

An Independent Investigation into the care and treatment of P in Kent & Medway NHS Partnership Trust

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1.0 EXECUTIVE SUMMARY

On the evening of 4 February 2009, TH was found stabbed to death in his own home by police. The alleged perpetrator was P. Both TH and P were treated by Kent & Medway NHS Social Care & Partnership Trust (KMPT) mental health services.

P had had contact with the police and a history of offending behaviour that dates back to 1998. He had a primary diagnosis of drug induced psychosis, and more latterly a diagnosis of schizophrenia. He was known to be reluctant to comply with medication. He had first been assessed and detained under section 2 of the Mental Health Act (1983) in October 2002 with four further admissions to psychiatric inpatient care, 2 of which were detentions under section 3 of the Mental Health Act (1983). This meant that P was entitled to receive aftercare under section 117 of the Mental Health Act (1983).¹

The last Care Programme Approach review which P attended, and the last recorded care plan review was dated 6 March 2007.² This appears to have been the last recorded time he was seen by his consultant psychiatrist, CP7.

He had a period of good contact with his care coordinators (CC1 and CC2) in Rochester Community Mental Health Team (CMHT) from 2006 until 2007, when he would attend the CMHT to receive his benefits approximately every two weeks. His mother had been his appointee for his benefits, and she would hand them to the CMHT for giving to P. This process stopped in or around March 2008 due to concerns over the appropriateness of this informal process, and also because P's longer term Care Coordinator was on long term sick leave for a period. He was replaced by a locum social worker in March 2008.

From this point onwards P's engagement with mental health services was almost non-existent. The last formal contact with P from mental health services was on the 5 March 2008. Despite many appointments being offered by letter, he failed to attend meetings with his new care coordinator, CC3, and also reviews of his care programme. There is no record that other more assertive methods of engagement were attempted during that period. He was warned (by letter) that failure to attend would result in discharge from the CMHT. On the 20 November 2008 P was discharged to the care of his GP.

Between June 2005 and February 2009 P had been seen by his GP on 3 occasions, and failed to attend 3 further appointments (one in 2007 and 2 in December 2008).

On 27 November 2008 P's mother had contacted the CMHT by telephone. She spoke to the duty worker, a locum social worker, expressing concern that P had recently been increasingly under the influence of drugs, spending all his

¹ Section 117 of the Mental Health Act imposes a duty on health and social services to provide aftercare services on discharge or extended leave to patients who have been detained under the Act under section 3 or 37.

² CPA 3 for P, dated 6th March 2007

money on drugs, asking for more money and becoming abusive and paranoid with aggressive behaviour. It was agreed with the duty worker that P would be visited the next day when he would be less likely to be intoxicated. P's mother agreed to call the police should she feel threatened.

The duty worker and a colleague, CPN 2 visited P on the 28 November at his home address but there was no response.

On the 1 December 2008 P presented at the offices of the CMHT, and met with the same locum social worker who had spoken with his mother. It was noted there were no overt symptoms of mental illness. P was still in need of money, and was asking for a crisis loan. As P's mother was still the appointee, both P and his mother were informed that she would need to apply for the crisis loan on his behalf. It is noted that P was satisfied with the outcome.

In February 2009, a member of Chatham Community Mental Health Team had been concerned for TH's welfare, as he had not attended for his medication or attended to his financial arrangements. On visiting TH's home on the 4 of February, he found lights on, curtains drawn and letters still in the letter box. He reported this to the police. Later that evening the police entered the premises and TH was found dead from multiple stab wounds.

On the 26 January 2009, P had told his half-sister that he had 'killed a bloke' having stabbed him 15 times. When she questioned him further for evidence and suggested calling the police the conversation became heated and P was asked to leave by her husband. On the 30 January 2009, P is reported to have told the partner of a friend he had killed TH, though when his friend questioned him on this he said it 'was a joke'.

P presented at the Emergency Department, Medway NHS Foundation Trust, on 5 February 2009, feeling suicidal after drinking 3 pints of cider and using several lines of cocaine. He was referred to the Medway Assessment and Short Term Treatment team (MASTT) and seen and assessed by two members of the team. He was noted to be feeling suicidal and requested admission for two weeks to 'sort his head out'. His previous non-engagement with Rochester CMHT was noted and his presenting problems were identified as mental and behavioural disorders due to his use of multiple drugs. P was advised to self refer to Kent Council on Addiction (KCA)³ for help with his drug problems, and also to attend A&E or contact his GP if things got worse.

P was arrested in a flat in Chatham on the 6 February 2009 by Kent Police. Evidence of contact with TH on the 26 January was found in P's possession, and he was subsequently remanded in custody until his trial for the murder of TH in November 2009.

P was found guilty of the murder of TH on the 15 January 2010.

³ Kent Council on Addiction (KCA) - a service for people with mental health or substance misuse problems

Our findings

P was diagnosed with paranoid psychosis made worse by substance misuse. He experienced persecutory ideas of people coming to harm him. At times he was threatening and abusive to those around him. He was known to be easily angered, and he frequently threatened his family and others with violence, and to kill them. He had kept dangerous weapons (both knives and a samurai sword), and often stated he was going to get a gun and shoot members of his family or the people that he thought were after him.

He had a history of significant drug abuse, involving cannabis, ecstasy and cocaine, and was difficult to engage with specialist mental health services.

He had five admissions, two under section 3 of the Mental Health Act, between 2002 and 2006, after which he had limited contact with mental health services, failing to attend for CPA reviews and out-patient appointments. He refused to have depot medication when informal in the community and was known to have poor compliance with oral medication.

He last saw his Consultant Psychiatrist at a CPA review in March 2007. He attended the CMHT fortnightly for a while to receive his benefits (provided by his mother via appointeeship) but when this stopped in 2008 he stopped attending the CMHT.

He last saw his Care Coordinator in March 2008, when he was noted to have no positive symptoms of psychosis.

He was discharged in November of that year to the care of his GP for failing to engage with services, after it was agreed in a team meeting. Even though his GP had also had very limited contact with P, there was no real attempt to engage the GP practice in discussion about P's needs, risks, or signs of relapse. Attempts to engage P with the CMHT were limited to writing letters inviting him to attend for appointments or phoning him to leave a message. It may have been appropriate earlier in his illness to refer him to Assertive Outreach, and this may have prevented further deterioration. However, there is no indication that his mental health condition in 2008 warranted referral, and more assertive practice on behalf of his Care Coordinator and Consultant Psychiatrist should have resulted in a more robust assessment of his condition and needs.

His Care Coordinator was a locum Social Worker from Australia, unfamiliar with the Mental Health Act 1983 and the requirements of section 117 aftercare. In retrospect Rochester CMHT appeared to have had a lot of locum or agency staff at that time, and there was a lack of organisational memory in the team. P had had seven Consultant Psychiatrists and three Care Coordinators during the seven years he was involved with Rochester CMHT.

His mother phoned the team in November 2008, after his discharge, worried about P, saying he had become increasingly paranoid and threatening.

He last met with two CMHT staff on 1 December 2008 expressing his frustrations with his benefit set up and appointeeship. It was noted there were no overt symptoms of mental illness.

P's last contact with mental health services was 5 February 2009 when he attended the emergency centre at Medway Hospital reportedly 'feeling suicidal', who referred him for assessment by the Medway Assessment and Short Term Treatment team (MASTT). He was seen and assessed by a doctor and another member of staff, and referred to KCA for support with his drug abuse.

There is no indication that P was seriously mentally unwell at this point.

He was later arrested and charged with the murder of TH.

Although his potential for violence and threats was well documented and taken seriously by the police, there is very little evidence of serious violence being perpetrated on anyone. His forensic assessment in 2004 did not indicate significant risk, and P had never been charged with a significant violent offence prior to his arrest in 2009. As there is no real evidence of violent behaviour after his last admission, it is our view that the murder of TH was not predictable.

Despite his lack of engagement with mental health services in general and his care team in particular, P seemed to be mentally stable with no positive signs of psychosis on the few occasions he was seen in 2008 and 2009.

His presentation when mentally unwell had previously always escalated to paranoia and violent threats involving the police and his family. Given that that this did not happen during the period of December 2008 to February 2009, and that his mental state did not arouse concern on the two occasions he was seen before his arrest it is unlikely that the murder was predictable or preventable. P was also convicted of murder rather than other offences and sent to prison.

Recommendations

This investigation has identified areas for improvement. The independent investigation team make the following 8 recommendations to improve practice.

Recommendation 1.

Following such catastrophic incidents the Trust should maintain a register of the full contact details, including professional body registration numbers, of all staff involved in the care and treatment of the patients in the incident, so that when required in the future there is a last known address with which to attempt to make contact .

Recommendation 2.

NHS England should use their best endeavours to obtain agreement on a protocol or memorandum of understanding, with all the UK major healthcare professional bodies, so that these bodies cooperate with independent investigation teams, and to provide the contact details of potential witnesses to facilitate these investigations.

Recommendation 3.

Where service users are in receipt of benefits via appointeeship that involve members of the Trust or Local Authority in any way, the Trust and Local Authority should ensure there is a clear documented plan and process for dispensing of the benefit, and adequate oversight and governance arrangements are in place in accordance with Department of Work and Pensions guidance.

Recommendation 4.

The Trust should ensure that it continues to be routinely informed of team compliance with the CPA standards for Risk Assessments and that it can demonstrate taking action when performance falls below standards.

Recommendation 5

The Trust should ensure that as part of monitoring CPA and section 117 practice that when any service user on Enhanced CPA or section 117 is considered for discharge to their GP's care that there is evidence of attempts to engage the GP with fully documented explanation of the risks and relapse indicators for that individual, and that rapid access to mental health expertise should it be required by the GP is clearly identified in the discharge plan.

Recommendation 6

With respect to the future management of people with substance misuse problems and psychosis the Trust should ensure its staff are able to support the competencies outlined in the NICE guidance for working with people with psychosis and substance misuse, and work with commissioners to develop appropriate commissioned pathways for people with dual diagnosis.

Recommendation 7

The Trust should ensure that within the Early Warning Trigger Tool, consistently high use of locum CMHT and medical staff is included as a potential warning for teams at risk of poor performance. For those teams where this occurs the Trust should ensure that the appropriate risk registers reflect the risk and that mitigation is put in place to reduce the underlying risk.

Recommendation 8

The Trust should ensure that team leaders and supervisory managers have the skills and understanding of quality performance management necessary to ensure the delivery of high quality care within teams. This should include the ability to closely supervise inexperienced staff, and model best practice including practicing assertively with vulnerable service users at risk of not engaging.

The organisation should also encourage and support staff to identify when services are at risk of delivering poor quality and to escalate their concerns to senior management.

2.0 INTRODUCTION

Niche Patient Safety was commissioned by NHS South East Coastal, the former Strategic Health Authority, to conduct an independent investigation to examine the care and treatment of P, a mental health service user.

Under Department of Health guidance⁴ independent investigations are required:

“When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

When it is necessary to comply with the State’s obligation 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 for 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 level.

Where the SHA determines that an adverse event warrants independent investigation. For example, if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.”

Since September 2013, independent investigations following such incidents are now commissioned by NHS England.

3.0 PURPOSE AND SCOPE OF INVESTIGATION

Independent investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is to investigate the care and treatment of P, to assess the quality of the internal investigation that took place following the incident and the implementation of subsequent learning and to establish whether any lessons can be learned for the future.

4.0 SUMMARY OF INCIDENT

On 4 February 2009, TH was found stabbed to death in his own home by police. The alleged perpetrator was P. Like TH, P was a mental health service user treated by Kent & Medway NHS Social Care & Partnership Trust (KMPT) services.

⁴ Department of Health (1994) HSG (94)27: *Guidance on the Discharge of Mentally Disordered People and their Continuing Care*, amended in 2005 by Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

P had had contact with the police and offending behaviour that dates back to 1998. He had a primary diagnosis of drug induced psychosis, and more latterly a diagnosis of schizophrenia, and was noted to have a reluctance to comply regularly with medication. He had first been assessed and detained under section 2 of the Mental Health Act (1983) in October 2002 with four further admissions to psychiatric inpatient care, 2 of which were detentions under section 3 of the Mental Health Act (1983). This meant that P was entitled to receive aftercare under section 117 of the Mental Health Act (1983).⁵

The last Care Programme Approach review which P attended, and the last recorded care plan review was dated 6 March 2007.⁶ This appears to have been the last recorded time he was seen by his consultant psychiatrist, CP7.

He had a period of regular contact with his Care Coordinators (CC1 and 2) in Rochester Community Mental Health Team (CMHT) from 2006 until 2008, when he would attend the CMHT to receive his benefits approximately every two weeks. His mother has been his appointee for his benefits, and she would hand them to the CMHT for giving to P. This process stopped in or around March 2008 due to concerns over the appropriateness of this informal process, and also because P's longer term Care Coordinator was on long term sick leave for a period. He was replaced by a locum social worker in March 2008.

From this point onwards P's engagement with mental health services was almost non-existent. The last formal contact with P from mental health services was on 5 March 2008. Despite many appointments being offered by letter, he did not attend meetings with his new care coordinator, CC3, and also reviews of his care programme. There is no record that other more assertive methods of engagement were attempted during that period. He was warned (by letter) that failure to attend would result in discharge from the CMHT. On 20 November 2008 P was discharged to the care of his GP.

Between June 2005 and February 2009 P had been seen by his GP on 3 occasions, and did not attend 3 further appointments (one in 2007 and 2 in December 2008) to review his medication and his condition.

On 27 November 2008 P's mother contacted the CMHT by telephone. She spoke to the duty worker, a locum social worker, expressing concern that P had recently been increasingly under the influence of drugs, spending all his money on drugs, asking for more money and becoming abusive and paranoid with aggressive behaviour. It was agreed with the duty worker that P would be visited the next day when he would be less likely to be intoxicated. P's mother agreed to call the police should she feel threatened.

The duty worker and a colleague, CPN 2, visited P on 28 November 2008 at his home address but there was no response.

⁵ Section 117 of the Mental Health Act imposes a **duty** on health and social services to provide aftercare services on discharge or extended leave to patients who have been detained under the Act under section 3 or 37.

⁶ CPA 3 for P, dated 6 March 2007

On 1 December 2008 P presented at the offices of the CMHT, and met with the same locum social worker who had spoken with his mother. It was noted there were no overt symptoms of mental illness. P was still in need of money, and was asking for a crisis loan. As P's mother was still the appointee, both P and his mother were informed that she would need to apply for the crisis loan on his behalf. It is noted that P was satisfied with the outcome.

In February 2009, a member of Chatham Community Mental Health Team had been concerned for TH's welfare, as he had not attended for his medication or attended to his financial arrangements. On visiting TH's home on the 4 of February, he found lights on, curtains drawn and letters still in the letter box. He reported this to the police. Later that evening the police entered the premises and TH was found dead from multiple stab wounds.

On 26 January 2009, it was reported that P had told his half-sister that he had 'killed a bloke' having stabbed him 15 times. When she questioned him further for evidence and suggested calling the police the conversation became heated and P was asked to leave by her husband. On 30 January 2009, P is reported to have told the partner of a friend he had killed TH, though when his friend questioned him on this he said it 'was a joke'.

P presented at A&E on 5 February 2009 feeling suicidal after drinking 3 pints of cider and using several lines of cocaine. He was referred to the Medway Assessment and Short Term Treatment team (MASTT) and seen and assessed by two members of the team. He was noted to be feeling suicidal and requested admission for two weeks to 'sort his head out'. His previous non-engagement with Rochester CMHT was noted and his presenting problems were identified as mental and behavioural disorders due to his use of multiple drugs. P was advised to self refer to KCA for help with his drug problems.

P was arrested in a flat in Chatham on 6 of February 2009 by Kent Police. Evidence of contact with TH on the 26 of January was found in P's possession, and he was subsequently remanded in custody until his trial for the murder of TH.

P was found guilty of the murder of TH on 15 January 2010.

5.0 MEETING WITH THE FAMILIES

The Independent Investigation Team would like to offer their deepest sympathies to the families of TH and P. It is our sincere wish that this report provides does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of P up to the point of the offence.

We have been in regular correspondence with the family of TH throughout this investigation, though at their request have not met with them. We would wish

to commend them for their fortitude and patience throughout this distressing process. Most importantly we want to extend our sincere condolences for their loss.

We have also been able to meet with and correspond with the mother of P and her husband. Through this meeting we have been able to get a sense of the terribly traumatic and difficult period they too have faced and continue to face. We would like to extend our sympathies to the family of P.

We have been unable meet with P during this investigation because he has been too unwell to meet with the investigation team.

6.0 ACKNOWLEDGEMENT OF PARTICIPANTS

This investigation involved interviews with five clinical staff and managers from Kent & Medway NHS and Social Care Partnership Trust (KMPT). We would like to acknowledge these very helpful contributions.

We would also like to especially thank the Patient Safety Manager, administration staff and the Medical Director from the trust for their valuable and helpful assistance throughout this investigation.

7.0 TERMS OF REFERENCE

The following terms of reference were agreed between NHS South East Coastal, the then Medway Primary Care Trust and Niche Patient Safety:

Terms of Reference

The investigator, with appropriate advice, will conduct a review that:

1. Review the report of the Trust's investigation limited to the Care and Treatment of P, with specific focus upon the action plan, including the achievement of objectives and milestones, evidence that the change has occurred in practice and that lessons have been learned.
2. Explore and analyse the systems and processes in place for assuring that:
 - Practice is safe, appropriate and meets best practice standards.
 - That appropriate Risk Assessments are undertaken.
3. Ensure that the views and concerns of the families of the victim and the perpetrator are responded to.
4. Consider any other matters that the investigation team considers arise out of, or are connected with the findings of this investigation. This includes consideration of the following:
 - Frequency and quality of risk assessments, as identified by the Trust Internal investigation report.
 - Appropriateness of P's clinical care and treatment.

- Forensic assessment and follow up, as there appears to be a significant forensic history with previous threats to kill.
 - Management of people with dual diagnosis as P was accessing a number of services.
 - Assertive Outreach referral process and documentation.
 - Discharge procedures, as P was subject to Section 117 aftercare.
 - Adult protection procedures and interagency communication pertaining to vulnerable adults, including local MAPPA procedures and discussions.
 - Management of P's non-attendance at appointments(DNA) and compatibility with the Trusts DNA procedures, and
 - The quality and appropriateness of the Trust's internal investigation and subsequent implementation of the recommendations.
5. Provide a written report that includes recommendations to the Strategic Health Authority so that the avoidable harm from this episode is reduced in similar future circumstances and that the opportunities for learning are identified for the trust.

Approach

The approach will be agreed with the investigator and will include access to appropriate expertise.

Publication

The outcome of the review will be made public. The nature and form of publication will be determined by the NHS South East Coast. The decision on publication will take account of the view of the relatives and other interested parties.

Comment

It is unfortunate that the commissioning of this investigation, and therefore its completion, has been delayed considerably, in large part because of various NHS reconfigurations over the course of the investigation. There were also delays in agreeing the terms of reference, obtaining consent and accessing the clinical records.

A further factor that has delayed this investigation has been that due to the passage of time, many of the staff who may have been able to provide valuable evidence have now moved on and their contact details have been lost. The investigation team attempted to locate many of these staff through their professional bodies, the General Medical Council, the Nursing & Midwifery Council, and the Health Professions Council. Because of concerns regarding potential breaches of confidentiality, we were further delayed in our attempts to make contact with these professionals, which in one case required us to provide a legal argument as to why the public interest overrode the confidentiality requirements within the Data Protection Act.

We therefore make our first recommendations to the Trust and NHS England regarding the contact details of witnesses in future investigations.

Recommendation 1.

Following such catastrophic incidents the Trust should maintain a register of the full contact details, including professional body registration numbers, of all staff involved in the care and treatment of the patients in the incident, so that when required in the future there is a last known address with which to attempt to make contact .

Recommendation 2

NHS England should agree a protocol or memorandum of understanding, with all the UK major healthcare professional bodies, so that these bodies do all in their power to cooperate with independent investigation teams, and to provide the contact details of potential witnesses to facilitate these investigations.

We have been considerably assured that the new steps taken by NHS England will ensure a much swifter investigation process, closer to the time of the incident, and that this should enable families and staff to feel assured that organisations are fully in a position to learn from, and prevent, future similar incidents.

8.0 THE INDEPENDENT INVESTIGATION TEAM

This investigation was undertaken by the following healthcare professionals who are independent of the healthcare services provided by Kent & Medway NHS and Social Care Partnership Trust:

Nick Moor Investigation Manager and Report Author, Director Niche Patient Safety.

Dr Ian Cumming Consultant Forensic Psychiatrist.

The investigation report was proof read by Carol Rooney, Senior Investigations Manager for Niche Patient Safety.

9.0 INVESTIGATION METHODOLOGY

This process for this investigation follows national guidance in the conduct of independent investigations following serious incidents in mental health services.⁷

Policies

In addition to the Trust's policies we referred to relevant national policies and guidelines, and DH Best Practice Guidance.⁸

Analysis

The documents from these sources were then rigorously analysed to develop themes and findings, and in particular to identify factors which may have contributed to the incident. Wherever possible information was triangulated, that is checked against other sources for reliability. As far as possible we have endeavoured to eliminate or minimise hindsight or outcome bias⁹ in this process. We have endeavoured to work with the information which was available to the Rochester CMHT at the time. However, where hindsight has informed some of our judgements we have identified this.

9.1 Consent

P's medical records were released using the 'Caldicott Guardian' process, as he was too unwell to provide consent himself.

9.2 Witnesses called by the Independent Investigation Team

The independent investigation team interviewed the staff involved making reference to the National Patient Safety Agency (NPSA) Investigation interview guidance¹⁰. Niche Patient Safety adheres to the Salmon Principles¹¹ in all investigations.

We attempted to contact twelve people who had been involved with the care and treatment of P or the management of services. Of these twelve we were

⁷ National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

⁸ DH (March 2008) "Refocusing the Care Programme Approach Policy and Positive Practice Guidance"; Mental Health Act (1983); DH (2008) "Code of Practice; Mental Health Act 1983 (revised)".

⁹ *Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident.*

Outcome bias is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair". (NPSA 2008)

¹⁰ National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

¹¹ The 'Salmon Process' is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.

only able to find the contact details for eight staff, despite trying to make contact through agencies, other employers and professional bodies.

Two of the staff we were unable to find included P's second and last two Consultant Psychiatrists (CP2 and CP7), who were both locums. Despite trying through the professional bodies we were unable to find contact details.

Eight staff were invited for interview. One person refused to attend, and two people did not reply (including the Care Co-ordinator who discharged P from Rochester CMHT, and his first Care Co-ordinator, CPN1 following his first admission). This is unfortunate as they would no doubt have had much to contribute to this investigation.

Five staff helpfully attended for interview. Only two of these were still employed by the mental health trust.

Every interview was recorded and transcribed and all the interviewees had the opportunity to check the factual accuracy of the transcripts and to add or clarify what they had said.

9.3 Root Cause Analysis

This report was written with reference to the National Patient Safety Agency (NPSA) guidance.¹² The methodology used to analyse the information gathered was by the use of Root Cause Analysis (RCA). Root Cause Analysis is a retrospective multi-disciplinary approach designed to identify the sequence of events that led to an incident. It is a systematic way of conducting an investigation that looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happened.¹³ The Fish Bone analysis was used to assist in identifying the influencing factors which led to the incident. This is represented diagrammatically on page 41.

10.0 SOURCES OF INFORMATION

The independent investigation team considered a diverse range of information during the course of the investigation. This included the Trust's Internal Investigation Report, CMHT records, Psychiatric Reports prepared for the Court, Approved Social Workers reports, Trust policies and procedures and internal performance management information.

A complete bibliography is provided in the appendices.

¹² National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

¹³ id p38

11.0 CHRONOLOGY

11.1 Background and history

P was born in Chatham in 1982. He grew up in Strood and describes his childhood as 'OK'. He started school at the age of five, attending the local infant and then junior schools. He reported he hated school and used to play truant from the junior school. He was involved in fights at school and was reported to be about to be expelled when he changed schools at the age of 8 at his mother's request.

He attended a nearby secondary school but estimated that he left at the age of 14 without any formal qualifications. Again he reports regular truanting, and also being the victim of some bullying, although he did not consider this as significant or severe. At the time he stopped going to school, he also reports he started getting into trouble with the police. This included offences against property, and taking a vehicle without consent. Mr P reports that someone had 'started on a friend' and he had responded, and was subsequently arrested by the police.

P has had two jobs, the first packing magazines at the age of 18. He reports that he was sacked along with the friend who had helped him get the job, when his friend was found writing names on a toilet wall. His second job was at a 'sheet metal place' which lasted four weeks. This ended because he reported he broke his wrist. P reports he has been 'on the sick since then'.

According to P, his father suffered with mental health problems. His parents separated when he was 16, and he blamed his mother for the breakup of the marriage. His mother remarried 5 or 6 years later.

He is the only child of that relationship, though he has step brothers and a sister from a previous relationship of his mother's, and a younger half-sister from his mother's remarriage.

He lived with his father until just before Christmas 2004, when he was made homeless. It is not known whether P chose to or was obliged to leave. Medway council found him temporary accommodation. He reports he has had limited contact with his father since.

11.2 Drugs and alcohol

P reports he started using cannabis at 12 and it became a regular habit. He used amphetamines between the ages of 17 and 19 and cocaine occasionally. He said he had used ecstasy for 18 months on a daily basis and denied using heroin or benzodiazepines but claimed to have used magic mushrooms.

He admits being a heavy user of cannabis (15-20) joints a day, and has a history of using skunk. He denies that the use of alcohol or illicit drugs was related to his offences or his illness. At the time he reported drinking up to 4 or 5 pints of lager a day.

In 2006 he admitted using cocaine, and had a positive urine drug screen when tested as an informal patient.

In February 2009 P presented to the accident centre, Medway Maritime Hospital, after consuming '3 pints of cider and several lines of cocaine'. He was seen by the Medway Assessment and Short Treatment Team (MASTT) and advised to self-refer to KCA (originally called Kent Council on Alcohol, KCA provides independent drug, alcohol and mental health services).

From the notes it is clear that P has a long history of drug use, mostly cannabis, skunk, amphetamines and more lately cocaine. The use of these has been inextricably linked with his mental health deterioration, frequently leading to persecutory beliefs, paranoia, suicidal thoughts, criminality, aggression, violence and admission to hospital.

11.3 Criminal History

From an early age P had problems with aggression and a short temper. He is reported to have head-butted another child in 1994. He is reported to have stabbed a friend in the arm in 1997.

He has a history of frequent threatening behaviour, reportedly holding a knife against a neighbour's throat, threatening to kill various members of his family and on several occasions, healthcare staff. He has threatened most members of his family, though mostly his mother and father, although he also repeatedly stated he would never kill his mother. These threats have included threats to get a gun and shoot people, often resulting in the police being called. During 2006, it is reported the police took the threats so seriously they worked with the family, identifying a safe place for his younger sister to hide should P arrive at the family home threatening violence. Until the murder of TH in 2009, he had never been convicted of a violent offence.

Table 1: Offending history¹⁴

1998	Reprimanded for offences against property
March 1999	Conditional discharge for 12 months after conviction for destroying or damaging property
May 1999	Community Service Order of 120 hours, and disqualified from driving for 12 months after being convicted of taking a vehicle without consent, driving without a licence, and driving whilst uninsured
February 2000	Conditional discharge 12 months, disqualified from driving for 12 months. Offence of being carried in a vehicle taken without consent, and breach of conditional discharge
October 2001	Burglary and theft resulting community rehabilitation order of 18 months and community punishment order of 100 hours
June 2003	Using threatening, abusive, and insulting words or behaviour, receiving a community rehabilitation order for 12 months

¹⁴ Information from various sources, but mostly Psychiatric reports on P by Forensic Consultant Psychiatrist 1, 11 June and 16 September 2009

11.4 Psychiatric History

P has reported he first became unwell between the ages of 19 and 21. He recalled starting to talk to himself, and staying in the house and not socialising. This resulted in his first contact with specialist psychiatric services in October 2002.

Prior to that there is one mention of suspected mental health problems and P's tendency toward violence in the GP notes¹⁵, dated 7 March 1994. The note records that he *"tends to lose his temper every few weeks at home & at school, approx. started at age 7. School Headmaster feels he needs help and may be suffering with schizophrenia. Recently head-butted another child – admitted to it and also apologised. Mrs strongly disagrees with H teacher. Plan – mum to keep a diary of incidence for 2/12 if continues to assess. To bring (P) with her at next appt. Ph Mrs X (Head teacher) re behaviour."*

However there are no further records until a note made on 15 October 2002, when his father attended the GP surgery worried about P's behaviour with odd thoughts, paranoid and persecutory beliefs and fears of violence. Prior to admission he is reported to have threatened to kill an old neighbour by holding a knife to her throat. His father intervened.

This resulted in an assessment under the Mental Health Act (1983) and admission under Section 2 for drug induced psychosis on the 18 October, 2002 to Abbeydale Court, an independent psychiatric unit in Walthamstow.

18 to 30 October 2002: Admission 1¹⁶

P was admitted under section 2 of the Mental Health Act to Abbeydale Court a medium secure unit for because he had become increasingly paranoid, delusional and aggressive. He felt he would be kidnapped and killed. He had suspicions that the house was bugged, and the neighbours were monitoring what was happening in his house. He admitted to using cannabis and skunk. His father reported that he had been throwing food away because he believed it to be poisoned.

He became verbally abusive to a member of staff when his shower gel went missing. He was also heard telling his sister that he would get a shotgun and blow his father's head off. It was noted he would take offence easily and lose his temper quickly if his wishes were not met. There was no evidence of mood disturbance or psychosis, and he had not received any medication during this period. He was diagnosed with drug induced psychosis.

On 29 October 2002 it was decided there were no grounds for continued detention. P agreed to follow up by local psychiatric services. It was noted at the time he did not fulfil any criteria of any formal psychiatric disorder.

¹⁵ Information from GP notes

¹⁶ Discharge summary, Rochester Mental Health Team, 4 April 2006

6 November 2002.

P was seen by Consultant Psychiatrist 1 (CP1) in outpatient clinic. He was reported to be eating better and not taking drugs. He was not started on any medication but a further appointment was arranged in one month's time.

28 November 2002, and December 2002.¹⁷

P missed his appointment with Locum Consultant Psychiatrist (CP2) on 28 November 2002 and in December 2002.

6 December 2002

P's sister contacted the service to say that P was 'going mad'. He was saying that people were planning to kill him and that he was going to attack someone. Due to his non-attendance, he was referred to a community psychiatric nurse service.

2 January 2003

He was seen by Community Psychiatric Nurse 1 (CPN1) at his home. Although he denied feeling anxious or low in mood, on gentle probing he revealed that for the last 6 months or so people had been coming in to the house and 'placing smack' (heroin), although he had never found any. He asked for a gun to shoot the intruders. He also believed that someone had got into the house and infected the speakers, giving him impetigo. He refused further contact with mental health services, as he denied he had any mental health problems.

6 May 2003

P was seen in the mental health emergency assessment clinic due to weight loss. He was advised outpatient appointments but missed most of them.

13 June 2003

P charged with threatening behaviour. He was reported to have gone to his neighbour's house, accused her of throwing his keys away and threatened to kill her and her child. He was remanded in custody, spending 6 weeks in HMP Elmley.

17 June 2003

CP2 attempted to see P in custody, but he had been released on a Community Rehabilitation Order without a psychiatric assessment having been carried out.

September and December 2003

P did not attend out-patient appointments with CP2.

6 January 2004¹⁸

P was assessed by Mental Health Social worker on behalf of the Court Liaison Service following arrest for breach of the peace. He initially appeared to be quite lucid, but on probing appeared to be experiencing bizarre and paranoid thoughts. He believed that people were breaking into the flat to harm

¹⁷ Psychiatric reports on P by Forensic Consultant Psychiatrist 1, 11 June and 16 September 2009

¹⁸ Psychiatric reports on P by Forensic Consultant Psychiatrist 1, 11 June and 16 September 2009

him, and that 'a firm had a contract out on him' and that he would jump out of the back window to escape. His mother confirmed that no had attempted to break into his flat. She also confirmed that over the Christmas period he had made threats to kill various members of the family, including children. He denied recent cannabis use.

The MHSW arranged for a Mental Health Act Assessment, but he was not deemed detainable at that time.

7 January 2004: Admission Two

P's mother took him to see his new GP, GP2. She arranged for him to go to Brooke Ward, Medway Maritime Hospital, to be assessed by a psychiatrist. P agreed to this provided the appointment was under a false name. He went to the ward with his mother, but left before being seen. Later that evening, he rang his mother from a telephone box, and she reports that he threatened to kill. He was kept talking whilst the police were called. After half an hour he rang off, saying he was going to his brother's house where he was going to kill his sister-in-law.

He was apprehended by the police and arrested under section 136 of the Mental Health Act (19383) and taken to Medway Maritime Hospital. He was assessed by an Approved Social Worker (ASW) and GP2, and he was then detained under Section 2 of the Mental Health Act (1983) under the care of consultant psychiatrist 2 (CP2).

9 January 2004

P absconded from the ward but was apprehended quickly.

12 January 2004.¹⁹

Although initially settled on the ward, he became agitated and restless with paranoid ideation. He verbalised threats to hurt and or kill members of staff. There is a note he was found to be in possession of a knife.²⁰ This behaviour continued over the week. He admitted using cannabis earlier in the week. He was given 'as required medication' or 'prn' for his psychotic thoughts on the 12th, 13th, 14th and 16th January.

16 January 2004.²¹

He was assessed by the team from Willow Suite and who advised a further dose of psychotropic medication and then transferred to Willow Suite, the Psychiatric Intensive Care Unit (PICU) at Little Brook Hospital in Dartford. This medication required P being restrained in order to give it to him.

He was assessed by and detained under Section 3 of the Mental Health Act, due to his lack of insight. P stayed on the Willow Suite until 16 April 2004. He was eventually transferred to an open ward and discharged on 23 Jun 2004.

¹⁹CPA4 Risk Assessment, 12 January 2004

²⁰ Hospital Discharged Summary for GP, received 8 July 2004

²¹ Psychiatric Report, Forensic Consultant Psychiatrist 1, 11 June 2009

Between the first and second admissions, CPN1 who visited him at home stated that P kept asking for a gun to shoot an intruder whom he believed had the keys to his house and had been placing 'smack' in his house. Nothing was found in his home.

19 January 2004²²

P was referred for Forensic Assessment by the Kent Forensic Psychiatry Service (KFPS) based in the Trevor Gibbens Unit, Maidstone.

16 February 2004

P assessed by Specialist Registrar in Forensic Psychiatry 1 (SpR1). It was noted that P was suffering from a psychotic disorder, with persecutory delusions. A drug induced psychosis was also seen as a possibility, given his recent use of cannabis. It was also thought possible that P had a primary psychotic disorder, precipitated by the use of cannabis. However, P reported he didn't have any mental health problems.

It was also noted that P had symptoms consistent with conduct disorder, and he now also presented with features of dissociative personality disorder.

His risk of harm to self was determined to be low. Due to his continued detention, and his assurances to the contrary, it was also thought P was at low risk of harm to others, in particular, his mother. However, this would need thorough feedback on how he coped with increased freedom to assess the future risk of harm to his mother, especially as his mental health was known to deteriorate if he stopped his medication or abused cannabis or other drugs.

During this assessment, P also disclosed he had been paid to beat people up, although this was never corroborated, and may have been part of his delusions. The assessment noted that it was therefore important to obtain as much corroborative history as possible to clarify the issue so as to make realistic assumptions about the future. It was suggested if there were an element of truth in the issue it would justify his paranoia.

Comment

This appears to be a suggestion that further information from the police and or probation service is sought, and in the circumstances is highly sensible, especially given P's record of contact with the police and courts. However, there is no record of this ever having been done. As a result we are unable to separate truth from hearsay and P's own assertions.

23 March 2004²³

Care Plan developed with Care Coordinator 1 (CC1) and Social Worker1 (SW1). Noted interventions included:

- continued taking prescribed medication, both oral and depot form;
- attend regular out-patient appointments and CPA meetings;
- help P apply for supported accommodation;

²²22 Referral Letter to Kent Forensic Psychiatry Service 19 January from CP3

²³23 CPA3 23 March 2004

- support P with budgeting, personal hygiene and developing structure to his days; and
- support to manage his finances.

There were also very clear relapse indicators which included irrational behaviour, persecutory beliefs, physical and verbal aggression, increased drug use (cannabis/ skunk), disengagement with services and deterioration in his personal care.

16 April 2004

P transferred to Shelley Ward, Medway Maritime Hospital.

23 June 2004²⁴

P was discharged from Shelley Ward under Section 117 aftercare, and a discharge summary was forward to his GP, received on the 8th July 2004. His aftercare included out-patient appointments, oral medication (Olanzapine) and fortnightly depot medication (Clopixol) given as an injection by CPN1.

15 July 2004

Mental Health Risk Assessment completed, which identified past risk of minor self-harm, suicide threats and serious contemplation of suicide

It also documented a past risk of violence to others, aggression without violence, expressions or fantasies of violence, and acknowledgement that P had possessed dangerous weapons in the past. It did not indicate he was a present risk. It clearly identified risk indicators including persecutory beliefs and verbal and physical aggression.

July 2004

P was seen by CP4, his fourth Consultant Psychiatrist in two years. It was noted things had worsened, with increased persecutory beliefs and drug abuse.

25 August 2004²⁵

Updated Care Plan Summary noted. This appears to have been a Section 117 and Enhanced CPA review, to which P, his father and mother, SW1, GP2 and CPN1 were all invited. However, when this meeting occurred is not clear, since the date of completion is blank, the only date is a date stamp to note receipt for filing. It is also not clear who attended the meeting.

This meeting updated the previously discussed care plan. He continued to receive depot injections from CPN1 until 14 September 2004. P's mother phoned the CPN and said that P no longer wished to have depot injections as he would be out working.

²⁴ Discharge Summary 8 July 2004

²⁵ Updated Care Plan Summary/ Care Programme Approach review, date stamped 24 August

CPN1 last had phone contact with P on 20 September when he was adamant he did not want any prescribed medication. He was however drinking 4 to 5 pints of lager a day, and smoking cannabis. CPN1 tried to contact P on several occasions, but was unsuccessful. P's family were to contact the mental health service if he became unwell.

P was noted to have begun to reject medication and disengage with psychiatric services over the last three months. He had been made homeless just before Christmas (though it is not clear if he left or was thrown out of his father's home) and temporary accommodation had been found by Medway Council. He had avoided contact with mental health services. However, there has been reports over the New Year that P was becoming increasingly paranoid, and services tried to re-engage with him. It was reported that he said he would kill the Social Worker and Community Nurse if they ever tried to visit him.

Again he was reported to have increasingly paranoid beliefs that people were trying to kill him and his family, and he wanted to obtain a firearm for protection.

14 January 2005

Assessment arranged for P under the Mental Health Act but he ran away. A samurai sword was found in his home, but this was not removed by the police. He later went to his mother's house and tried to get in. He was reported to be abusive and swearing. Though the police were called he evaded them again. It was reported that he was saying that 200 people were out to get him, and that he would kill anyone from mental health services who tried to see him.

18 January 2005

Mental Health Risk Assessment completed by Care Coordinator CC1. Identified P as past risk of suicide or self-harm, with a past risk of violence towards others. His risk of aggression without violence, fantasies of violence expressed and being known to have possessed dangerous weapons was note be both past and present. There is a discussion about the behaviours that will arise if P becomes worse. However, this risk is not graded as high, low or medium risk and is merely a description of what is already known about P.

19 January 2005: Admission Three²⁶

P was assessed under the Mental Health Act by Approved Social Worker 1 (ASW1) accompanied by the police to ensure public safety. P continued to voice his persecutory beliefs, saying he had walked 50 miles to evade capture from the 200 people out to kill him, and if they killed him, he would kill them. On questioning he admitted having recently smoked cannabis.

P was detained under Section 2 of the mental Health Act (1983) and admitted to Ash Ward, Little Brook Hospital. He again maintained he did not have any mental illness

²⁶ Approved Social Workers Report, Medway Council, 19 January 2005

20 January 2005

P was transferred to Willow Suite secure unit as he threatened to kill some of the staff and was at risk of absconding. Urine Drug Screen (UDS) tested positive for cannabis on 20th and 21st January, but negative on the 25th January 2005.

16 February 2005.²⁷

P was transferred back to Shelley Ward, Medway Maritime Hospital. By this time, Section 2 of the Act had been converted to the Section 3 of the Mental Health Act 1983. He still expressed persecutory delusions but remained non-violent.

The plan on transfer back to Shelley Ward is reported²⁸ to have been transfer to an open ward, consider depot medication (Depixol), referral for Cognitive Behavioural Therapy (CBT) and Assertive Outreach.

Comment

Given P's history of disengagement with services, referral to Assertive Outreach was a sensible option. That this did not happen seems to have been a missed opportunity to help keep P engaged with services. However, this also may have aspects of hindsight bias, since efforts by Rochester CMHT and collection of his benefits from the team meant that P maintained contact until the procedures for collection of his benefits changed in early 2008, and even though he disengaged with services throughout most of 2008 there is no indication that his mental state had worsened, even when seen by CMHT staff on 1 December following a telephone call from his mother.

31 March 2005

Mental Health Review Tribunal report prepared by a new locum Consultant Psychiatrist, CP5 noted that P continues to persecutory beliefs, that people and a millionaire gangster were after him, and that people had been hired to kill him. He had tested positive for cannabis and amphetamines, and admitted using ecstasy. He maintained he didn't have a mental illness and questioned the need for prescribed medication.

P had been granted leave but tested positive for cannabis on return. P's family were invited to the ward round, and expressed their concern that he should be on a secure unit, as they were very scared of him, and felt he could kill one of the medical team on discharge.

8 June 2005.²⁹

P was discharged from Shelley Ward. At the time of his discharge his consultant was Consultant Psychiatrist 5. He also had a new Care Coordinator, CC2, due to his old Care Coordinator being on long term sick. His final diagnosis was Persistent Delusional Disorder and Paranoid

²⁷ Discharge summary, Rochester Mental Health Team, 4 April 2006

²⁸ Psychiatric Report, Forensic Consultant Psychiatrist 2, 11 June 2009

²⁹ Discharge summary, Shelley Ward, Kent & Medway Mental Health Social Care and NHS Trust, 8 June 2005

Schizophrenia. At discharge, he still had delusional beliefs that people were after him.

His discharge summary stated that as he was still known to abuse drugs, it was not possible to assess the prognosis. He was not suicidal at the time of discharge. He was discharged with Depixol Injection 100 mg once every three weeks and oral Olanzapine 5 mg at night.

Prior to discharge a CPA Care Plan had been formulated which recognised again the need to maintain stable mental health with medication, along with support for housing and clear relapse indicators as before.

20 June 2005.³⁰

P attended the accident centre at Medway Maritime Hospital for 'needs psych help'. He was given re-assurance and advice, and a note was sent to his new GP, GP4.

21 June 2005.³¹

P did not attend his first out-patient appointment with CP5 since discharge. In a letter to his GP it was noted he would be 'offered one more appointment in due course'

22 June 2005.³²

P attended the accident centre at Medway Maritime Hospital for 'needs psych help'. He was given re-assurance and advice, and a note was sent to his new GP, GP4.

21 October 2005: Admission Four³³

P admitted under Section 3 to Shelley Ward, Medway Maritime Hospital because of his deteriorating mental state. His mother was concerned that his mental state was deteriorating. His Care Coordinator had attempted contact on several occasions without success. He was becoming increasingly paranoid and aggressive, and his self-care had deteriorated.

4 November 2005.³⁴

He told a staff member that his stepfather, mother and Consultant Psychiatrist were responsible for his admission and that he would kill them all.

A managers meeting (date unknown) upheld his Section 3 but shortly after that he was discharged from his Section as he had agreed to stay on the ward informally.

5 December 2005.³⁵

P discharged from Shelley Ward.

³⁰ Contact note from the accident centre, Medway Maritime Hospital to GP4, 20 June 2005

³¹ Letter to GP4 from locum Consultant Psychiatrist CP5

³² Contact note from the accident centre, Medway Maritime Hospital to GP4, 22 June 2005

³³ Approved Social Workers report, 21 October 2005; Discharge summary, Rochester Mental Health Team, 22 June 2006

³⁴ CPA4 Risk Assessment

³⁵ Discharge summary, Rochester Mental Health Team, 4 April 2006

It is not clear what contact, if any P then had with mental health services until March 2006, since we have not seen any copies of medical records for this period. A discharge summary dated 22 June 2006 notes that P had a new Consultant Psychiatrist, CP6. This summary was apparently written on 8th December 2005 but not signed until July 2006.

This discharge summary records that follow up was to continue to be out-patient appointments in the Rochester sector clinic, and Care Coordinator visits. He was prescribed oral Olanzapine, 10mg at night, and Propranolol. His diagnosis was now recorded as paranoid schizophrenia and drug induced psychosis.

28 March 2006³⁶

Care Coordinator 2 wrote to GP4 inviting him to attend P's Care Programme Approach (CPA) Review on 4 April 2006.

30 March 2006³⁷: Admission Five

P was informally admitted to Brooke Ward, Medway Maritime Hospital by the home treatment team on account of a relapse. He reported he had been using £500 to £600 worth of cocaine daily with two other friends and that he felt the cocaine was doing his head in. He had presented himself to the Home Treatment Team for admission so he could get away from the people who were 'winding him up'. He denied hearing voices or seeing things but said he was not having enough sleep. It was reported that he had been experiencing suicidal thoughts for the past 2 days but had no intention of acting on these thoughts. Urine Drug Screen tested positive for cocaine

31 March 2006³⁸

Care Coordinator 2 wrote to GP4 to inform him that P's CPA review on 4 April 2006 had been postponed as P had been admitted to Brooke Ward, Medway Maritime Hospital.

Through this admission, P was pleasant and appropriate in behaviour. He related well with staff and denied thoughts of self-harm or suicide. No psychotic features were noted.

3 April 2006

Note to be flat in mood, not joining in, refusing to join the community meeting or Occupational Therapy. However, his mental state improved over the day. The following day he noted to be cheerful and joking with fellow patients.

5 April 2006

P was discharged following a CPA meeting.

The discharge summary dated 22 June 2006 records that follow up was to continue to be out-patient appointments in the Rochester sector clinic, and Care Coordinator visits for one month. He was prescribed oral Olanzapine,

³⁶ Letter from Care Coordinator 2 to GP 4, 28 March 2006

³⁷ Discharge summary, Rochester Mental Health Team, 4 April 2006

³⁸ Letter from CC2 to GP4 on 31 March 2006

10mg at night, and Propranolol. His diagnosis was now recorded as paranoid schizophrenia and mental and behavioural disturbances due to substance misuse. Propranolol had been stopped and P was prescribed Mebevrine 135mg three times a day. The plan also comments that P was to be referred for a forensic assessment if he had not already had one.

7 May 2006³⁹

P attended the accident centre, Medway Maritime Hospital with complaint of 'allergic reaction'. A note was sent to his GP (GP4).

Little is known about contact with P through the remainder of 2006 as no records have been provided.

7 February 2007⁴⁰

P attended the CMHT offices in St Bartholomew's ('St Bart's') Hospital, Rochester to see his care coordinator, CC2. As she was on leave until 8th February, the services support assistant met with P in reception. P was apparently asking for his care coordinator to sign his passport photograph as he was applying for a driving licence. As P was due to call in tomorrow to receive his benefit from the CMHT (via his appointeeship) the support assistant said he would ask CC2 the next day on her return to sign the photograph.

Comment

This is the first record of P attending the CMHT to obtain his benefits. Prior to this there is no record of planning to do this, and how it would be monitored. In future such processes and plans should be documented to demonstrate good governance.

Recommendation 3.

Where service users are in receipt of benefits via appointeeship⁴¹ that involve members of the Trust or Local Authority, the Trust and Local Authority should ensure there is a clear documented plan and process for dispensing of the benefit, and adequate oversight and governance arrangements are in place in accordance with Department of Work and Pensions guidance.

19 February 2007.⁴²

GP4 invited to attend review of P's Care Plan on 6 March 2007

CC2 wrote to P inviting him to attend his CPA review on 6 March 2007.⁴³

³⁹ Contact note from the accident centre, Medway Maritime Hospital to GP4 7 May 2006

⁴⁰ Social Services contact record

⁴¹ Appointeeship. An officer of grade EO (Executive Officer) or above acting on behalf of the Secretary of State can authorize someone else to act on a customer's behalf only if the customer is incapable of managing their own affairs. This is called an appointment to act and the person or organization appointed to act is called an appointee.

An appointment to act is made under Regulation 33 of the Claims and Payments Regulations 1987. An officer of grade EO or above acting on behalf of the Secretary of State can also revoke an appointeeship under Regulation 33 of the Claims and Payments Regulation if the appointee is not acting in the customer's best interests. It is important to determine whether an individual is acting in a personal or a professional capacity. See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226772/Part-05_Appointee.pdf

⁴² Letter to GP4 from support services assistant, Rochester CMHT, 19 February 2007

⁴³ Letter from CC2, Rochester Community Mental Health Team St Bart's to P on 26 February 2007

26 February 2007

Care Coordinator2 wrote to P reminding him of his CPA review on 6 March 2007.⁴⁴

6 March 2007

Enhanced CPA Care Plan review held at St Barts' Hospital, Rochester. In attendance were P, CC2, P's mother and new Consultant Psychiatrist CP7. There is no mention that P was subject to Section 117 aftercare. This is the last recorded time he was seen by CP7 prior to his arrest in February 2009. His mental health was noted to be have been better in the last few weeks. His finances were still being sorted and it appears his mother was sorting out his appointeeship. No relapse indicators were noted.

26 March 2007

Appointment sent to P for Out Patient Appointment on 12 June 2007 in Strood, with Staff Grade Psychiatrist (SGP).

3 May 2007

P attended Rochester CMHT to collect his benefit. Reported limited use of drugs. Noted to be alert and communicative.

17 May 2007

P attended Rochester CMHT to collect his benefit. He was seen by Care Coordinator CC1. No evidence of psychosis noted.

28 May 2007⁴⁵

P attended the accident centre, Medway Maritime Hospital with complaint of DIB (difficulty in breathing).

12 June 2007⁴⁶

P did not attend his outpatient appointment with the staff grade psychiatrist (SGP).

13 June 2007

Letter sent from SGP to GP4 and P regarding missed appointment by P.

13 July 2007⁴⁷

P called into office to collect fortnightly money. He was seen by care coordinator CC1. There were no signs of mental illness reported or observed and he continued to state that he was no longer doing drugs and felt better for it. CC1 felt that there was no need to see a psychiatrist.

⁴⁴ Letter from CC2, Rochester Community Mental Health Team St Bart's to P on 26 February 2007

⁴⁵ Contact note from the accident centre, Medway Maritime Hospital to GP4, 28 May 2007

⁴⁶ Letter from SGP GP4 and P, 13 June 2007

⁴⁷ Contact Record, CC1 Senior Practitioner, 13 July 2007

26 July 2007⁴⁸

P called into the office to collect his fortnightly money and was seen by He was seen by Care Coordinator CC1. There was no evidence of psychosis or relapse indicators.

30 July 2007⁴⁹

P arrived to see CC1 or CC2 but as neither were in he saw the CMHST support services assistant. He told this person that he wanted to move out of the Medway area quickly as he had had enough of his friends who laughed at him for not using drugs. P was told that he would leave a message for CC1 to contact him on Monday of the following week.

23 August 2007⁵⁰

P went to see CC1 to collect his fortnightly money. His mental health was satisfactory.

10 September 2007⁵¹

P went to see CC1. He admitted taking an unspecified substance but assured him it was a 'one off' incident.

Care Coordinator CC1 wrote to the Benefits Office in Chatham confirming P was still receiving services from Rochester CMHT.

13 September 2007⁵² 0915 – 0935Hrs

P called into the office unexpectedly, and spoke to CC1. It was clear that he was not well He said that he had recommenced taking cocaine daily for the past 5 days. He enquired about admission as a means to distancing himself from his associates who took drugs. They discussed option for action such as spending a few days with his father or fiends in London and advised him to avoid contact with his associates. CC1 offered to assist him with the tasks by referring to a vocational advisor and liaising with his current housing association.

13 September 2007 1330Hrs⁵³

P attended St Bart's (Rochester CMHT office) saying he had lost £60 and whether he could get food vouchers. P spoke with a Social Worker, and was advised to budget better as he had had food vouchers in the past. P stated he had an interview o work for the Royal Mail.

1 November 2007⁵⁴

Service support assistant wrote to GP4 informing inviting him to attend P's CPA Care Plan review along with his care coordinator and consultant

⁴⁸ Contact Record, Senior Practitioner 26 July 2007

⁴⁹ Contact Record, service support assistant, 30 July 2007

⁵⁰ Contact Record, CC1,Senior Pracitioner,30 August 2007

⁵¹ Contact Record, CC1, Senior Pracitioner,10 September 2007

⁵² Contact Record, CC1 ,Senior Pracitioner,13 Septmeber2007

⁵³ Contact Record, locum CPN,13 September 2007

⁵⁴ Letter to GP4, 1 November 2007

psychiatrist. CC2 wrote to P informing him of the upcoming CP on 23 November 2007.⁵⁵

20 February 2008⁵⁶

CC3 wrote to P informing him of his CPA Care Plan review on 29th February 2008. This appears to be around the time that CC1 went on long term sick leave, and was replaced with Care Coordinator CC3. CC3 was a locum Social Worker from Australia.

GP4 was also written to inviting him to attend the CPA Car Plan review.⁵⁷

20 February 2008.⁵⁸

GP4 invited to attend review P's Care Plan on 29th February 2008.

5 March 2008⁵⁹

P visited St Bart's to discuss his concern about the management of his finances by his mother. He spoke with CC3. He felt that he was frustrated with his mother, implying she was manipulating him by holding back his money. He requested that CC3 contact his mother to put his benefits into his control. There was no evidence of positive symptoms throughout contact. He denied experiencing any mental health problems, though his speech was reported to be pressured. He recognised that his medication helped with his thoughts and that he no longer felt suicidal. He admitted that he was using cocaine at the moment but said it was only about once or twice a month. CC3 discussed organising an OPA to review his medication but P refused to attend.

8 April 2008⁶⁰

CC3 telephoned P to review his progress. He left him a message asking him to contact Rochester CMHT.

14 April 2008

GP4 invited to attend P's Care Plan review on 18 February 2008.⁶¹ The letter was received on the 17th April 2008. Care coordinator CC3 wrote to P inviting him to attend a review of his Care Plan on the 18 April.⁶²

15 April 2008⁶³

P failed to attend an appointment and CC3 made a note to liaise with the treating doctor to review P's status.

21 April 2008⁶⁴

CC3 wrote to P, saying that he had attempted to contact him to discuss the financial issues raised in his last appointment. CC£ informed P that he had

⁵⁵ Letter from CC2 to P, 1 November 2007

⁵⁶ Letter from CC3 to P, 20 February 2008

⁵⁷ Letter to GP4 20 February 2008

⁵⁸ Letter to GP4 from support services assistant, Rochester CMHT, 19 February 2007

⁵⁹ Contact Record, CC3, Care Coordinator, 5 May 2008

⁶⁰ Contact Record, CC3, Care Coordinator, 8 April 2008

⁶¹ Letter to GP4, 14 April 2008

⁶² Letter from CC3 to P, 14 April 2008

⁶³ Contact Record, CC3, Care Coordinator, 8 April 2008

⁶⁴ Contact Record, CC3, Care Coordinator, 21 April 2008 and letter from CC3 to P, 21 April 2008

made a new appointment for the 6 May 2008 at St Bart's Hospital to review progress.

6 May 2008⁶⁵

P did not attend to discuss his finances or to his CPA review with CC3.

19 May 2008⁶⁶

CC3 at Rochester MHT wrote to P informing him that P's care plan review would be held on 6th June 2008 at 3 pm. He informed P that he would meet him at St Bartholomew's at 3 pm and would attend the interview with him. Letter sent to GP4 inviting him to attend.

6 June 2008

P did not attend his CPA Care Plan review with Care Coordinator CC3 and Consultant Psychiatrist CP7.

29 September 2008⁶⁷

CC3 discussed P in the CMHT Team Meeting. Advised by treating doctor and team to offer an appointment, and if P 'DNA's again' to discharge his care back to his GP.

30 September 2008⁶⁸

CC3 wrote to P informing him that it had been a long time since he had been in contact and he asked him to come to St Bart's on 10th October 2008 at 1 pm. CC3 said that it was imperative that he attend the appointment and if he failed to do so without notifying CC3 of a reason he would have to discharge him from the service and his care would be transferred back to the hospital.

10 October 2008⁶⁹

CC3 wrote to GP4 informing him that P had failed to attend outpatient appointments and had not been in contact with the services. Therefore they would be discharging him back to Dr Martin's care.

15 October 2008⁷⁰

Consultant psychiatrist CP7's secretary sent P a letter saying that as he persistently failed to engage with services over the last three years, he would be offered one last appointment on 19 November 2008 and failure to attend the appointment could lead to him being discharged back to the care of his GP.

20 November 2008⁷¹

Consultant psychiatrist CP7 wrote to GP4 informing him that P had been discharged from their services due to lack of engagement and that should he

⁶⁵ Contact Record, CC3, Care Coordinator, 6 May 2008

⁶⁶ Letter from CC3 to DP on 19 May 2008

⁶⁷ Contact Record, CC3, Care Coordinator, 29 September 2008

⁶⁸ Letter from CC3 to DP on 30 September 2008

⁶⁹ Contact Record, CC3, Care Coordinator, 10 October 2008

⁷⁰ Letter from secretary to CP7, 15 October 2008

⁷¹ Letter from CP7 to GP4 on 20 November 2008

have any concerns regarding his mental health in the future, he could re-refer him to the service.

27 November 2008⁷²

On 27th November 2008 P's mother had contacted the CMHT by telephone. She spoke to the duty worker, a locum social worker, expressing concern that P had recently been increasingly under the influence of drugs, spending all his money on drugs, asking for more money and becoming abusive and paranoid with aggressive behaviour. It was agreed with the duty worker that P would be visited the next day when he would be less likely to be intoxicated. P's mother agreed to call the police should she feel threatened.

28 November 2008⁷³

The locum social worker / duty worker and a colleague, CPN2, visited P on 28th November at his home address but there was no response.

1 December 2008

P presented at the offices of the CMHT, and met with the same locum social worker who had spoken with his mother. It was noted there were no overt symptoms of mental illness. P was still in need of money, and was asking for a crisis loan. As P's mother was still the appointee, both P and his mother were informed that she would need to apply for the crisis loan on his behalf. It is noted that P was satisfied with the outcome.

5 February 2009⁷⁴

P presented at the accident centre feeling suicidal after drinking 3 pints of cider and using several lines of cocaine. He was referred to the Medway Assessment and Short Term Treatment team (MASTT) and seen and assessed by two members of the team. He was noted to be feeling suicidal and requested admission for two weeks to 'sort his head out'. His previous non-engagement with Rochester CMHT was noted and his presenting problems were identified as mental and behavioural disorders due to us multiple drugs. P was advised to self refer to KCA for help with his drug problems, his GP or A&E.

This was the last recorded contact with P before his arrest for the murder of TH on 6 February 2009.

⁷² Contact record, locum social worker/ duty worker, 27 November 2008

⁷³ Contact record, locum social worker/ duty worker, 28 November 2008

⁷⁴ Emergency Department, Medway NHS Foundation Trust, contact note to GP4 5 February 2009, MASTT Management Plan, 5 February 2009

12.0 REVIEW OF CARE AND TREATMENT OFFERED TO P BY THE MENTAL HEALTH TRUST

12.1 Risk Assessment and Section 117

For the majority of the time between 2002 and 2009 P was subject to Enhanced CPA and also the provisions of aftercare under section 117 of the Mental Health Act.

This should have meant he received regular assessment of the risks he posed to himself and others, and should not have been discharged without his Care Coordinator and Responsible Clinician convening a multi-disciplinary meeting.⁷⁵

The investigation team have noted only 4 occasions when P's risk was assessed and recorded. These were 16 January 2004, in the Kent Forensic Psychiatric Service assessment, 22 January 2004 in his initial CPA Care plan, Mental Health Risk Assessments on 18 of January and 15 July 2005. There were further later CPA Care Plans documented, and also several discharge summaries and Approved Social Workers Reports. However, the issue of risk of harm to self or others was not recorded in any of these. The quality and frequency of risk assessments from July 2005 was inadequate.

Comment

This is a clear breach of Trust policy for both the Care Programme Approach and section 117 aftercare, and also the requirements of the Mental Health Act (1983) under Section 117. Risk Assessment at key points in an individual's care, such as admission and discharge, and on transfer from one service to another have been a cornerstone of mental health policy since 1990, and further guidance and policy has only reinforced this. Not only was risk not assessed under the CPA review process, there appears to be no documented consideration of risk in either discharge summaries or Approved Social Worker Reports completed when he was sectioned.

The latter is of particular concern since risk of harm to self or others is the key indicator for use of the Mental Health Act.

However, we are aware of the findings of the 2009 CPA Audit on Care Planning and Risk Assessment. We also note that the Trust now measures CPA Care Plans and Risk Assessments as part of its routine quality performance monitoring, and that a high number of risk assessments not being completed is one of the factors that will alert service managers to the potential of poor team performance as part of the Early Warning Trigger Tool now in use.

⁷⁵ "Section 117 of the Mental Health Act 1983 Operational Procedures June 2003", West Kent NHS & Social Care Trust, Kent County Council and Medway Council Social Services Department

Recommendation 4.

The Trust should ensure that it continues to be routinely informed of team compliance with the CPA standards for Risk Assessments and that it can demonstrate taking action when performance falls below standards.

This practice should extend to ensuring those in receipt of section 117 aftercare also have appropriate care plans and discharge arrangements.

12.2 Admission

As well as the first admission to Abbeydale Court in 2002, P had 4 further admissions between 2002 and 2006, two of which involved detention under Section 3 of the Mental Health Act. On one of these occasions he was admitted under section 136 by the police, which was then changed to a section 2 and then section 3.

On two occasions he was admitted to Willow Suite PICU in Dartford for short periods.

Comment

When ill he was often unwilling to receive treatment. Given the nature of his presenting problems, with attempts to abscond, paranoia and substance misuse, these admissions and detentions appear to have offered appropriate and responsive treatment in the least restrictive environment when needed.

The involvement of a member of staff from Willow Suite to advise and help the open ward manage P on his return to it in 2004 is a very positive example of joint working and good practice.

12.3 Medical Treatment

There is no doubt that P had a severe psychosis. Whether this was drug induced or his substance misuse was linked to the development of a full blown psychosis is hard to assess from the notes up to the point of his arrest, although a more formal diagnosis is apparent now, following his admission to a secure psychiatric unit after a period in prison.

His last diagnosis recorded on a discharge summary was recorded as paranoid schizophrenia and mental and behavioural disturbances due to substance misuse.

P was treated with two different medication regimes. He was variously given depot anti-psychotic medication (Clopixol and Depixol) during his admissions and for as long as possible afterwards with positive results, although as soon as he could, P would refuse the injections. He was also treated with a regular oral anti-psychotics, such as Risperidone, Amisulpiride and Olanzapine. Although he did attend his GP in 2008 asking for more Olanzapine (he had

lost his latest prescription) he was known to have poor compliance with his treatment and oral medication.

Comment

It is likely that nowadays the use of a Compulsory Treatment Order would be used for someone like P, who was hard to engage with mental health services and not compliant with treatment. However, this option was not available to the CMHT after his last admission in 2006 as the law permitting compulsory treatment in the community did not change until 2008.

More assertive attempts to engage P and support his compliance with medication would no doubt have been of benefit.

12.4 Forensic assessment, MAPPA procedures and interagency communication

P was known to be easy to anger. He frequently made threats to kill people, including his neighbours and his family, particularly his mother. However, he is also recorded as saying he would never kill his mother. However, there is no doubt that the police took his threats seriously, identifying a 'safe space' in the house for his younger sister should he turn up and threaten the family. He was known to possess dangerous weapons (knives, and a samurai sword) and frequently stated he wanted, or was going to get, a gun to shoot somebody.

These threats and aggressive behaviour were always much worse when he had relapsed, and frequently included paranoia and persecutory beliefs that people (gangsters, millionaires) were 'out to get him'.

Despite his history of threats to kill, and threatening people with weapons, before his arrest in 2009 he had no convictions for serious violent offences.

Comment

Between 2004 and 2009 there were only two recorded comments that he should be referred for Forensic Psychiatric Assessment, the first when he was referred for assessment (which he duly received in 2004) and the second after his last admission in April 2006, which stated he 'should be referred or forensic assessment if he hasn't already had one' as part of his aftercare plan.

As his initial forensic assessment had identified that he was low risk provided he was within a restricted environment receiving treatment or supported to maintain stable mental health in the community it is not clear what benefit further forensic assessment would have had. In any case, on the few occasions he was seen by his care coordinators in 2007 and 2008 he was reported to be stable and not presenting with mental health problems. However, a more thorough assessment by his own psychiatrist at this time would perhaps have been more use in identifying the presence of underlying mental health problems.

P was convicted of threatening behaviour and there are several reports of his threats to other people, and his statement that he had been 'paid to beat people up'. He was known to consort with drug dealers and had a history of low level crime himself. It has also been reported he had threatened TH. More effective liaison and discussion with the police about the risks they perceived P presented would have been helpful in formulating a more comprehensive assessment and picture of P. It is not clear if he was ever considered for referral to MAPPA, but it is unlikely since he doesn't fit the criteria.⁷⁶

When his father contacted the GP practice initially in October 2002, P was appropriately referred by his GP for Mental Health Act Assessment in 2002 and then admitted under Section 2. P changed GP Practice twice between 2002 and 2008 and five GPs are named in his clinical records.

Between 2005 and 2008 he saw a GP on just three occasions (16 May 2007, 14 July 2007 and 1 August 2008) and was recorded as 'Did Not Attend' (DNA) for three further appointments, made by letter and telephone.

Whilst the Practice was informed of appointments, DNA's, admissions, invitations to attend Care Plan reviews, and P's attendance at A&E etc, they were never integral to P's care.

Comment

The GP Practices had a lack of involvement with P, and there was a complete lack of any real liaison and dialogue regarding the nature of P's problems, risks, and signs of relapse between the CMHT and the Practice. Without significant efforts to engage the GP and communicate effectively about P's care needs, the decision to discharge P back to the care of his GP seems inappropriate.

⁷⁶ There are 3 categories of offender eligible for MAPPA

Registered sexual offenders (Category 1)

Sexual offenders who are required to notify the police of their name, address and other personal details and notify any changes subsequently.

Violent offenders (Category 2)

Offenders sentenced to imprisonment/detention for 12 months or more, or detained under hospital orders. This category also includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children.

Other Dangerous Offenders (Category 3)

Offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm, there is a link between the offending and the risk posed, and they require active multi-agency management.

Registered sexual offenders remain MAPPA offenders until the period of registration and or probation supervision (whichever is the longest) ends. Sex offender registration can be anything from 12 months to life; the registration period depends on the offence and length of sentence and whether the offender is under 18 or an adult at the time of sentence. Violent and other sexual offenders remain under MAPPA management until the licence period or hospital order ends.

For other dangerous offenders they will remain within MAPPA until their level of risk has reduced sufficiently to manage the offender safely by ordinary agency management. Once this stage is reached offenders become de-registered from MAPPA

Recommendation 5

The Trust should ensure that as part of monitoring CPA and section 117 practice that when any service user on Enhanced CPA or section 117 is considered for discharge to their GP's care that there is evidence of attempts to engage the GP with fully documented explanation of the risks and relapse indicators for that individual, and that rapid access to mental health expertise should it be required by the GP is clearly identified in the discharge plan.

12.5 Management of dual diagnosis

Although P was known to have significant substance misuse issues, he is not known to have been involved with or referred to substance misuse services.

There are likely to be several reasons for this. Firstly there was a shortage of staff within the Dual Diagnosis service, with only two staff available for the whole trust. Traditionally staff in the CMHT reported 'just getting on' with working with people with substance misuse problems. A further reason maybe that when well, P had less problems from his substance misuse, though he still no doubt took drugs. But his substance misuse compounded his mental health problems and vice versa. Treating his mental health problems (by admission and psychotropic medication) lessened his use of illicit substance misuse. During 2007 when he had engaged with the CMHT for the longest period, it appears that he was not presenting with serious problems related to his illness or drug use. Even in 2008 on the few occasions he was seen, he appeared stable. There are contact notes of CMHT staff discussing ways of reducing drug abuse. The final reason may be there was an expectation that P should take responsibility for his substance misuse. On his last contact with mental health services (MASTT team in February 2009) he was given the contact details of KCA to self-refer for support with his drug misuse problems.

Comment

Since 2009 NICE have issued new guidance on managing people with substance misuse and psychosis.⁷⁷ There is no doubt that practice and resources available fell short of this best practice guidance.

Recommendation 6

With respect to the future management of people with substance misuse problems and psychosis the Trust should ensure its staff are able to support the competencies outlined in the NICE guidance for working with people with psychosis and substance misuse, and work with commissioners to develop appropriate commissioned pathways for people with dual diagnosis.

⁷⁷ NICE clinical guideline 120 "*Psychosis with coexisting substance misuse; Assessment and management in adults and young people*" March 2011

12.6 Assertive Outreach and engagement with services

P was known to not engage with services, even when well. It appears that he engaged with the CMHT during 2007 and 2008 purely to receive his benefits. During that period it is notable that he rarely attended CPA reviews and out-patient appointments, even when he had recently attended the CMHT for his benefits.

However, the process for providing P with his benefits during this period fell short of the recommended practice outlined by the Department of Work and Pensions, and it is understandable that the CMHT felt uncomfortable with the duplicity involved (P's mother was the appointee, but let P believe it was the CMHT) and reluctant to continue the practice. With hindsight it may have been better to arrive at a more formal solution where the Care Coordinator or other member of the Local Authority was the appointee, although it is not clear if P's mother would have agreed to this.

This process does appear to have kept P in contact with mental health services, however briefly. Once the practice stopped P virtually ceased contact with the CMHT and his Care Coordinator. Although it was known that P often relapsed without engagement, on the few occasions he did see CMHT staff between 2007 and 2008, he was noted to be mentally stable. He did not appear to be paranoid or psychotic. Because of this the grounds for referral to assertive outreach were limited.

Between 2002 and 2005 P had 5 admissions. During his third admission in early 2005 the plan on discharge was reported⁷⁸ to have been consider depot medication (Depixol), referral for Cognitive Behavioural Therapy (CBT) and Assertive Outreach. P did not receive either CBT or Assertive Outreach.

Comment

It is unfortunate that P was not referred for Assertive Outreach at that time. It is possible that from that point onwards they may have managed to maintain more engagement with P, and perhaps prevented further admissions. In hindsight it appears that the criteria for referral to Assertive Outreach varied between teams, as TH was referred and seen by Assertive Outreach, and by all accounts appears to have been less likely to disengage than P, and without the same paranoia and threatening behaviour.

However, the need for referral appears to have diminished in 2007 and 2008 as he was noted to be well when seen by the CMHT.

More assertive attempts to maintain his engagement with the CMHT are likely to have been beneficial in preventing relapse. The practice of writing to P, inviting him to attend an out-patient appointment or CPA Review and then repeatedly recording his 'DNA' was never going to increase his engagement.

⁷⁸ Psychiatric Report, Forensic Consultant Psychiatrist 2, 11th June 2009

An additional aspect which must have had a bearing on his engagement was the lack of consistent medical and CMHT staff involvement in P's care.

We have identified seven different Consultant Psychiatrists involved in P's care between 2002 and 2007 (excluding Forensic Consultant Psychiatrists), although it is not clear who his Responsible Medical Officer/ Responsible Clinician was at times. Alongside this he had appointments with various Staff Grade and junior medical staff.

He also had three different Care Coordinators. From 2008 onwards, when he disengaged almost completely with mental health services CMHT, he had a locum Care Coordinator, who did not know the proper procedures and policy to be followed under the Care Programme Approach and section 117 after care.

Comment

In effect this meant that few if any of the team knew P well and were therefore in a position to step in and suggest more robust interventions. It is also not clear why supervision processes fell down and why the Care Coordinator, a locum social worker, was allowed to practice in that manner and was not told that discharge without assessment would be very poor practice, and would be contrary to Trust policy and procedure.

It is additionally concerning that this lack of oversight extended to the medical team.

Recommendation 7

The Trust should ensure that within the Early Warning Trigger Tool, consistently high use of locum CMHT and medical staff is included as a potential warning for teams at risk of poor performance. For those teams where this occurs the Trust should ensure that the appropriate risk registers reflect the risk and that mitigation is put in place to reduce the underlying risk.

Recommendation 8

The Trust should ensure that Team Leaders and supervisory managers have the skills and understanding of quality performance management necessary to ensure the delivery of high quality care within teams. This should include the ability to closely supervise inexperienced staff, and model best practice including practicing assertively with vulnerable service users at risk of not engaging.

The organisation should also encourage and support staff to identify when services are at risk of delivering poor quality and to escalate their concerns to senior management.

12.7 The quality and appropriateness of the Trust's internal investigation

The Trust's Internal Investigation Report was benchmarked using the National Patient Safety Agency's "*Investigation credibility and thoroughness criteria*"⁷⁹. The Trust Internal Report achieved a medium score. The investigation included documentary management review, scrutiny of Specialist Registrar supervision notes and interviews with staff from the CMHTs. It could have been improved by further analysis of the information in the clinical records.

The main body of the report did not have the usual subheadings that one would expect.

A further criticism of the report is that its findings are rooted in the transactions of staff without wider consideration of root causes and contributory factors. There is no evidence that a systematic Root Cause Analysis or other method of analysis was used.

For example, though it identifies action is required to prevent inexperienced locum staff acting as Care Coordinators, the investigation has not identified the significant contributory factor of high turnover of locum staff within the CMHT (we identified seven Consultant Psychiatrists and three Care Coordinators over the period). This is important, as this requires a different response from the organization.

A further contributory factor we identified is a lack of clear team management procedures and accountabilities. There seems to have been a lack of oversight of P's last Care Coordinator, and a general failure to uphold and reinforce standards of good practice. Again this requires a different organizational response.

Liaison with families

Despite the requirement for appropriate liaison to take place with families and victims and perpetrators of homicides being well documented in national guidance such as the Being Open framework⁸⁰ the perpetrators family involved in this case have not been contacted by the Trust.

12.8 Implementation of the recommendations

Recommendation 1: Service users should never be discharged from service without following appropriate CPA process

We are aware of the CPA Audit that arose in 2009 and the findings of poor compliance across the Trust with CPA policy and Risk Assessment procedures. We are aware of the considerable inroads the Trust has made since then to assure itself of compliance with CPA and Risk Assessment policy and procedures.

⁷⁹ National Patient Safety Agency (2008) "RCA Investigation: Evaluation, checklist, tracking and learning log"

⁸⁰ National Patient Safety Agency (2004) "Being Open" (Updated Nov 2009)

The Trust now uses an Early Warning Trigger Tool to identify teams at risk of failing to meet standards. One of the triggers identified is lack of completion of Risk Assessments.

Recommendation 2: Community teams should be encouraged to request forensic assessments.

Forensic services have developed guidance for CMHTs and other services on what service user behaviours/history might constitute a reason for referral for risk assessment

Recommendation 3: Dual Diagnosis advice, information and case management information should be raised as a priority within teams.

Although the Dual Diagnosis Nurse Consultants had produced a protocol outlining their role and support available, this action is not completed as the role is reported to be no longer available within the Trust.

Recommendation 4: Every CMHT should have a dedicated Assertive Outreach team with specific guidelines for referral of difficult to engage service users.

Although this action is not complete, we are aware that community mental health teams in Kent have undergone substantial redesign.

We are also aware that this recommendation indirectly links with one of our recommendations, in that one of the factors involved in the lack of engagement with P was the lack of assertive practice from within the CMHT, in turn linked to robust team management.

We are aware of the investment the Trust has put in to developing its Team Leader capacity. This includes more specific operational and supervisory management training, and the development of a leadership academy.

Recommendation 5: Any locum staff employed by KMPT must have adequate induction and training to meet the roles and requirements that they are expected to fulfil.

We have seen the new Temporary Workers policy. We are also aware that the Trust has new induction policy arrangements for all staff which lasts a week, and includes training on CPA and Risk Assessment procedures. All Locum and Agency staff must undergo this training before being allowed to work for the Trust.

12.9 Current governance arrangements in relation to learning from serious incidents

Considerable changes have taken place within the Trust with regard to governance in relation to the investigation of, and learning from, serious incidents.

There has been extensive training in root cause analysis techniques has taken place for incident investigators within the Trust has taken place and a governance and accountability process has been developed. The current governance process for SUI's outlined in current Trust policy⁸¹ are that the Trust board are responsible for ensuring that systems and processes are in place to undertake suitable and sufficient investigations to ensure that learning and implementation can be demonstrated.

In order to do this the Trust board receive assurance from the Trust's Governance and Risk Committee through summary and exception reporting, and Trust governance structures continue to evolve

The Trust's Governance and Risk Committee review incident reports and ensure the procedure is suitable to identify any learning. They also have responsibility to ensure that lessons are shared and learned across the organisation and are implemented.

The Trust policy states that the Trust's Governance and Risk Committee will:

Receive assurance that underpins that change has been systemic and embedded throughout the trust where it is appropriate to the learning.

And that:

They will provide leadership and support to Service line Directors in undertaking their programme in continuous learning, review, implementing and sustaining change and then evaluating outcomes.

Additionally a Root Cause Analysis (RCA) Action Group is responsible for reviewing all completed investigation reports and ensuring that evidence is available to demonstrate the learning and to monitor and support local teams, managers and clinicians to implement arising action plans.

The RCA Action Group are also responsible for ensuring that learning is disseminated across the Trust in the form of a newsletter.

Each clinical service line have groups in place who ensure that local learning and action plan implementation has taken place and put any necessary arising risk reduction strategies in place.

The Medical Director is the designated executive lead for patient safety within the Trust.

Comment

The independent investigation team are satisfied that governance processes in relation to the investigation and learning from serious incidents has developed considerably since 2009. The Trust have developed a clear accountability framework and policies, which if followed, will ensure that

⁸¹ Kent & Medway NHS and Social Care Partnership Trust "Investigation of Serious Incidents, Incidents, Complaints and Claims" V3 October 2011

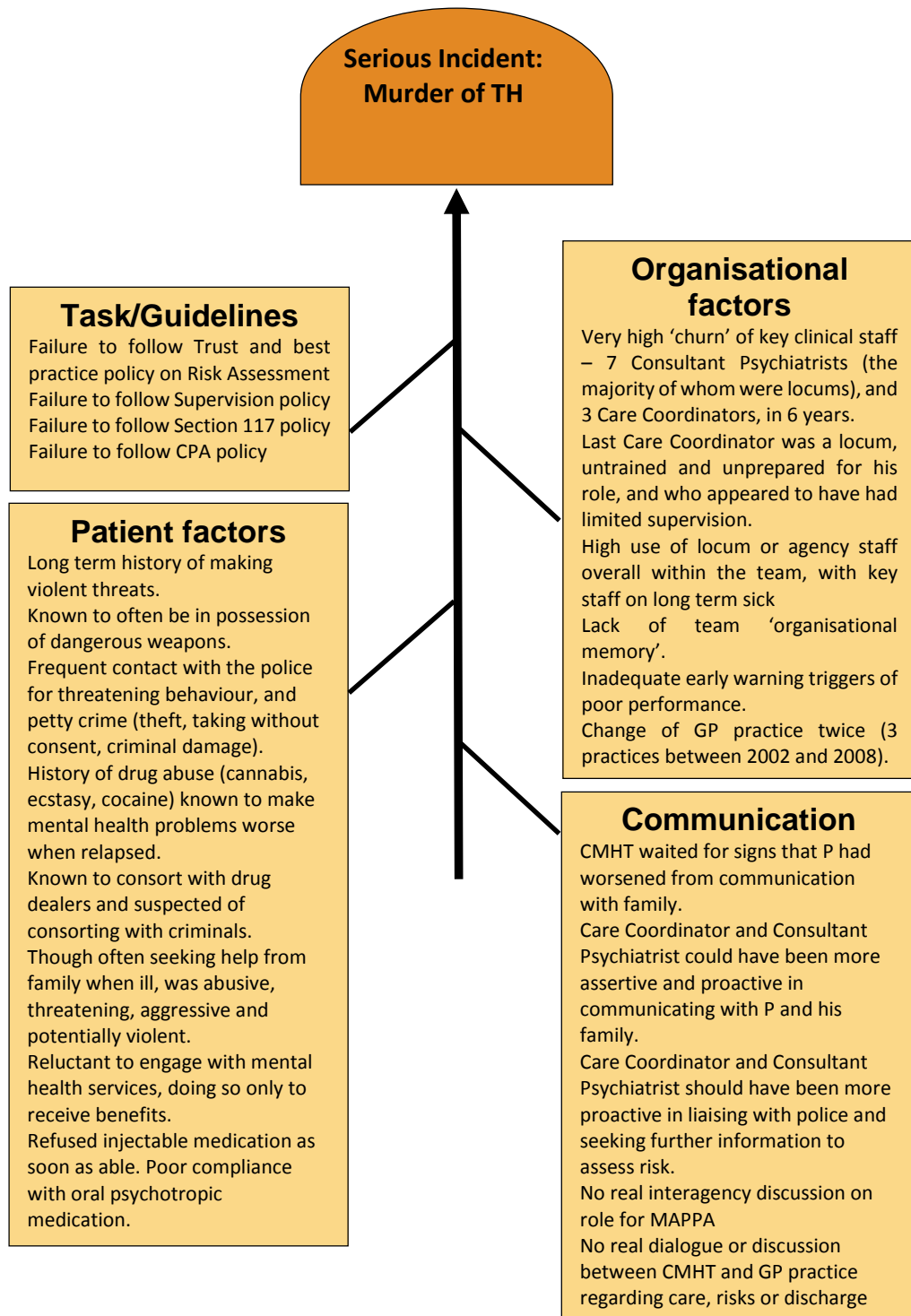
robust processes for investigation and the identification and dissemination of learning takes place.

We are aware of the Quality Impact Assessment tool that facilitates close monitoring of team performance across a range of quality measures for services undergoing change, so that an early detection of risks to quality are picked up and addressed.

The implementation of the Early Warning Trigger Tool will help identify teams at risk of substandard performance, as long as it is supported by other ways of triangulating information about services such as management and Board visits to teams.

13. ROOT CAUSE ANALYSIS

Fishbone Analysis



14.0 CONCLUSIONS

P had a psychotic disorder made worse by substance misuse. He experienced paranoid thoughts with persecutory ideas of people coming to harm him. He would become threatening and abusive. He was known to be easily angered and he frequently threatened his family and others with violence, and to kill them. He kept dangerous weapons, and often stated he was going to get a gun and shoot members of his family or the people that he thought were after him.

He had a history of low level crime and significant drug abuse, involving cannabis, ecstasy and cocaine, and was difficult to engage with specialist mental health services.

He had five admissions, two under section 3 of the Mental Health Act, between 2002 and 2006, after which he had limited contact with mental health services, failing to attend for CPA reviews and out-patient appointments. He refused to have depot medication when informal in the community and was known to have poor compliance with oral medication.

He last saw his Consultant Psychiatrist at a CPA review in March 2007. He attended the CMHT fortnightly for just over a year to receive his benefits (provided by his mother via appointeeship) but when this stopped in 2008 he stopped attending the CMHT.

He last saw his Care Coordinator in March 2008, when he was noted to have no positive symptoms of psychosis.

He was discharged in November of that year to the care of his GP for failing to engage with services, after it was agreed in a team meeting. Even though his GP had also had very limited contact with P, there was no real attempt to engage the GP practice in discussion about P's needs, risks, or signs of relapse. Attempts to engage P with the CMHT were limited to writing letters inviting him to attend for appointments or phoning him to leave a message. It may have been appropriate earlier in his illness to refer him to Assertive Outreach, and this may have prevented further deterioration. However, there is no indication that his mental health condition in 2008 warranted referral, and more assertive practice on behalf of his Care Coordinator and Consultant Psychiatrist should have resulted in a more robust assessment of his condition and needs.

His Care Coordinator was a locum Social Worker who was not UK trained and was unfamiliar with the Mental Health Act 1983 and the requirements of section 117 aftercare. Rochester CMHT appeared to have had a lot of locum or agency staff at that time, and there was a lack of organisational memory in the team. P had had 7 Consultant Psychiatrists and 3 Care Coordinators during the 7 years he was involved with Rochester CMHT.

His mother phoned the team in November 2008, after his discharge, worried about P, saying he had become increasingly paranoid and threatening.

He last met with two CMHT staff on December 1 2008 expressing his frustrations with his benefit set up and appointeeship. It was noted there were no overt symptoms of mental illness.

P's last contact with mental health services was February 5, 2009 when he attended the emergency centre at Medway Hospital, who referred him for assessment by the Medway Assessment and Short Term Treatment team (MASTT). He was seen and assessed by a doctor and another member of staff, and referred to KCA for support with his drug abuse. Information from the records suggest it is very likely that he had already killed TH by this date.

There is no indication that P was seriously mentally ill at this point.

He was later arrested and charged with the murder of TH.

Although his potential for violence and threats was well documented and taken seriously by the police, there is limited evidence of serious violence being perpetrated on anyone. His forensic assessment in 2004 did not indicate significant risk, and P had never been charged with a significant violent offence prior to his arrest in 2009. As there is no real evidence of violent behaviour after his last admission, it is our view that the murder of TH was not predictable.

Despite his lack of engagement with mental health services in general and his care team in particular, P seemed to be mentally stable with no positive signs of psychosis on the few occasions he was seen in 2008 and 2009. In the past his behaviours had always escalated to paranoia and violent threats involving the police and his family. Given that this did not happen during the period of December 2008 to February 2009, and that his mental state did not arouse concern on the two occasions he was seen before his arrest, it is unlikely that the murder was preventable.

APPENDIX A: TABLE OF RECOMMENDATIONS

<p>Recommendation 1.</p> <p>Following such catastrophic incidents the Trust should maintain a register of the full contact details, including professional body registration numbers, of all staff involved in the care and treatment of the patients in the incident, so that when required in the future there is a last known address with which to attempt to make contact .</p>
<p>Recommendation 2.</p> <p>NHS England should agree a protocol or memorandum of understanding, with all the UK major healthcare professional bodies, so that these bodies do all in their power to cooperate with independent investigation teams, and to provide the contact details of potential witnesses to facilitate these investigations.</p>
<p>Recommendation 3.</p> <p>Where service users are in receipt of benefits via appointeeship that involve members of the Trust or Local Authority, the Trust and Local Authority should ensure there is a clear documented plan and process for dispensing of the benefit, and adequate oversight and governance arrangements are in place in accordance with Department of Work and Pensions guidance.</p>
<p>Recommendation 4.</p> <p>The Trust should ensure that it continues to be routinely informed of team compliance with the CPA standards for Risk Assessments and that it can demonstrate taking action when performance falls below standards.</p>
<p>Recommendation 5</p> <p>The Trust should ensure that as part of monitoring CPA and section 117 practice that when any service user on Enhanced CPA or section 117 is considered for discharge to their GP's care that there is evidence of attempts to engage the GP with fully documented explanation of the risks and relapse indicators for that individual, and that rapid access to mental health expertise should it be required by the GP is clearly identified in the discharge plan.</p>
<p>Recommendation 6</p> <p>With respect to the future management of people with substance misuse problems and psychosis the Trust should ensure its staff are able to support the competencies outlined in the NICE guidance for working with people with psychosis and substance misuse, and work with commissioners to develop appropriate commissioned pathways for people with dual diagnosis.</p>
<p>Recommendation 7</p> <p>The Trust should ensure that within the Early Warning Trigger Tool, consistently high use of locum CMHT and medical staff is included as a potential warning for teams at risk of poor performance. For those teams where this occurs the Trust should ensure that the appropriate risk registers reflect the risk and that mitigation is put in place to reduce the underlying risk.</p>

Recommendation 8
The Trust should ensure that Team Leaders and supervisory managers have the skills and understanding of quality performance management necessary to ensure the delivery of high quality care within teams. This should include the ability to closely supervise inexperienced staff, and model best practice including practicing assertively with vulnerable service users at risk of not engaging.
The organisation should also encourage and support staff to identify when services are at risk of delivering poor quality and to escalate their concerns to senior management.

APPENDIX B: REFERENCES and BIBLIOGRAPHY

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Kent & Medway NHS and Social Care Partnership Trust *“Care Programme Approach Policy”*, 2012

Kent & Medway NHS and Social Care Partnership Trust *“Quality Impact Assessment: Tool and Process”* v2, 2013

Kent & Medway NHS and Social Care Partnership Trust *“Investigation of serious incidents, incidents, complaints and claims V3”* October 2011

Clinical Notes and records

Clinical Notes for P including discharge summaries, CPA Care Plans, CMHT Contact sheet, copies of letters and assessments

RCA Investigation - P and TH

Action Plan – P and TH

GP Notes for P – City Way Medical Practice

Significant Event Review – Summary of events, City Way Practice, December 2009

Summary of meeting with Mental Health Trust and City Way Medical Practice 27th April 2009

Psychiatric Report from Kent Forensic Psychiatric Service 2004

Psychiatric Report from Forensic Consultant Psychiatrist 11th June 2009