrates a determination by the Trust to overcome the difficulties in the Lewisham EIS.
- This evidence is convincing as interviews with the practitioners and senior managers supported the aims of a realignment of the service despite significant practical difficulties. It has therefore been well described and documented. However, the implementation of this is still in progress (March/April 2014 target date). This would suggest Level 1 compliance in our framework.

Panel Consideration

For realignment of the EIS to happen together with more effective inter-professional working across agencies to occur, staff have to believe that the advantages to them and to EIS clients are worth the efforts and problems associated with major change. In addition, trust, respect and understanding between professionals will emerge from positive experiences in co-operating in case work and day to day working more than from team building exercises and talk about co-operation.

7.17 In summary the Trust has made significant progress towards implementing all the recommendations. Recommendations One, Two and Three have been implemented,

although continuous monitoring of the implementation of One and Three is required. Additional consultant time has been recruited to the Lewisham EIS. Recommendations Four and Five are still in progress. The difficulties of identifying a suitable single location for the team means that they are still not operating from the same base and a decision has been taken to defer this move until a more extensive restructure of the Adult Mental Health Services have been completed, expected in March/April 2014. The number of locations has, however, been reduced from three to two and the 'zoning meetings' are now held three times a week. The Trust reports that this increase in 'zoning meetings' has appears to have led to 'more proactive management of the clinical risk and staff anxieties about the risk'. (Trust information, provided October 2013). The difficulties involved in relocating teams and in restructuring ways of working without the relocation of the Lewisham EIS into a standalone team are acknowledged.

Summary of Findings and Conclusions

8 Summary of Findings and Conclusions

8.1 The Independent Investigation Panel reviewed and analysed the clinical records (including prison and current records and CPS Case Summary), national and local policies and interviewed all key staff, including Mr DE's current care team. The Panel concluded that there were a number of items of notable practice in the overall care and treatment provided to Mr DE by the Trust. There were also a number of weaknesses, in both professional practice and the organisation of services.

8.2 Positive practices were identified.

- Appropriate diagnosis and treatment during both Mr DE's in-patient treatment and on discharge.
- Appropriate risk assessment and documentation when he was an in-patient.
- Detailed risk assessment by the ABT at the seven day follow- after discharge.
- Care plans recorded during the hospital admission.
- Good practice by the COS Welfare/Vocational Specialist, appropriately recorded.
- Inter-ward transfers were well-documented and appropriate documentation and care plans were handed over.
- Prompt and appropriate referral to the EIS.

8.3 Care delivery problems were identified.

- Inadequate risk assessment, leading to a number of historical risk factors apparently not being taking into account when under the care of the Lewisham EIS.
- Limited number of contacts made by Trust professionals with Mr DE (13, of which five were by telephone) over a six month period, despite the fact that Mr DE was new to community mental health services and had a history of risk behaviours.
- Care plans were not documented, so that the effectiveness of care against plans could not be evaluated.
- The interpretation, application and implementation of CPA was a fundamental weakness, including inadequate social circumstances assessment, lack of a carers' needs assessment.

8.4 Together, these represent failing to adhere strictly to both national and local policies. In addition, the Independent Investigation Panel noted the following:

- over-reliance on information provided by Mr DE to the care team;
- lack of monitoring closely his compliance with medication, including checking with his GP regarding Mr DE collecting his prescriptions – identifying that he was not collecting his prescriptions might have triggered a more assertive approach to Mr DE about compliance with medication;

- four ward moves during his 4-week in-patient stay, the final one to a different hospital and discharge after taking his medication for less than one week - possibly indicative of pressures on in-patient beds in the Trust; and
- a lack of formal mental state examinations carried out within Mr DE's community-setting, which might have elicited information indicative of recurring psychotic symptoms.

8.5 Together, these represent failing to adhere strictly to both national and local policies.

8.6 Service delivery problems were identified.

- Heavy case-load of the Lewisham EIS at the time of Mr DE's referral.
- Delay in allocating an EIS specialist consultant to oversee his care and treatment.
- The geographical spread of the Lewisham EIS team across three locations, leading to difficulties for the team in acting as a specialist team and for the team manager in providing clinical supervision.

8.7 However, despite these areas for improvement which were identified, the Panel concluded that nothing in Mr DE's presentation during his contacts with mental health professionals and services was predictive of the homicide and that the homicide would not have been prevented even if these weaknesses had not occurred.

8.8 The Independent Investigation Panel concluded that the Internal Investigation as supplemented by the BLI was thorough and comprehensive, that the recommendations followed on from the findings and that an appropriate action plan had been agreed through the Trust processes.

8.9 The Trust has achieved progress towards full implementation of the actions identified, including those addressing the care delivery problems. Additional consultant time has been recruited to the Lewisham EIS. However, the difficulties of identifying a suitable single location for the team mean that all members are still not operating from the same base. The number of locations has been reduced from three to two and the 'zoning meetings' are now held three times a week. These meetings appear to have led to improved management of clinical risk.

8.10 Other than failings identified above, the Independent Investigation Panel agreed that the care delivered to Mr DE was provided in accordance with statutory obligations, relevant national guidelines from the Department of Health and local policies.

9 Recommendations

- 9.1 Following the internal investigation and the Board Level Inquiry an action plan was designed based on the framework of contributory factors. This was intended to address the identified findings and lessons learned. These have been reviewed in the relevant sections of our report in accordance with our Terms of Reference.
- 9.2 The Independent Investigation Panel commends the detailed analysis of the internal investigation incorporating the BLI and we were able to confirm that the recommendations made to the Trust were appropriate and necessary.
- 9.3 We were not required to add further recommendations as part of our Terms of Reference and we were reluctant to do so as the conventional practice of listing a number of recommendations requires caution. It is not always practicable or desirable to anticipate the effects of changes which demand significant resources from a single case of the nature of Mr DE despite the severity of the outcome.
- 9.4 The Independent Investigation Panel are also cognisant that a Trust the size and complexity of this Trust will accumulate numerous recommendations from analysis of a series of SUIs.
- 9.5 We have used the findings of the Internal Investigation to identify a small number of core vulnerabilities which we think can be sensibly addressed in a systematic way as the Trust pursues the action plan. The few recommendations we have made are associated with the areas of our panel considerations, which in turn link with factors that contributed to either practitioner or systemic weaknesses.
- 9.6 Any improvement and development of the EIS aimed at assisting people, who present as Mr DE did, will require investment in staff development, forging stronger collaboration between agencies including the probation service and the acquisition of estate with capital development.
- 9.7 We have identified from the policies and procedures, together with the Trust's proposed organisational structures, alongside the internal investigation findings that these actions are likely to be achieved by a continuing improvement approach.
- 9.8 This process appears to be reflected in the framework of clinical governance of the Trust.
- 9.9 Consequently our few recommendations, rooted in the actions already being taken as a result of the internal investigation, are intended to encourage partnership, effective EIS outcomes and the dissemination of learning from good practice. Our recommendations are:
 1. That the implementation process of actions required to ensure compliance with Recommendation One of the internal investigation (risk assessment, care planning

and performance management) is kept under regular review and an audit of progress is conducted before the end of 2013 to be considered by the Board.

2. That when amendments are made to the organisation of the EIS, a specific audit of the quality of documentation is undertaken in order to measure the fidelity with the Trust's policy standards and intended outcomes.
3. That the initiative which is being undertaken to acquire fit for purpose accommodation for the Lewisham EIS to be subject to on-going evaluation of progress and quarterly reports be given to the Board.
4. That the restructure of the Lewisham EIS aimed at producing a more integrated team, be subject to on-going evaluation of progress with bi-annual reports to the Board.

9.10 In addition to supporting recommendations from the Trust's *Comprehensive Level Two* report, the Independent Investigation Panel would add:

5. That the Trust review how their EIS teams monitor compliance with medication, including checking that prescriptions have been collected and taking an assertive approach to medication compliance where there is reason to believe that this may be an issue.
6. The Trust stress the importance of a comprehensive social circumstances assessment which is updated and of the carers' needs assessment, to collect comprehensive information as one component of care planning and care provided. This is particularly relevant with a high risk, complex and sometimes transient population.

Appendices

Appendix One:
South London and Maudsley NHS Foundation Trust
Reports, Policies and Protocols Reviewed

Missing Persons' Policy for Detained Patients (AWOL) and Informal Patients, v8, September 2011
Bed Management when Demand exceeds Capacity in Local Acute Services Protocol, April 2005
Clinical Records Policy, v7September 2011
Clinical Records Policy, v7.2, October 2012
Clinical Risk Assessment and Management of Harm Policy, v6.1, October 2011
Non-clinical Records Policy, v1.1, October 2008
Corporate Records Policy, v2, June 2012
CPA Policy – Refocusing the Care Programme Approach, v2, September 2008
Discharge and Transfer Policy, v1, November 2011
Engagement and Formal Observation Policy, v 5.1, September 2011
Engagement and Observation Policy, v 5.3, December 2012
Incident Policy , v 2.2, December 2011
Learning and Embedding the Lessons arising from Complaints, Incidents and Claims, v3.1 November 2011
Mandatory Training Policy, v1.1, October 2011
Medicines Management Policy, v3, February 2010
Medicines Management Policy, v4, July 2012
Non-compliance with Treatment Guidelines, May 2005
Policy for the Development and Management of Trustwide Procedural Documents, v4 April 2012
Psychiatric Intensive Care Units (PICU) Operational Policy, April 2010
Risk Management and Assurance Strategy, v5, August 2011
Risk Management and Assurance Strategy, v6, November 2012
Southwark Home Treatment Team Medication Policy, September 2002
Notification of a Serious Incident, 21 November 2013
Acute Mental Health Comprehensive Level two Report and Immediate Management Review. Report on the investigation into the circumstances leading to the arrest of a client of Lewisham Early Intervention Service on a charge of murder.

Appendix Two:

National Guidance and Research Reviewed.

Table 1: National Policy Guidance

National Service Framework: Mental Health, Modern Standards and Service Models, Department of Health, 1999
No Health Without Mental Health, A cross-Government mental health outcomes strategy for people of all ages. Department of Health, 2011
Modernising the Care Programme Approach, Department of Health, 2008
Department of Health (2001) 'Early intervention in psychosis' in <i>The Mental Health Policy Implementation Guide</i> , pp. 43 – 61

Table 2: Research reviewed.

T. Craig, P. Garety, P. Power et al. (2004) 'The Lambeth Early Onset (LEO) Team: randomized controlled trial of the effectiveness of specialised care of early psychosis', <i>British Medical Journal</i> , 329 pp 1067 – 1070
G. Dodgson et al. (2008) 'Early intervention in psychosis service and psychiatric admissions', <i>Psychiatric Bulletin</i> 32, pp 413 – 416
P. McCrone, S. Dhanasiri and M Knapp (2006), <i>Modelling the Economic Impact of Early Intervention Services</i> , Kings College London, Institute of Psychiatry, Personal Social Services Research Unit, LSE, Health and Social Care, London School of Economics and Political Science. Commissioned by the Department of Health
V. Pinfold, J. Smith and D. Shires (2005) 'Audit of early intervention in psychosis service development in England in 2005', <i>Psychiatric Bulletin</i> 31, pp. 7 – 10.
P. Swaran, Singh and H. L. Fisher (2005) 'Early Intervention in psychosis: obstacles and opportunities', <i>Advances in Psychiatric Treatment</i> , Vol 11, pp. 71-78

Appendix Three:

The Independent Investigation Panel

Mr Anthony Thompson F.Inst LM, MA, B. Ed (Hons); RMN, RNLD, RNT, Cert. ED, DN (Lond), Lead Investigator. A Senior Associate of Caring Solutions (UK) Ltd, he has led a number of Independent Investigation Panels and brings many years of experience representing mental health and learning disability services within a multi-disciplinary context. His career has spanned senior positions in statutory services, higher education, NHS and the Independent Sector. He continues to work at an international level and is a Fellow of the Institute of Leadership and Management. He is currently a director of Bridge R&D International, a not for profit company and a management consultant for Roefield Specialist Care Ltd.

Dr Michael Rosenberg FRCPsych, Independent Consultant Psychiatrist. A Senior Associate of Caring Solutions, Dr Rosenberg has extensive experience of the investigation of critical incidents and advised on the management of complaints in his Trust, and has contributed his medical and director expertise to a number of external investigations. He is a retired consultant general psychiatrist with interest and experience in psychiatric intensive care and triage. He has held posts as clinical director, then medical director and finally chief executive of a community and mental health trust. He was the lead director for the Trust Patients' Advisory Forum and responsible for developing the Trust Strategy for Patient and Public Involvement.

Ms Maggie Clifton, MA, MCMI, Investigations Manager. A Senior Associate of Caring Solutions (UK) Ltd, Ms Clifton has managed and contributed to a number of Independent Investigation Panels and to the review and audit of internal and independent SUI investigation reports. She is social scientist, specialising in qualitative research in health and social policy related areas; and a general manager with extensive experience in the voluntary sector of managing services for homeless people and for people with long-term mental health problems. She is currently an independent research and management consultant, specialising in quality assurance, mental health service development, and training and development for managers. She is trained in advanced investigation skills and in the use of the European Foundation for Quality Management Excellence Model.

All members of the investigation team are independent of any of the organisations involved with the incident in and have had no involvement in any of previous investigations into this homicide.

Appendix Four:

Abbreviations and Definitions

ABT	Assessment and Brief Treatment
BLI	Board Level Inquiry – an additional level of internal inquiry, chaired by a Non-Executive Director (lay person) who purpose is to identify lessons learned with a view to making recommendations to improve Trust services, and provides a ‘quality assurance’ check on the internal structured investigation
Blue Light Bulletin	A report designed to communicate Trust-wide issues, lessons learned from serious incidents, which goes to senior managers at each CAG. It is cascaded through the management structure, team meetings and clinical supervision as appropriate to the specific content.
CCG	Clinical Commissioning Group
COS	Community Outreach Service
CPA	Care Programme Approach
CMHT	Community Mental Health Team
DHR	Domestic Homicide Review
EIS	Early Intervention Service
EIP	Early Intervention in Psychosis
ePJS	Electronic Patient Journey System
HCR-20	An internationally recognised, standardised tool for assessing risk of violence.
ICPA	Integrated Care Programme Approach
IM	intra-muscular
MHA	Mental Health Act
NHSLA	National Health Service Litigation Authority
NIKL	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
PICU	Psychiatric Intensive Care Unit
RCA	Root Cause Analysis
SUI	Serious Untoward Incident
Zoning meetings	Team meetings held to review service users considered to present a high/medium risk to self and/or others and to proactively manage that risk. These are ideally held on a daily basis.

Appendix Five:

Anonymisation Index

Anonymisation	Role
Miss FG	Victim
Mr DE	Perpetrator
Mr HJ	Care Co-ordinator
Dr KL	ABT Consultant, responsible for Mr DE's care and treatment in the community until shortly before the homicide.
Dr MN	EIS Consultant, who took over responsibility for Mr DE's care and treatment shortly before the homicide.
Ms OP	Lewisham EIS Team Leader
Ms QR	Deputy Director for Early Intervention and Complex Care, Psychosis CAG.

Appendix Six:

National guidance on the Early Intervention Service Model

Two major clinical outcomes of the EIS (T Craig et al. 2004), based on a research trial in 2004 in Lambeth, are pertinent to the work being undertaken to re-structure the Lewisham service. Firstly, the known association between long duration of untreated psychosis and a poor outcome in the short term. Secondly, is the notion that the first three years of psychosis constitute a critical period during which repeated relapses occur. The level of disability accrued in the first two years of the illness may set the ceiling for recovery in the long-term.

The 'standalone' early intervention service was advocated the gold standard for the UK by the Department of Health in 2001. The other models were enhanced community mental health teams and the 'hub and spoke' model as depicted in the structure in Lewisham at the time of this homicide. In this model, the hub is a central specialist service which supports mainstream services by providing specialist input to individual cases.

Many comprehensive services have a functional recovery focal point and include specialist-supported employment workers (similar to the vocational specialist for Mr DE) However, there are also partial EI models where only partial funds are available to resource a small number of dedicated specialists who work within an existing service provision, typically generic community mental health teams (CMHTs), with large case-loads.

The 'hub and spoke' model has been seen as having some disadvantages: these are described by Swaran, Singh and Fisher 2005 "*There is potential for uncertainty and confusion regarding each services responsibility for these patients, together with a disruption of continuity of care. As yet no evidence exists to support the effectiveness of one particular form of service delivery over any other*".

However the 'hub and spoke' model was seen in 2008 (Dodgson et al) as demonstrating; "*the usefulness of the Mental Health Policy Implementation Guide shows it can be modified successfully in a mixed urban/rural area using a hub and spoke model with the hub being a key role in ensuring functional fidelity to the guidelines*"

Other advantages of this service have been described since 2008 as being easier to establish and demanding fewer resources. Other disadvantages are seen as perpetuating any existing problems with services, having no independent identity, and having interface responsibility problems.

An audit (V Pinfold et al. 2005) found that forty six EIS operational teams (75 percent) described themselves as adherent to the Mental Health Policy implementation guide but the degree of fidelity was variable and the greatest divergence was in the provision of designated acute beds and out of hours support. This situation was likely to be recognised in the South London EIS systems.

More contemporary policy would appear to point towards primary care based generic teams which would at least avoid duplicating assessments and false positive predictions.