VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr Q

A report for
NHS England, London Region

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1 Introduction

1.1 Background to the independent investigation

Mr Q, a 31-year-old man who had recently been discharged from the care of Barnet, Enfield and Haringey Mental Health NHS Trust (BEH), stabbed and killed a 79-year-old woman.

Mr Q and the victim were neighbours and were reported to be friends.

On 15 August 2012 Mr Q visited the victim at her home address. While in her home, Mr Q stabbed her multiple times and she subsequently died from wounds to the heart and spleen.

After the attack Mr Q called 999 and when police arrived he told them: "I was told to deal with her - you should be happy the antichrist is dead", the prosecuting QC said during the trial.

Mr Q was arrested and later charged with murder.

On 17 June 2013 Mr Q pleaded guilty to the lesser charge of manslaughter after psychiatrists agreed his responsibility was diminished by mental illness.

Once informed about the homicide, the trust completed a 24-hour report and an initial desktop review was undertaken and approved by the trust board on 5 September 2012. The review recommended a board-level panel enquiry into the care and treatment provided by the trust to Mr Q which was subsequently commissioned.

The panel met with the family of the victim on 7 November 2012. They were unable to meet with Mr Q due to the on-going legal proceedings at that time.

The panel submitted its report to the trust board on 28 January 2013 and made eight recommendations. An action plan was subsequently compiled and all actions were recorded as being complete by July 2013.

In November 2013, NHS England, London Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out this independent investigation.

The independent investigation follows the Department of Health's guidance published in HSG (94) 27, Guidance on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2.

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the person involved. An independent investigation might not find root causes or aspects of the provision of healthcare that directly caused an incident but will often find things that could have been done better.

Amber Sargent, assistant director, and Emily Ewart, associate for Verita, carried out the investigation with expert advice provided by Dr Mostafa Mohanna, consultant general adult psychiatrist (and previously, medical director). Derek Mechen, partner, peer-reviewed this report. Copies of their biographies are included in appendix A.

1.2 Overview of the trust

BEH is a large provider of integrated mental health and community health services, following the transfer of Enfield Community Services in January 2011.

BEH provides specialist mental health services to people living in the London boroughs of Barnet, Enfield and Haringey, and a range of more specialist mental health services to its core catchment area and beyond. Following the transfer of Enfield Community Services, it also provides the full range of child and adult community health services in Enfield.

BEH has moved from a service structure based on boroughs to a service line system. The services are now organised into seven clinical service lines:

- common mental health problems;
- crisis;
- dementia/cognitive Impairment;
- forensic;
- psychosis;
- severe and complex non-psychotic; and
- Enfield community services.

BEH has two service directors who each coordinate three mental health service lines, while each mental health service line has a clinical director providing clinical leadership, supported by an assistant director. Enfield community services has a slightly different internal management arrangement, reflecting the nature of its services.

The personality disorder service sits within the severe and complex non-psychotic service line. Further information relating to the model of care in the Haringey personality disorder service can be found in section 8 of this report.

2 Terms of reference

2.1 Commissioner

This independent review is commissioned by NHS England (London) in accordance with *Guidance on the discharge of mentally disordered people and their continuing care in the community*, published by the Department of Health in circular HSG 94 (27), and the updated paragraphs 33–36 issued in June 2005.

2.2 Terms of reference

The aim of the independent review is to evaluate the mental health care and treatment provided to Mr Q to include:

- review of the internal investigation to assess the scope of the inquiry, the adequacy of its findings, recommendations and action plans;
- involving the families of both Mr Q and the victims as fully as is considered appropriate in liaison with the police;
- chronology of the events to assist in the identification of any care and service delivery problems leading to the incident;
- an examination of the mental health services provided to Mr Q and a review of the relevant documents;
- the appropriateness and quality of assessments and care planning;
- the extent to which Mr Q's care was provided in accordance with statutory obligations relevant national guidance from the Department of Health, including local operational policies;
- the interface, communication and joint working between the agencies involved with Mr Q;
- the extent to which the police, probation service and the trust worked together and communicated effectively;
- assess the extent to which Barnet, Enfield and Haringey Mental Health NHS Trust implemented internal reports recommendations, and how the trust board is assuring itself of progress;
- consider other such matters as the public interest may require; and
- an independent review report for presentation to NHS England, London Region within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

2.3 Approach

The review team will conduct its work in private and will take as its starting point the rust internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

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

3 Executive summary and recommendations

3.1 Executive summary

NHS England, London Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr Q, a mental health service user.

The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005.

The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. The independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident but equally it may find elements of care that could have been better provided.

3.2 The incident

Mr Q, a 31-year-old male, stabbed and killed a 79-year-old woman (a neighbour) on 15 August 2012. Mr Q and the victim were neighbours. During the trail the court heard that they had been friends and he had referred to her as ‘grandma’. It is documented that the victim was very well-liked in the area and many of her neighbours referred to her as ‘aunty’ or ‘grandma’.

On 15 August 2012 Mr Q visited the victim at her home address. While in her home, Mr Q stabbed her multiple times and she subsequently died from wounds to the heart and spleen.

After the attack Mr Q called 999 and when police arrived he told them: "I was told to deal with her - you should be happy the antichrist is dead", the prosecuting QC said during the trial.

Mr Q was arrested sitting outside the victim’s house on the pavement half naked, covered in blood. He was later charged with murder.

On 17 June 2013 Mr Q pleaded guilty to the lesser charge of manslaughter after psychiatrists agreed his responsibility was diminished by mental illness.

Mr Q was remanded in custody and pleaded guilty to manslaughter. On 17 June 2013 he was sentenced at the Old Bailey to remain indefinitely in hospital.

Until three weeks before the incident Mr Q had been under the care of the personality disorder service provided by BEH**.** He was discharged from mental health services at the time of the incident.

3.3 Overview of care and treatment

Mr Q first came into contact with mental health services in 2000 when he was diagnosed with an acute stress reaction during a hospital admission in Cardiff.

In 2005 Mr Q was under the care of Central and North West London NHS Foundation Trust (CNWL). His working diagnosis was "?Depression", personality disorder and co-morbidity. This was subsequently altered to an acute stress reaction and personality disorder. In 2008 he moved house and his care was transferred to BEH. At this point his diagnosis was considered to involve borderline/histrionic personality traits.

Mr Q's care was transferred to the trust's personality disorder service in July 2009. He received treatment in the day unit with group sessions and weekly appointments with his care coordinator until a violent incident in October 2010 resulted in him being removed from the group sessions. He continued working with his care coordinator with scheduled weekly meetings until July 2012.

3.4 Overall conclusions of the independent investigation

Several important aspects could have changed the way trust services understood and engaged with Mr Q. We have identified the following aspects of care that could have been improved:

- diagnosis;
- treatment model;
- identification of the impact of khat/cannabis use;
- risk assessments;
- discharge from services; and
- communication between agencies.

3.4.1 Diagnosis

The documentary evidence suggests that, from very early on, the diagnosis of personality disorder was made and this diagnosis was the only one being considered. As a consequence, there is little information in the clinical records that suggests diagnosis and symptoms were continually re-assessed with an open mind, focusing on symptoms.

However, Consultant Psychiatrist 1 told us at interview that he remained open-minded about Mr Q's diagnosis - which he said - along with his symptoms were continually reviewed. He told us that he, Specialist Practitioner in Psychotherapy 1 and the wider team discussed the case although these discussions were not documented.

There are entries in the records that allude to Mr Q experiencing 'paranoid' symptoms although these are in the context of how Mr Q manages his thoughts rather than whether they are symptomatic of anything other than personality disorder.

Mr Q displayed symptoms that could have been attributed to a psychotic illness. However, these were considered by most of the clinicians involved in Mr Q's care as being attributable to personality disorder, within a particular treatment model. The issue is not so much what the exact diagnosis was but how these disturbing features and experiences were managed.

A combination of paranoid and psychotic features operated at the time Mr Q committed the homicide. Whether or not these features, and in this combination, existed before in quite in the same way, there had been harbingers of that mental combination previously.

Potentially significant clinical findings were overlooked or their significance missed because some of the key professionals involved appeared to focus on a diagnosis of personality disorder. There is nothing in the clinical records to indicate that other diagnoses were being considered but based on the clinical records, insufficient information was obtained to support a definitive diagnosis of personality disorder on sound or solid grounds.

3.4.2 Treatment model

Due to the complex nature of Mr Q's difficulties, he may have benefited more from being under the Complex Care Team (CCT) in order to facilitate a more comprehensive understanding of his psychological, social and health care needs. He frequently presented in crisis and clearly had difficulty coping with day-to-day life. Once some of these fundamental stressors had been further assessed and supported then he would have been more likely to benefit from talking therapy.

3.4.3 Identification of the impact of khat/cannabis use

Mr Q used khat regularly until November 2010, when he significantly reduced his use following support from the Drug Advisory Service Haringey (DASH). He began smoking cannabis in November 2010 and thus appeared to have swapped one drug for another rather than addressing the underlying problem.

There appear to be conflicting opinions among Mr Q's care team regarding the impact substance misuse had on his mental state, behaviour and presentation. It may have been helpful if there was more joint working with the dual diagnosis worker in order to understand this issue better.

3.4.4 Risk assessments

Risk assessments are usually considered to be part of a dynamic process and should be regularly reviewed and monitored, particularly when there are changes to a patient's condition or circumstances. The purpose of a risk assessment is not to predict an incident of violence – it is to plan for what should be done when a patient with a history of previous violence (and other risk factors) becomes unwell, in order to prevent a similar possible violent incident. The risk assessments in Mr Q's case did not do this.

The trust's internal panel inquiry report says the care coordinator did an "on-going assessment of risk" which apparently entailed her "looking out" for any further risk indicators. The risk does not appear to have been registered or documented in the way that it should have been according to best practice guidance.

Mr Q's care coordinator (Specialist Practitioner in Psychotherapy 1) carried out an assessment of risk after he attended a session with a screwdriver on 26 July 2012 – three weeks before the fatal assault on his elderly neighbour. Mr Q initially told Specialist Practitioner in Psychotherapy 1 that he had the screwdriver as a weapon. Specialist Practitioner in Psychotherapy 1's assessment was that she did not view this as an indicator of serious risk to Mr Q or others. However, in accordance with the Trust Risk Assessment Policy the RiO Risk Assessment Form should have been updated to include this incident.

3.4.5 Discharge from services

Upon discharge from the personality disorder service, the onus was placed on Mr Q to get back in touch with mental health services if necessary. Staff working with Mr Q considered that he was someone who could access support when needed.

As someone who tended to locate the cause of his problems externally it is questionable whether Mr Q had enough insight into his own condition to recognise when he needed psychiatric help.

It is likely that Mr Q felt "contained" by being subject to the Care Programme Approach (CPA) at the personality disorder service. He had previously reported difficulties when staff were on leave and not accessible to him. Rather than a complete discharge from the service Mr Q may have benefited from remaining on the consultant's caseload or at least from a gradual reduction in frequency of therapy sessions. This would have allowed him (and services) the opportunity to see if he could manage more independently while still being offered some containment.

3.4.6 Communication between agencies

Mr Q's care team relied on Mr Q to tell them when he had any contact with the police. Towards the end of his treatment (Spring 2012) Mr Q told his care coordinator that he was phoning the police less. However, the police report does not support this. There was no arrangement in place between the police and the trust to enable the care coordinator to check such information with the police. It appears that Mr Q continued to contact the police but did not necessarily inform his care team that he was doing so. This demonstrates the need for better communication between agencies to support individuals who are making frequent contact with the police and who are known to mental health services.

Mr Q was sentenced to a nine-month community order (for two counts of common assault) and attended his first appointment with his probation officer on 21 March 2011. Mr Q's clinical records show that Mr Q's care coordinator spoke to his probation officer on 3 March 2011. Specialist Practitioner in Psychotherapy 1

recorded that Mr Q's probation officer intended to see him weekly for up to six month. Mr Q attended regular sessions with his care coordinator throughout the rest of March and she recorded that he "appears stable in mood". There is no record of any further contact between the probation officer and mental health colleagues.

The police, probation service, mental health service and the ambulance service all held information about Mr Q that would have helped inform risk assessments. Although there is nothing in Mr Q's past to indicate that such extreme violence was predictable - better joint working between the services could have helped to identify and manage Mr Q's risk better, particularly if there had been arrangements in place for the police to be notified that Mr Q was known to the personality disorder service and had recently been discharged.

3.5 Improvements to service provision since the incident in 2012

3.5.1 Model of care

The model of care delivered by the trust has changed significantly since Mr Q was under its care.

In November 2013 a single point of entry was introduced per borough for non-urgent routine referrals. This triage service offers a face-to-face assessment for people with routine needs which the previous Intake service did not offer.

The new model enables staff to go to the person in the community – he or she will be seen within four hours. The trust no longer has walk-in facilities. There is a crisis resolution and home treatment (CRHT) service which was formerly the home treatment team (HTT).

3.5.2 Liaison with the Probation Service/Police

One of the steps taken by the trust in this area was amending the personality disorder operational policy to say:

> "In cases where patients are on probation, the PD [personality disorder] service will proactively liaise with probation services, and document this contact according to normal record-keeping protocols."

The service has clearly taken steps to ensure that information is shared between agencies in a much more proactive way.

We have not sought to ensure that this new approach is being used routinely or that it is resulting in improved communication between services.

3.5.3 Medication/prescribing

During a team meeting on 21 November 2012 the following actions regarding GP prescribing were agreed:

> "To ensure liaison with GPs re: robust guidelines for the prescription of benzodiazepines. It was noted that the PD [personality disorder] service has a general policy, which is written in the service operational policy, of not prescribing benzodiazepines in personality disorder. In cases where patients have been put on them by external prescribers, the policy is to liaise with those external prescribers and explain our guidance on this. All clinicians with prescribing responsibility will be reminded to follow this protocol."

3.5.4 Discharge planning

In response to the issues identified by the board level inquiry panel report regarding patient discharge, a team meeting was held on 21 November 2012 and the following actions regarding discharge planning were agreed:

> "The final recommendation was to review procedures to ensure crisis plan and discharge planning reflect risk and mitigating action for patients with a long history of attachment to staff members. This was discussed also in the context of the SUI [serious untoward incident] re: Mr Q. It was felt that this should not affect decisions to discharge. Operational policy to be updated to reflect this."

It is not clear from the action plan evidence whether this review took place and what subsequent action was taken.

3.5.5 Drug advisory service, Haringey (DASH)

Although Mr Q's care coordinator was notified of his non-attendance, this was not recorded on RiO. A DASH clinical team meeting on 24 July 2013 noted that it is:

> "…important for all keyworkers to note all communications with both clients and anyone involved with the clients' care on RiO at all times but most especially when discharging a client. Please see your manager for clarification."

3.6 Predictability and preventability

3.6.1 Predictability

There were occasions where, with hindsight, more could have been done to ensure Mr Q's risk was fully understood and appropriately managed. For example, instances such as Mr Q attending his last session with his care coordinator with a screwdriver should have resulted in action being taken. However, there is nothing in Mr Q's past to indicate that such extreme violence was predictable or likely to occur. As such we

consider that while practice could have been improved, based on the information held by the mental health services alone, the homicide was not predictable.

3.6.2 Preventability

In the interviews that we have carried out and in our review of the clinical records we have not identified any words, actions or behaviour that should have alerted staff that this tragedy would occur.

While there is some evidence that Mr Q, at times, had acted aggressively and had described difficulty with neighbours, there was nothing to suggest that it would result in such an incident. Therefore this tragedy was not preventable by actions that the NHS alone should have taken. However, we do consider that more could have been done to support Mr Q and to try to fully understand the risk he posed. This includes taking action when he called to tell his care coordinator that he had been visited by god two weeks after he had been discharged. We are also of the view that his discharge could have been phased and that he could have been offered some alternative support rather than relying on him to make contact if his mental health deteriorated.

While we do not consider that mental health services alone could have prevented the homicide we believe that the police, probation service and mental health service could have worked together to share information in order to manage any risk better. If the police had been aware that Mr Q had recently been discharged from mental health services their response to his calls may have been different.

3.7 Recommendations

3.7.1 Record keeping

The trust should ensure that staff understand the importance of thorough record keeping, in line with trust and national policy. This includes the need to record discussions about patients when their symptoms, diagnosis and treatment has been considered and any subsequent action agreed. The trust should carry out six-monthly audits to ensure compliance.

3.7.2 Diagnosis

In circumstances where the clinical lead has indicated that there is uncertainty about an individual patient's diagnosis and/or treatment plan, the care coordinator/allocated worker should meet regularly with the clinical lead to discuss the case. These discussions should focus on and agree the plan for risk management, treatment plan and diagnosis.

3.7.3 Care Programme Approach

The trust should assure itself that its process for CPA (including care planning, risk assessment and risk management planning) is robust. The clinical governance team

should audit compliance at least every six months and report its findings to the board.

3.7.4 Discharge planning

In instances where a service user has had a long and intensive intervention, a multidisciplinary discussion should take place to determine the most appropriate way to discharge that individual. The discharge process should be tailored to meet the needs of the service user. This may include a staged discharge to test the service user's readiness to be discharged. Consideration should also be given to whether discharge arrangements should be shared with other agencies, such as the police or the probation service.

3.7.5 Partnership working

All partnership agencies should work in collaboration with the trust to continue to develop their relationship and processes for joint working. This development should include the trust reviewing the protocols in place with partnership agencies to ensure effective communication and information sharing for the safety of patients and the general public. For example, information sharing arrangements with the police, probation service and London ambulance service. This should take place within the next three months.

4 Approach to the investigation

Our independent investigation comprised a review of documents and a number of interviews. We used information from Mr Q's clinical records and evidence gathered from the trust's internal panel inquiry. As part of our investigation we interviewed:

- Specialist Practitioner in Psychotherapy 1;
- Consultant Psychiatrist 1; and
- Interim Service Manager 1.

We also met with the coordinator for personality disorder treatment within the Complex Care Service to discuss the progress of recommendations made in the internal report.

We had full access to trust papers produced at the time of the internal investigation.

We wrote to Mr Q at the outset of the investigation, explained the nature of our work and asked to meet him. We then met him during the course of our investigation. Mr Q gave written consent for us to access his medical and other records. We told him that the report was likely to be published. We gave Mr Q the opportunity to comment on a draft before it was finalised.

Although there are some references in the clinical records to Mr Q having a sister in the UK, we were unable to obtain details of any family members whom we might meet as part of our investigation.

We met with the victim's son at the outset of our investigation. We would like to thank him for the information he shared with us about his mother, including the profound emotional and psychological effect her murder has had on him and his family.

4.1 Structure of this report

Section 5 sets out the details of Mr Q's care and treatment. We have included a full chronology of his care in order to provide the context in which he was known to trust services.

Sections 6 to 19 examines the themes arising from Mr Q's care and treatment.

Section 20 reviews the trust's internal panel inquiry and reports on the progress made in addressing the organisational and operational matters identified.

Section 21 sets out our overall analysis and recommendations.

5 The care and treatment of Mr Q

Most of the information in this section has been taken from Mr Q's clinical records and therefore most of what is recorded is Mr Q's self-reporting history. We have not sought to clarify historical information contained in his notes.

Mr Q was born and raised in Somalia, the youngest of nine children. He reports that he was a twin but that his brother drowned in the sea when he was a teenager. Mr Q's medical records say that his family arranged for him to move to England in 1999 (when he was 18-years-old) and he was granted leave to remain in the UK in 2000. His father is no longer alive and his mother, six other brothers and one sister remain in Somalia.

On arriving in the UK, Mr Q first lived in Cardiff and worked as a security guard.

5.1 First contact with mental health services

The medical notes suggest that the first time Mr Q made contact with mental health services was in 2000 when he was admitted to hospital with an acute stress reaction. There are no further details about his presentation, admission or follow up.

In September 2002 Mr Q informed his GP that his father had died a month before and that he felt depressed and needed counselling.

In October 2002, Mr Q's GP referred him to the Sealock Centre Community Mental Health Team (CMHT) where he was seen by a clinical nurse leader. In the clinical nurse leader's letter to the GP, he records that Mr Q's difficulties are due to the "tragic death of his father". He recommended that in the first instance he should be seen by the practice counsellor and for him to refer himself to CRUSE Bereavement Care as he may need bereavement counselling.

The GP referred Mr Q to the Sealock Centre CMHT again in 2004 to discuss his difficulties. Mr Q was offered an appointment on 27 May 2004 but he failed to attend.

Mr Q was taken to Llandough Hospital, Vale of Glamorgan, following an overdose of tablets on 31 August 2004. He stayed in hospital for two days. He gave his sister's details as his next of kin and said that she lived in London.

Mr Q was seen by a CMHT doctor on 26 October 2004. Mr Q described having anxiety problems on and off for several years. He told the CMHT doctor that he had experienced problems with other Somalis who had come to his house and taken advantage of his generosity. He had found this situation increasingly stressful. This resulted in him taking an overdose of paracetemol and cutting his wrists in August 2004. He said that the overdose was impulsive and followed an argument with a friend. Following his discharge from hospital on 2 September 2004, Mr Q was prescribed citalopram (an antidepressant) 20mg once daily and he subsequently arranged with the Housing Association for a transfer to London. He said he had many friends in London and now felt that his problems had been completely resolved. He denied any depressive anxiety.

In February 2005 Mr Q's GP notes record that he was feeling low in mood and was requesting antidepressants. He told the doctor that he did not feel able to face work and asked for a sick note. He described no abnormal thoughts or delusional ideas. He had recent morbid thoughts but no suicidal plan or intent. The plan was to start Mr Q on escitalopram with a review in two weeks. On 4 March 2005 Mr Q reported feeling better on medication and said that he planned to move to London – which he did later that month.

5.2 Forensic history

There are no reports of violence in Mr Q's clinical records prior to an incident involving two other patients in 2010. On this occasion he was charged with two counts of common assault and given a probation order.

5.3 Contact with London mental health services

Mr Q moved to Brent in March 2005 and a new patient health check was completed by his London GP surgery in April 2005. It notes that Mr Q had had a history of depression (since September 2004) and a self-harm episode in August 2004. However, the GP records indicate that Mr Q first told his GP he was depressed in 2002.

Mr Q was under the care of CNWL. He told mental health services in London that his father and brothers had been violent towards him when he was a child and he continued to have nightmares related to his childhood and difficulties he experienced in Somalia.

The records indicate that Mr Q has no close relatives in England and there is limited information in his clinical records about relatives that he has contact with.

5.4 Contact with CNWL (September 2005 – January 2008)

Mr Q went to a north London accident and emergency department (A&E) and was referred to a consultant psychiatrist from the Brent North-West sector team for assessment in September 2005. Mr Q said that he was hearing voices and felt that he had to harm himself. He was assessed by the consultant psychiatrist as not needing to be admitted and was referred for an out-patient appointment at Park Royal Centre for mental health. He was recorded to be taking escitalopram 20mg daily for anxiety/depression.

In 2005 Mr Q's provisional diagnosis was *"*?Depression", personality disorder and co-morbidity. This was subsequently altered to an acute stress reaction and personality disorder. He was prescribed citalopram (20mg once daily) then escitalopram (anti-depressant) but he did not consistently take them.

Mr Q had a history of deliberate self-harm, the first reported episode being in 2004, when he took an overdose and cut his wrists. He also claimed to be suicidal and was admitted to Pond Ward as an inpatient on several occasions. Mr Q attended A&E

departments, primarily at Central Middlesex Hospital, on at least a further eight occasions between September 2005 and January 2008.

5.4.1 Comment

It is unclear from the clinical records whether a formal transfer of care took place between CNWL and Barnet, Enfield and Haringey Mental Health NHS Trust. There is no evidence of a discharge summary or risk history.

5.5 Contact with Barnet, Enfield and Haringey (BEH) Mental Health NHS Trust (January 2008 to July 2012)

Mr Q moved to Haringey on 14 January 2008 because of difficultly he was experiencing with his neighbours in Wembley. As a result of the move his psychiatric care was transferred from CNWL to BEH.

Mr Q first came into contact with BEH later that month having been found threatening to jump off Holloway Bridge. He was prescribed 1mg lorazepam (used to treat anxiety) at night and 20mg paroxetine (for anxiety) once a day. The assessing clinician described Mr Q as having an:

> *"*Hx [history] of depression and self-harm. Current distress and depressive mental state has exacerbated by recent move to Haringey… he has no active plans to harm himself*".*

Mr Q was subsequently assessed by the West Haringey Crisis, Assessment and Treatment Team (CATT) who then referred him to Alexander Road Crisis Unit (ARCU)[1].

His care was transferred from CATT to the short-term assessment and recovery team (START) during a CPA handover on 31 March 2008. The letter to Mr Q's GP describing this meeting recorded that Mr Q has a:

> *"*Complex psychopathology involving borderline/histrionic personality traits, resulting in frequent crisis presentations*".*

The GP was asked to continue to prescribe 20mg paroxetine daily, reduced to 10mg daily in August 2008.

The plan was for Mr Q to see his START care coordinator monthly for six months but with an aim to be referred to the continuing care team at the earliest opportunity.

[1] Alexandra Road is a residential unit for people experiencing emotional or mental distress and who are having difficulty in coping with daily life. For some people this placement is an alternative to a hospital admission. It also offers respite from stressful situations and support to prevent a crisis during short placements of up to three weeks. This is followed by phone support if needed.

5.6 First referral to addiction services

Following his assessment by START in March 2008, Mr Q was referred to the dual diagnosis team for assessment. This was because he was chewing six or seven bundles of khat[1] a day, three days a week. He was also referred to the Halliwick Centre[2] for psychological assessment with a view to considering therapy involving "mindfulness or dialectical behaviour therapy[3]".

Mr Q went to the A&E department at North Middlesex Hospital in May 2008 saying that he had taken an overdose of 4–6 paracetamol. He became angry while waiting to be assessed and "smashed the door hinges". He then refused to be seen.

Mental health services primarily managed Mr Q by referring him to the CATT and then discharging him back to his care coordinator. His engagement with the dual diagnosis service and his care coordinator was poor during 2008.

Mr Q's care coordinator described him as "mentally stable" in June 2008. Mr Q told the care coordinator about an incident with a neighbour when he was living in Brent which resulted in Mr Q being issued with an injunction and a fine to pay. The care coordinator recorded in the clinical records that she left a message for Mr Q's solicitor and documented that Mr Q would contact her directly.

On 22 July 2008, Mr Q went to North Middlesex A&E at 4am and told staff he was experiencing auditory hallucinations telling him to kill people. He was taken to the emergency reception centre (ERC) by ambulance for further assessment and became angry, saying he was having thoughts of killing a male friend because he was calling him a "faggot".

Four days later Mr Q was referred again to ERC by North Middlesex A&E after going there with suicidal ideation. He was accepted by the CATT for short intervention with daily contact. He was then referred back to START.

Mr Q was assessed by the dual diagnosis/START service on 7 August 2008. He was offered a review appointment with a dual diagnosis worker (HK) on 29 October. During this review he reported using up to six bundles of khat over one or two days and harm minimisation strategies were discussed.

On 21 September 2008 Mr Q was taken to St Ann's A&E by British Transport police after expressing suicidal thoughts at Finsbury Park train station. He told the

[1] Khat is a leafy green plant containing two main stimulant drugs which speed up your mind and body. Their main effects are similar to, but less powerful than, amphetamine.
[2] The centre is run by a multi-skilled team of nurses, doctors and psychological therapists, who work together, to help understand individual psychological needs. The service provides assessment and treatment programmes for service users between the ages of 18 and 65, with complex personality difficulties.
[3] Dialectical behavior therapy (DBT) is a therapy designed to help people change patterns of behavior that are not effective, such as self-harm, suicidal thinking and substance abuse. This approach works towards helping people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helping to assess which coping skills to apply in the sequence of events, thoughts, feelings and behaviors that lead to the undesired behavior.

assessing nurse about his “ghosting” experiences, which he described as being in a certain place without being physically there. The nurse documented the following in the notes:

> *“*The contents of his conversation to some extent sounded distorted thoughts, however he seemed quite clear about his thinking and beliefs*”.*

5.6.1 Comment

> In June 2008 Mr Q told his care coordinator about a dispute with a neighbour in Brent, which resulted in an injunction and him having to pay a fine. The circumstances of this offence do not appear to have been explored further by mental health services. Mr Q also caused damage to property at A&E on one occasion. In July 2008 he was hearing voices telling him to kill people, and said he was thinking of killing a friend. This suggests that in 2008 information began to emerge suggesting risk issues are apparent but these were not recorded.

Mr Q attended assessment sessions with Specialist Practitioner in Psychotherapy 1, senior nurse in psychotherapy, in August, September, October and November 2008. Specialist Practitioner in Psychotherapy 1 subsequently referred Mr Q for a short-term individual mentalisation-based therapy with Staff Grade Psychiatrist 1 in order to establish if he would be suitable for longer-term, more intensive treatment. In November 2008 Specialist Practitioner in Psychotherapy 1 wrote to Mr Q’s GP to say that she anticipated the therapy would start in the next couple of weeks and would last 4–6 months with regular reviews.

Mr Q attended his first therapy session with Staff Grade Psychiatrist 1 on 11 December 2008. Their next meeting was scheduled for 15 January 2009. Mr Q failed to attend this appointment and was offered a further appointment for 19 February. He engaged in therapy with Staff Grade Psychiatrist 1 until March 2009.

Mr Q was taken to St Ann’s Hospital by ambulance in the early hours of 22 January 2009. He told an ERC nurse that he had thoughts of self-harm. He was discharged but returned in the early hours of 24 January saying that he was hallucinating. His diagnosis was recorded as attention-seeking personality disorder and he was discharged. The plan was for him to contact his care coordinator after the weekend and go to ERC if necessary.

Mr Q was attending sessions with his care coordinator and the dual diagnosis service throughout early 2009, albeit irregularly. On 13 February 2009 he told his dual diagnosis worker during a phone call that he had had an “altercation” the previous night and was still feeling quite upset and shaken. Progress notes on RiO report:

> *“*Denied involvement of police or any injuries, but said that after this fight he does not want to chew khat at all.*”*

5.6.2 Comment

In February 2009 the clinical records state that Mr Q got into an “altercation”, although it is not documented what this entailed, or whether it was violent. There is nothing in the clinical records to suggest that this incident was explored and it is not mentioned in the risk overview.

On 24 February 2009 Mr Q was seen by Staff Grade Psychiatrist 1 for a medication review. Mr Q reported poor sleep, vivid nightmares and seeing white smoke in his living room. He said that he heard voices and had a spirit inside him for most of the day. The plan was to discontinue Paroxetine and start sertraline (antidepressant) 25mg and zopiclone (a hypnotic to aid sleeping) 3.75 mg daily.

Mr Q attended North Middlesex Hospital’s A&E department with psychiatric symptoms once in February and three times in March 2009. During March he said that he was not taking his psychotropic (antidepressant and hypnotic) medication.

During assessment by the duty doctor on 10 March Mr Q reported seeing a “white ghost” in his flat for the past month and hearing a voice “all the time inside his head”. He denied that the voice told him to harm others but said that at times it tells him to harm himself. He was referred to the START team for management and his care coordinator was to arrange in-patient admission at Maytree[1] as soon as possible.

Maytree staff spoke to Mr Q the following day (11 March) and he reported seeing devils and having hallucinations. Staff at Maytree informed Mr Q that he was not suitable for admission as he was experiencing hallucinations and was not ready for group therapy.

Mr Q attended his appointment with his dual diagnosis worker on 13 March 2009 and stated he had not used khat for four to five days. He reported still hearing voices and seeing a “ghost” in his flat, but felt less afraid.

Mr Q telephoned the START team repeatedly on 18 March 2009 and threatened to take an overdose if not provided with a respite bed at ARCU. A couple of hours later he called the START team saying he wanted to say goodbye to Staff Grade Psychiatrist 1 as he had taken an overdose. The START team phoned for an ambulance and Mr Q was taken to North Middlesex Hospital.

A meeting was held between Mr Q, Staff Grade Psychiatrist 1, Specialist Practitioner in Psychotherapy 1 and his dual diagnosis worker on 20 March 2009, during which Mr Q recounted that the fact that his sessions with Staff Grade Psychiatrist 1 had finished at the Halliwick Centre was impacting on his mental health. A respite admission to ARCU was arranged for the period 3 April–17 April 2009.

[1] Maytree is a registered charity supporting people in suicidal crisis in a non-medical setting.

5.6.3 Comment

At the start of 2009 Mr Q was presenting with, what appeared to be, psychotic symptoms, saying he was seeing and hearing things which could well have been genuine auditory and visual hallucinations. There is nothing recorded in the clinical records outlining the reason why these experiences were considered to be "attention-seeking" nor any argument put forward in support of the diagnosis of personality disorder. He was not offered a respite admission until the beginning of April 2009.

Mr Q told staff that the fact that his therapy sessions with Staff Grade Psychiatrist 1 were ending had a negative effect on his mental health. He appeared to benefit from the containment of a therapeutic relationship and sought help from other services when this was not available to him.

Following a CPA review on 6 April 2009 Mr Q was prescribed the atypical antipsychotic drug quetiapine 25mg bd. At a review meeting the following week he stated that the quetiapine had helped to "dampen down" the female voice in his head and make him react in a calmer manner around the presence of "a ghost" in his flat.

Mr Q was assessed by the Haringey personality disorder service in April 2009 to determine his suitability for intensive treatment at their day unit. On 21 April 2009 Consultant Psychiatrist 1 reviewed Mr Q and recorded:

"… I am unclear about a diagnosis but he does show anxiety states and some likely histrionic personality features and he does seem to have some features of dependent personality. I have agreed that we will offer him a place in our day unit so that we can make a longer and more detailed assessment of his personality function and how he manages his arousal states".

5.6.4 Comment

Consultant Psychiatrist 1 states that he is "unclear about the diagnosis" but admits him to the personality disorder unit. He mentions "histrionic" and "dependent" aspects of the personality but then refers to "anxiety states" as well. It is not clear whether by admitting him to the personality unit, the diagnosis had been decided as one of personality disorder and that what remains was to carry out a "more detailed assessment of his personality function" – thus ruling out any diagnoses other than personality disorder or whether the diagnostic aspect was still open for consideration. Some aspects of the presentation, for example, the hearing of voices and the seeing of, for example, "ghosts" is not addressed directly in the clinical records. It is our view that there was insufficient discussion of these matters and that there was insufficient clarity about what further work was needed to clarify the diagnosis.

Consultant Psychiatrist 1 told us at interview that he remained open-minded about Mr Q's diagnosis - which he said - along with his symptoms were continually reviewed. He told us that he, Specialist Practitioner in Psychotherapy 1 and the wider team discussed the case although these

discussions were not documented. Whilst we acknowledge that Consultant Psychiatrist 1 remained open-minded and that he felt additional work was required to assess Mr Q's personality function, this was not reflected in the care Mr Q received. There is nothing in the clinical records to record that on-going reviews and assessments took place. It also appears that other members of the team, particularly Specialist Practitioner in Psychotherapy 1 who had more contact with Mr Q, were more strongly in favour of a diagnosis of personality disorder.

A specialty registrar wrote to Mr Q's GP on 5 May 2009 to provide him with an update on Mr Q's progress with mental health services. He outlined the plan for Mr Q to:

- continue with quetiapine 25mg bd (to be prescribed by the GP);
- remain with START team and continue to engage with dual diagnosis worker and care coordinator as a community psychiatric nurse (CPN);
- continue to attend the Clarendon Centre[1] and engage in their activities; and
- probably discharge from START when he starts therapy at the Halliwick Day Unit.

Mr Q attended dual diagnosis sessions throughout May and June 2009. In July the plan was for Mr Q to be discharged from START and the dual diagnosis service once he was established at the Haringey personality disorder service.

5.7 Transfer to the personality disorder service – treatment in the day unit, July 2009 to October 2010

Mr Q started his placement at the Haringey personality disorder service on 27 July 2009. However, his attendance for the following month was sporadic. The treatment programme included daily group attendance and weekly individual therapy with Specialist Practitioner in Psychotherapy 1.

Specialist Practitioner in Psychotherapy 1 wrote to Mr Q's GP on 16 October 2009 to provide him with an update on Mr Q's progress. Specialist Practitioner in Psychotherapy 1 noted that Mr Q has found the group sessions quite challenging but that he seems "better contained" by the treatment he receives at the Halliwick Unit. Specialist Practitioner in Psychotherapy 1 provided Mr Q's GP with a further update on 18 November.

Mr Q attended North Middlesex Hospital's A&E department once in August and September, twice in October and twice in November 2009. He described suicidal

[1] This day service offers social, educational and work opportunities for people who are recovering from severe and enduring mental illness in partnership with Six8four centre in Tottenham. Sustained recovery, independence and social inclusion are promoted through a variety of group and individual activities. Skills training including IT, music technology, publishing, ceramics, jewellery-making, printmaking, textiles and catering is available.

thoughts and anxiety. The plan was for him to attend the day hospital and, on occasion, for his medication to be reviewed.

Mr Q's care was transferred to the personality disorder service in October 2009. This included transferring his care coordination to Specialist Practitioner in Psychotherapy 1. The treatment plan remained a structured group programme and weekly individual therapy with Specialist Practitioner in Psychotherapy 1.

Mr Q attended North Middlesex Hospital's A&E department twice in January 2010 with psychiatric problems and was diagnosed with an anxiety disorder. The clinical records state that Mr Q had stopped taking quetiapine and noted on 5 January 2010 that he had failed to pick up his prescriptions for the previous two weeks. The quetiapine was stopped and he was started on the antidepressant citalopram 20mg daily as the only regular medication.

Mr Q attended the Haringey personality disorder service sporadically throughout January and February 2010. He was not taking medication at this time. A referral was made to ARCU for telephone support and he had the option to attend ERC if in crisis.

Mr Q had an MRI brain scan in March 2010 due to his concerns that he had suffered damage when he was hit on the head by his brother when he was young. The findings (reported in June) were normal.

On 8 and 9 April 2010 two separate doctors recorded that Mr Q was attending police stations and mosques most nights due to anxiety that made him feel unable to stay at home. He referred himself to ARCU but they had no beds. He had a panic attack on a day when the Haringey personality disorder service was closed so he called an ambulance. He then had a week's stay at ARCU and attended some groups.

Police took Mr Q to ECR/START on 17 May 2010. This was following a difficult group session that morning when Mr Q thought his care coordinator had made a facial expression that indicated that she disapproved of him. He told the police officer that he felt people were staring at him and that he would "harm someone if this was not dealt with".

Mr Q's care coordinator recorded that Mr Q experienced real difficulties with group therapy during August 2010. He also described feeling very tense about his relationship with his care coordinator. Mr Q had some contact with the police and there appeared to be good liaison between the police and mental health services. In early August, Mr Q's GP recorded that Mr Q had visited A&E complaining of poisoning but nothing abnormal was discovered.

A CPA review on 5 October 2010 recorded that Mr Q had increased his khat use and was experiencing memory problems. It was noted that he had made progress over the last year but still needed to think about his feelings and responses in order to manage his thinking more effectively.

Mr Q attacked two patients during a therapy group at the Halliwick Day Unit, St Ann's Hospital, on 14 October 2010. One of the patients verbally challenged him so he hit

her over the head with a clipboard, pulled her hair and threw two chairs, one of which broke a window. The second patient was hit in the eye when she tried to intervene. Unit staff informed the police of the incident. Mr Q later telephoned the unit to apologise.

Mr Q's violence was described by Specialist Practitioner in Psychotherapy 1 in a subsequent discharge summary as "sudden" and "not predicted". Mr Q went to court in November 2010 and was charged with two counts of common assault and was sentenced to a probation order. He was subsequently not allowed to attend group sessions but could continue with individual sessions. This incident was recorded in the Risk Assessment but he was deemed to be "not a current physical risk to others and shows remorse about his actions".

5.7.1 Comment

> There is a lack of detail regarding this incident and the clinical notes recorded Mr Q as having physically assaulted a fellow client, when in fact he assaulted two clients. There is no risk management plan around his risk to others other than continuing to explore in therapy "the dynamics of bullying that [Mr Q] can experience in his relationships".

5.8 Follow-up individual treatment at the Halliwick Unit, October 2010 to July 2012

Mr Q was discharged from the Halliwick Day Unit, St Ann's Hospital in October 2010. The notes from the CPA review meeting on 19 October state that:

> "Following [Mr Q] being violent to 2 patients in day unit on 14/10/10 he has had to be discharged from the unit. [Mr Q] still needs psychological support".

Mr Q told Specialist Practitioner in Psychotherapy 1 that he had stopped using khat but started smoking cannabis daily in November. He was discharged from DASH in late November 2010 for failing to attend, having attended sporadically since August 2008.

In early January 2011 Mr Q had lots of contact with health services, the police and the ambulance service. The notes suggest that "the crisis" may have been triggered by Mr Q's care coordinator being away from work for two weeks. Specialist Practitioner in Psychotherapy 1 had made Mr Q aware of her leave at their last appointment and gave him names of two alternative people to contact in her absence. Mr Q was admitted to ARCU for respite on 7 January 2011 for a few days. He was then under the care of the HTT until being discharged back to the care of his care coordinator on 12 January.

Mr Q attended regular appointments with Specialist Practitioner in Psychotherapy 1 throughout the remainder of January and February 2011.

5.9 Mr Q's care and treatment in the 18 months leading up to the offence

Mr Q's clinical records show that Mr Q's care coordinator spoke to his probation officer on 3 March 2011. Specialist Practitioner in Psychotherapy 1 recorded that Mr Q's probation officer intended to see him weekly for up to six month. Mr Q attended regular sessions with his care coordinator throughout the rest of March and she recorded that he "appears stable in mood".

On 15 April Mr Q told his care coordinator about a "couple of incidents" with a court official and a bus driver which he "managed without losing control" but felt were unjust and he wanted revenge/justice. His care coordinator was due to go on leave and a CPA review was booked for 12 May.

A CPA review took place on 12 May 2011. The records indicate that Mr Q appeared to recognise that he may be reliant on cannabis to manage some of his feelings. He regularly attended weekly therapy sessions and struggled when his care coordinator was away.

Mr Q was assessed at ERC in the early hours of 8 June 2011. He was experiencing anxiety and chronic depressive symptoms. He was described by the nurse assessor as "inappropriately requesting admission". The nurse assessor referred Mr Q to the HTT which subsequently carried out daily home visits until 13 June when he was discharged from the HTT.

Mr Q had a one-to-one session with his care coordinator on 9 June. That night he called START every minute for half an hour, being abusive and threatening to get staff sacked. He then continued to make many calls in the morning as he had (mistakenly) been expecting a visit in the morning that was actually planned for the evening. A social worker visited Mr Q at his home on 10 June. Mr Q then spoke to his care coordinator by phone that afternoon.

Mr Q made multiple calls to START on the night of 10 June/early hours of 11 June. He was visited by an HTT worker at 4pm on 11 June. He was recorded by the HTT worker to be "feeling anxious". He was visited again that evening when he denied hearing voices but reportedly said "he hears commanding voices from a man who jumps behind his seat and tells him to do frightening things".

5.9.1 Comment

Again, Mr Q is reporting that he is hearing voices and, as before, there is no documentation to indicate that these were considered in any detail. The evidence suggests that they were not considered to be true hallucinations.

An HTT worker visited Mr Q at home on 12 June. One of the members of staff sensed some tension from Mr Q and noted that this could be because he had previously assessed Mr Q and had declined to admit him to hospital. He was therefore seen by another member of staff. Mr Q was discharged from the HTT on 13 June and the plan was for him to continue to attend individual therapy sessions at the Halliwick Day Unit, St Ann's Hospital.

Mr Q's care coordinator recorded on 17 June that Mr Q had phoned to speak to her every day that week. They had a planned session during which he gave her some perfume and said that she is the only one who understands him. She recorded in the clinical records that she discussed the need for Mr Q to reduce his reliance on her as their therapy will end at some point.

5.9.2 Comment

Entries in the clinical records would suggest that Mr Q had developed a reliance on Specialist Practitioner in Psychotherapy 1. By this point they had been working together weekly on a one-to-one basis for a significant period. It may have been useful at this point for Specialist Practitioner in Psychotherapy 1 to seek advice on the relationship with Mr Q and whether it would have been beneficial for another staff member to work with him.

Mr Q was likely to have felt contained by his relationship with Specialist Practitioner in Psychotherapy 1 but it appears that this was misinterpreted by staff as a sign that Mr Q was improving. His chaotic behaviour would suggest otherwise and the clinical notes would suggest that Specialist Practitioner in Psychotherapy 1 viewed his presentation in the context of her previous knowledge of him rather than re-assessing him as new information came to light. The fact that he felt so contained by their relationship is another reason why he should have been followed up in outpatients or referred on to the CCT rather than being completely discharged from the service back to primary care at the end of his engagement with the personality disorder service (July 2012).

While Consultant Psychiatrist 1 had ultimate responsibility for the diagnosis and treatment of Mr Q as the clinical lead Specialist Practitioner in Psychotherapy 1 took on responsibility for the planning of Mr Q's care and treatment.

Mr Q attended North Middlesex A&E by ambulance with anxiety on 21 June. He was seen by psychiatric liaison, requested medication and advised to discuss this with his care coordinator. They discharged him home and told him to contact START or the ERC if necessary. During an individual session with Specialist Practitioner in Psychotherapy 1 on 22 June, Mr Q expressed fears that a ghost may be wanting to kill him.

Throughout the remainder of June and early July 2011 Mr Q attended regular sessions with his care coordinator and continued to call her frequently. During the calls he was encouraged to use his coping strategies and save issues up for sessions. He also made some contact with START/ERC.

Consultant Psychiatrist 1 telephoned Mr Q on 27 July 2011. His subsequent entry in the records states:

> "Called patient as he feels that when he contacted in a panic yesterday he was not listened to properly. I was able to reassure him about things. He says that he feels paranoid at the moment and worries that people are going to hurt him. Talked to him about using his friends to manage his anxieties better. He felt better at the end of the conversation."

Consultant Psychiatrist 1 told us that he considered admitting Mr Q to the crisis unit at this point but this admission was not deemed appropriate.

Mr Q's care coordinator recorded an escalation in paranoia on 28 July and planned to discuss the case with her manager and consultant psychiatrist (Consultant Psychiatrist 1) the following day (29 July). There is however no record of this discussion taking place nor any evidence that a plan arose from it. However, Mr Q was given an appointment with Consultant Psychiatrist 1 for 10 August 2011 although he subsequently cancelled it. Consultant Psychiatrist 1 told us that the reason for the cancellation was because Mr Q was feeling much better but this is not documented in the clinical records.

5.9.3 Comment

> Mr Q's mental health was clearly deteriorating in the summer of 2011. There is nothing in the clinical records to indicate that steps were taken to try to address this/identify the cause of the deterioration, nor that his management plan or risk assessments were updated to reflect his presentation.

In relation to khat use, Mr Q's risk overview in July 2011 records:

> *"*[Mr Q] has a history using khat… use of khat had a detrimental impact on his mental health primarily through lack of sleep as well as by stimulating… [Mr Q] and increasing his paranoia*".*

5.9.4 Comment

> It is documented that khat use has a detrimental impact on Mr Q's mental health. However, there is no evidence to suggest a strategy or management plan was developed to help Mr Q reduce his khat use.

Mr Q had a session with his care coordinator on 3 August 2011. She noted he had started anti-depressants and was feeling better. Although there is no record of what they were, when he started taking them or who prescribed them.

Mr Q attended sessions with his care coordinator throughout the remainder of August and throughout September 2011. During the sessions they discussed Mr Q interacting with friends in a more consistent way to increase his independence from services. There was one record of Mr Q accessing START during this period and of him self-referring to ARCU due to bed bugs in his flat. He was recorded by his care coordinator to still be using cannabis.

5.9.5 Comment

There is no mention of Mr Q's khat use during this time or of Specialist Practitioner in Psychotherapy 1 giving consideration to referring Mr Q to DASH for support to reduce his drug use.

There are no records of sessions between Mr Q and his care coordinator throughout October 2011. It is not clear from the notes how regularly Mr Q should have been meeting with his care coordinator at this point, although previous engagement would suggest that he should have been attending weekly. Mr Q reported to his GP on 31 October that he had stopped taking quetiapine (anti-psychotic) and that sertraline (anti-depressant) had kept his mental health and anxiety states stable. It appears that the GP commenced Mr Q on sertraline 50mg in August 2011, with increases to the current dose of 150mg.

Mr Q attended regular sessions with his care coordinator throughout November 2011. There is one record of him calling an ambulance due to anxiety that month. His care coordinator recorded on 21 November 2011 that Mr Q spoke about being in a "child mood" and that this is a "self-induced trance" that he employs to avoid certain feelings and aspects of reality. On 16 November Mr Q's GP advised him to cut down on cannabis (he was at the time smoking eight joints a day).

On 2 December 2011 Mr Q discussed with Specialist Practitioner in Psychotherapy 1 (care coordinator) difficulty he was having with a neighbour. Mr Q said that the police had been involved and had given him advice. Specialist Practitioner in Psychotherapy 1 documented that Mr Q was managing the situation well and was able to recognise that the neighbour was someone who had suffered from mental health problems and substance misuse and may be relapsing.

The only other recorded session between Mr Q and his care coordinator that month took place on 8 December. During the meeting they discussed the reduction in Mr Q's anxiety levels which he attributed to taking his medication. There is nothing in the notes to explain why Mr Q had no further appointments in December or how regularly he should have been seen, although appointment history suggests that he should have been attending weekly sessions.

Mr Q attended two sessions with his care coordinator in January 2012. He failed to attend a third planned appointment. The main focus of the sessions was to discuss ways in which he could reduce his cannabis use.

Mr Q went to the police station on 8 February 2012 threatening to walk in front of cars and saying he was hearing voices from God about hurting himself. The police took him to Haringey primary care mental health team (PCMHT) where he was assessed by trust staff and reported cannabis use. He also said that his medication had now kicked in. It is not clear from the records what medication Mr Q was taking at this point.

The nurse assessed his risk to be low and Mr Q said he was not "inclined" to harm himself or others. The risk assessment form was updated and risk to self was considered low/minimal. The assessing nurse gave Mr Q information about DASH and referred him back to his care coordinator to make contact the following day. The risk overview at that time stated:

> *"*Client's mood will further deteriorate if he refuses to engage with professionals and continues to smoke cannabis*".*

Mr Q attended one-to-one sessions with his care coordinator throughout the remainder of February. They focused on addressing Mr Q's cannabis use. He attended DASH asking to be locked up and detoxed. The DASH worker agreed for Mr Q to attend a triage appointment.

Mr Q attended a session with his care coordinator on 1 March 2012. The session focused on Mr Q's cannabis use and the effect this was having on his life. Mr Q said that his life was not worth living but denied having a suicide plan. His care coordinator documented that she planned to discuss Mr Q's case with her head of service. She also noted that her sessions with Mr Q were due to end in July and suspected that his current difficulties may be related to this.

5.9.6 Comment

Specialist Practitioner in Psychotherapy 1 regularly attributed Mr Q's behaviour and disengagement to the fact that their sessions were scheduled to end in July 2012. This may well have been the case, although there is no evidence in the notes that Specialist Practitioner in Psychotherapy 1 considered any other reasons for Mr Q's behaviour or whether it impacted on risk, diagnosis or management.

In responding to comments on her practice, Specialist Practitioner in Psychotherapy 1 disputed the above comment. She stated:

> "The very nature of my psychotherapeutic work means I would be remaining open minded about what is happening for a client and this was the case with [Mr Q]".

5.10 Second referral to addiction services

Mr Q attended DASH for a triage appointment on 2 March 2012. The assessor explained to Mr Q that he would be allocated a key worker the following Thursday and they would then contact him. Mr Q told the assessor that he felt suicidal and she advised him to attend the ERC.

Mr Q subsequently went to the walk-in centre at St Ann's Hospital. He talked to a nurse at the ERC about having no money due to cannabis addiction and was given daily food vouchers for a week. The plan was for Mr Q to attend his follow-up appointment with his care coordinator at the Halliwick Day Unit, St Ann's Hospital and his DASH appointment the following week.

Following his triage assessment, Mr Q attended his first cannabis group on 7 March. A nurse noted that Mr Q participated well. Mr Q reported that he had not smoked cannabis for several days and was confident that he could remain drug-free.

The following day, Mr Q attended DASH – without an appointment – requesting a drug test. He was noted by the duty nurse as reporting that he was well and in a good mood but "was clearly unwell". The duty nurse further noted that "he was engaged in an earnest conversation with himself". He said he had "gone into my head for a minute". Mr Q tested positive for cannabis but negative for other drugs. He later attended a session with his care coordinator. She told him that she had seen him earlier that day through her window behaving more bizarrely than he had for a long time. Specialist Practitioner in Psychotherapy 1 recorded that Mr Q:

> *"*Acknowledged that our last 2 sessions have been difficult and that today it felt more possible for us to have a meaningful conversation – even though he felt I had brought him out of his child mood*".*

5.10.1 Comment

> There is much to suggest that Mr Q's mental health was deteriorating during this period. This was particularly apparent to those not close to Mr Q, although Specialist Practitioner in Psychotherapy 1 acknowledged that Mr Q had been behaving "bizarrely". There is nothing in the clinical records to suggest that Specialist Practitioner in Psychotherapy 1 had a plan to address this deterioration in Mr Q's mental state or that his risk or care management was reviewed. Additionally, there is no evidence to suggest that, at this point, she discussed the case with Consultant Psychiatrist 1, who had ultimate responsibility for Mr Q's care.

Mr Q was taken to Haringey Primary Care Mental Health Team by police under MHA Section 136 late in the evening of 10 March 2012. He had contacted police to tell them that he wanted to kill himself. They picked him up at a tube station and took him to St Ann's Hospital. He was recorded by the assessing nurse to be taking sertraline (anti-depressant) 50mg and had recently been using cannabis. He denied hearing voices and he displayed no evidence of experiencing hallucinations. He described feeling depressed and having fleeting suicidal intent, and reported that he had been relapsing for three weeks. After assessment, it was not considered necessary for Mr Q to stay in hospital. He was accepted for home treatment and the plan was for him to attend weekly appointments with his care coordinator and DASH.

Mr Q was visited by a home treatment worker on 11 March. He said that the incident the previous day had been triggered by seeing the air ambulance at the tube station and seeing a body bag. The clinical notes say that Mr Q reported feeling well and asked to be discharged stating that:

> *"*He did not need us and that he was going to take care of himself better than ever. He said that he won't touch cannabis again and he would pray to God for support*".*

Mr Q agreed to be seen by a doctor before discharge and a medical review was planned for 14 March. Mr Q was discharged from the home treatment team back to his care coordinator following the medical review meeting.

5.10.2 Comment

> Within months of Mr Q stopping his medication he is described as paranoid and hearing voices from God. In March he "was clearly unwell", "engaged in an earnest conversation with himself", and was considered by his care coordinator to be "behaving more bizarrely than he had been for a long time".
>
> Yet despite this there is no evidence of action being taken by mental health services such as carrying out a new risk assessment, a new care plan or reviewing the diagnosis. This may have given staff the opportunity to step back and consider the presenting behaviour and given them greater insight into Mr Q's underlying problems.

On 20 March Mr Q's care coordinator had a discussion with a representative of a hate crime advocacy group which was helping Mr Q because a neighbour had made homophobic remarks to him and had been banging on his door. His care coordinator suggested that Mr Q was able to deal with it himself or ask for help in their one-to-one sessions.

Mr Q attended a cannabis group session on 21 March. He was recorded by the group worker as being engaged and motivated. The following day he asked a DASH worker for a drug test. He tested positive for cannabis. He was seen by his care coordinator later that day. She recorded that Mr Q was "angry" because she challenged him about not waiting for her in reception. She recorded in the clinical notes that Mr Q:

> *"*… remained fairly fixed and angry with me for my perceived rejection of him… I believe his reaction comes in the context of our ending in July…. I have put this to [Mr Q], he believes that I am treating him differently because I know that we will be finishing*".*

Mr Q went to the A&E department at North Middlesex Hospital in the evening of 18 April 2012. The A&E doctor described Mr Q's presenting problem as "anxiety issues FB [foreign body] stuck in ear*"*.

Mr Q failed to attend cannabis group sessions in April 2012 but attended one-to-one sessions with his care coordinator. During a session on 26 April he and his care coordinator talked about Mr Q's:

> "… tendency to go into child mood and how this ultimately undermines the more adult side of him.*"*

On 21–22 May 2012 Mr Q made frequent calls to Haringey adult commissioning and became quite verbally aggressive. A social worker was concerned that Mr Q was unwell. She emailed the intake team on 21 May stating:

> *"*I am sending you a very important referral this man needs to be seen asap he sounds very unwell, please email me an outcome on this case*."*

The social worker also emailed Specialist Practitioner in Psychotherapy 1, care coordinator, to inform her of the contact she had had with Mr Q. In her email she wrote:

> *"*He is clearly unwell as he is calling me constantly and he is getting quite aggressive on the phone. He is claiming he has a red chest, he wants to support the royal family and today he has rung me twice to tell me that he has not eaten for days.*"*

Specialist Practitioner in Psychotherapy 1 responded to the social worker the same day as follows:

> *"*I do not think this [aggressiveness] is a symptom of illness, though he does at times present as if he was unwell. He can become threatening when anxious and this I would consider to be an aspect of his personality disorder*".*

She added:

> *"*We are due to finish working together on 27 July and I think this current presentation is related to that and perhaps also to the fact that he has chosen not to come to his last 2 sessions*".*

Mr Q attended only one of five planned sessions with his care coordinator in May 2012. Specialist Practitioner in Psychotherapy 1 noted that she reminded Mr Q of how many sessions they had left (sessions due to end in July) and noted that he felt "appropriately sad" about this. She also recorded that he felt "daunted" about not having a care coordinator.

5.10.3 Comment

> It is interesting that a professional who had no prior experience of working with Mr Q described him as "clearly unwell" in her email to his care coordinator, asking her to contact Mr Q urgently.
>
> Specialist Practitioner in Psychotherapy 1 surmises that Mr Q's presentation at this time is related to his personality disorder and their sessions together ending in two months. At their next session on 24 May 2012 the impact of this ending was further explored but there is nothing in the notes to indicate that Specialist Practitioner in Psychotherapy 1 assessed Mr Q psychiatrically (reassessing his diagnosis and treatment requirements). Instead Specialist Practitioner in Psychotherapy 1 tried to get Mr Q to consider how the social worker may have come to experience him as "unwell".

On reviewing this report Specialist Practitioner in Psychotherapy 1 told us that she would have remained open minded about what was happening for Mr Q. However, this is not reflected in the clinical records.

While Consultant Psychiatrist 1 had ultimate responsibility for the diagnosis and treatment of Mr Q as the clinical lead Specialist Practitioner in Psychotherapy 1 took on responsibility for the planning of Mr Q's care and treatment.

When commenting on this report when it was in draft form, Consultant Psychiatrist 1 told us that Specialist Practitioner in Psychotherapy 1 *did* meet with him to reflect on the case but these meetings were not documented in the clinical records.

Mr Q phoned his GP on 8 June 2012. He explained that he had felt scared that morning and had visited the surgery and told reception staff that he felt suicidal but denied suicidal intent. He returned home and spoke to the GP by phone. Mr Q's GP suggested he call his care coordinator/ERC. His GP also offered him an appointment for that afternoon which he failed to attend. Mr Q's GP chased him by phone but it is not clear (from the notes) whether he managed to speak to him.

Mr Q was discharged from DASH on 11 June 2012 following discussion at a meeting of the multidisciplinary team (MDT) on 31 May. The clinical records note that Mr Q first went to DASH on 2 March 2012 asking for support with reducing his cannabis use. However, he failed to engage with the service and efforts by DASH staff to engage with him were not successful. After 2 March Mr Q attended only two cannabis group sessions and subsequently dropped out.

Mr Q did not attend any of the planned sessions with his care coordinator, Specialist Practitioner in Psychotherapy 1, in June. Specialist Practitioner in Psychotherapy 1 was anxious in July that she had not seen Mr Q since the end of May (he was scheduled to attend weekly appointments). This prompted her to raise her concerns with her service manager and consultant psychiatrist, whom she asked to contact him. She recognised that Mr Q's non engagement was "out of character" for him but linked it to their sessions coming to an end rather than considering that it might be a sign of deterioration in his mental state.

5.10.4 Comment

Despite Mr Q being twice assessed as "clearly unwell" in March and May 2012, mental health services seem to have effectively lost sight of him. He attended only one meeting with the care coordinator in April, one in May and was then not seen at all until July, when they planned to discharge him.

In Specialist Practitioner in Psychotherapy 1's email to Consultant Psychiatrist 1, on 17 July 2012, Specialist Practitioner in Psychotherapy 1 appears to put Mr Q's non-engagement in the context of their therapy sessions coming to an end. She writes, "My hunch is it may be the way he can manage the ending with me (which may be why he doesn't return my calls)".

It is unclear from the clinical records whether Consultant Psychiatrist 1 contacted Mr Q as requested, and if so what the outcome was. There is no documentary evidence to suggest that anyone treated Mr Q in a responsive way to his worsening condition. There was a lot of conjecture but no one really attempted to get to the bottom of his changing needs. The focus appeared to be on his impending discharge, which was not reviewed in the light of his recent presentation.

Mr Q attended a session with his care coordinator on 19 July. A discharge CPA meeting was planned for the following week. The review team discussed reducing his sertraline dose from 150mg to 100mg daily. Mr Q continued to experience paranoia about other people and had an on-going problem with a neighbour. He reported feeling better than when he began treatment and that he now felt more aware of other people's feelings.

Specialist Practitioner in Psychotherapy 1 recorded that Mr Q calls the police and ambulance less frequently and has stopped chewing khat. He continues to smoke cannabis but a weaker strain than skunk. Specialist Practitioner in Psychotherapy 1 recorded in Mr Q's crisis plan that he was to:

- manage anxiety with self-help methods that he has learnt in therapy; and
- contact PCMHT if needed.

Mr Q attended his last planned session with his care coordinator, Specialist Practitioner in Psychotherapy 1, on 26 July 2012. Specialist Practitioner in Psychotherapy 1 recorded that Mr Q was in a good mood but feeling appropriately sad about leaving. Specialist Practitioner in Psychotherapy 1 documented that Mr Q had a screwdriver in his pocket and talked about having it as a weapon because he was scared by his neighbour. He readily volunteered to give the screwdriver to his care coordinator, who put it in the sharps bin.

Mr Q said the police were aware of the threats that had been made to him and had given him advice. He reported feeling reassured that lots of other people in his neighbourhood were aware of the situation.

5.10.5 Comment

Neither of these claims made by Mr Q were followed up. Specialist Practitioner in Psychotherapy 1 did carry out an assessment of risk – her assessment was that she did not view this (carrying a screwdriver) as an indicator of serious risk to Mr Q or others. However, in accordance with the Trust Risk Assessment Policy the RiO Risk Assessment Form should have been updated to include this incident.

Mr Q was discharged from Haringey personality disorder service on 26 July 2012 after being in psychotherapeutic treatment within the service since March 2009.

Specialist Practitioner in Psychotherapy 1 completed a discharge summary for Mr Q on 10 August, although the summary was not sent to Mr Q's GP until 22 August (a week after the incident).

5.10.6 Comment

> Mr Q was discharged back to his GP having had the opportunity to attend weekly sessions with Specialist Practitioner in Psychotherapy 1 for the last three years. There was no reduction in management or a trial to see how Mr Q would manage with no support in place (other than his GP).

Mr Q spoke to his GP on 6 August. He felt that he didn't need sertraline (anti-depressant) any more. His GP agreed and put him on a weaning-off plan for six weeks.

5.10.7 Comment

> There is no evidence in the notes that Mr Q's GP was aware at this stage that Mr Q had been discharged from mental health services back to the sole care of the GP.

Mr Q went to the A&E department at Chase Farm Hospital on 7 August 2012. He was complaining about a problem he was experiencing with his ears. No further details of the visit are recorded.

Mr Q phoned his care coordinator, Specialist Practitioner in Psychotherapy 1, on 10 August to let her know that he had been visited by God who had totally healed him. Specialist Practitioner in Psychotherapy 1 told Mr Q that their work together had finished; Mr Q said that he wanted to let her know that he no longer needed her.

5.10.8 Comment

> The records suggest that Specialist Practitioner in Psychotherapy 1 had decided, early on, that this was a case of personality disorder and there is limited evidence to indicate that any other diagnosis was being considered.

During interview Specialist Practitioner in Psychotherapy 1 told us:

> "I think it was clear from the referral that there was a view that he had a personality disorder."

She went on to say:

> "I asked [Consultant Psychiatrist 1] to see him as well to help with that [diagnosis] process. I think that we did end up deciding that he did have

> enough traits of borderline personality disorder, and with his other dependent traits, that would warrant him coming into the intensive part of our Service."

During interview we asked Specialist Practitioner in Psychotherapy 1 whether everything fitted in the 'box' of personality disorder or whether there were other things that sat outside that made her feel uncomfortable or could be attributed to something else. Specialist Practitioner in Psychotherapy 1 replied:

> "I think that they sat inside that box. They didn't seem to have a delusional quality to them."

Thus Mr Q's increasing agitation in the months leading up to the planned discharge is put down to his anxiety around the ending of the therapy. In this context, it is likely that his being "visited by God" is seen as a reflection of the "histrionic" aspects of his personality disorder. Aside from the voices and the ghosts and other related experiences, which Specialist Practitioner in Psychotherapy 1 does not address during the long therapy, the possible effects of cannabis and khat use are not thoroughly considered. Nor is there documented evidence of Specialist Practitioner in Psychotherapy 1 liaising with other professionals or in particular with Consultant Psychiatrist 1 to reflect on the case and to perhaps look at other ways of interpreting the presentation. We consider this was a missed opportunity to continually review progress, symptoms, and diagnosis and treatment options.

When commenting on this report when it was in draft form, Consultant Psychiatrist 1 told us that Specialist Practitioner in Psychotherapy 1 *did* meet with him to reflect on the case but these meetings were not documented in the clinical records.

If indeed the therapy had been effective or successful, one would not have expected such hostility or agitation from the patient at the culmination of the therapy. It was incumbent on Specialist Practitioner in Psychotherapy 1 at this juncture, or this and various other reasons already mentioned, to reconsider her views and to question them and to seek advice and guidance before going ahead with the planned discharge.

When responding to our comment at 5.10.8, Specialist Practitioner in Psychotherapy 1 told us that her clinical judgement at the time was that Mr Q was not describing experiences that were psychotically driven.

It is not clear from the progress notes which followed the telephone contact on 10 August (referred to above), that Specialist Practitioner in Psychotherapy 1 had attempted to establish what, if any, help Mr Q needed.

Specialist Practitioner in Psychotherapy 1 recorded in the discharge summary that the plan was for Mr Q to attempt to reduce his anxieties with self-help methods and by remembering what he has learnt in therapy.

Specialist Practitioner in Psychotherapy 1 also recorded that Mr Q knows that he can contact PCMHT (formerly START) at ERC if necessary. Mr Q will continue to have his anti-depressant medication prescribed and reviewed by his GP. He could also re-refer himself to DASH if he wants to. The letter also stated that Mr Q is likely to need

assistance during times of crisis and he is aware of the crisis pathway should he need it.

In the early hours of 14 August 2012 Mr Q phoned the emergency services. The emergency operator described him as a:

> "… very delusional male rambling about having killed the demons and everything is now clean."

The London Ambulance Service (LAS) were asked by the emergency operator to attend Mr Q's home address. They asked for support from the Metropolitan Police Service (MPS) but there was no unit available to assist them at that time. The LAS did not enter Mr Q's address alone as they were not happy to approach if Mr Q was delusional. It was approximately three hours later that Mr Q was seen by LAS & MPS. We have not seen any further information from this evening and nothing to suggest that this incident was shared with mental health services. On the information available at that time, there was no indicator of the extreme violence that was to follow the next day.

Mr Q and the victim were neighbours. During the trial the court heard that they had been friends and he had referred to her as 'grandma'. It is documented that the victim was very well-liked in the area and many of her neighbours referred to her as 'aunty' or 'grandma'.

On 15 August 2012 Mr Q visited the victim at her home address. While in her home, Mr Q stabbed her multiple times and she subsequently died from wounds to the heart and spleen.

After the attack Mr Q called 999 and when police arrived he told them: "I was told to deal with her - you should be happy the antichrist is dead", the prosecuting QC said during the trial.

Mr Q was arrested sitting outside the victim's house on the pavement half naked, covered in blood. He was later charged with murder.

On 17 June 2013 Mr Q pleaded guilty to the lesser charge of manslaughter after psychiatrists agreed his responsibility was diminished by mental illness.

6 Issues arising

In the following sections we analyse aspects of Mr Q's care and treatment and consider processes in place in the trust when Mr Q was known to their services. We also review the trust's current practice in specific areas to establish what improvements have been made since the incident in August 2012. We interviewed senior trust managers who gave us examples of how policies and procedures have been operationalised. A full list of the documents reviewed can be found in Appendix B.

As these sections consists mainly of comment and analysis we have not separated this out from the narrative.

The trust's board level panel inquiry report highlighted specific concerns about the care and treatment provided to Mr Q and made eight recommendations for service improvement. We consider these issues in addition to the terms of reference for our independent investigation and further areas that have emerged during our investigation. We have not undertaken an independent audit but rely on information provided by the trust about developments in the service.

The terms of reference for this investigation asked that we assess:

- any care and service delivery problems leading to the incident;
- the appropriateness and quality of assessments and care planning; and
- the extent to which Mr Q's care was provided in accordance with statutory obligations and relevant national guidance from the Department of Health, including local operational policies.

The information is based on our review of Mr Q's clinical records, our interviews with trust staff and, where relevant, extracts from the trust's internal review. We give particular attention to the following themes:

- diagnosis;
- model of care in Haringey personality disorder service;
- suitability of treatment and care;
- team roles and responsibilities;
- staff supervision;
- use of medication;
- khat/cannabis use;
- risk assessment and risk management;
- discharge – planning and appropriateness;
- crisis planning; and
- liaison with other services (police/probation).

7 Diagnosis

Since Mr Q arrived in London (in 2005) he has had frequent contact with mental health services. He regularly accessed services through A&E and the emergency services. He was given diagnoses of personality disorder, depression and acute stress reaction.

7.1 The 'personality disorder' diagnosis

A personality disorder is defined, in the Diagnostic and Statistical Manual of the American Psychiatric Association, 4th Edition (DSM-IV), as an enduring pattern of inner experience and behaviour that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances.

The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organization 1992), defines a personality disorder as: a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable personal and social disruption.

The ICD-10 gives nine categories of personality disorder. In DSM-IV there are ten personality disorders that are divided into three clusters, designated A, B, C:

A - Paranoid personality disorder
B – Antisocial personality disorder
C – Avoidant personality disorder

There are often personality traits that fall into more than one sub-type, this can therefore make diagnosis difficult.

Mr Q's diagnosis of personality disorder (PD) appeared to be set among most professionals involved in this case, from early in his care. The emotionally unstable subtype (cluster B) was opted for and in the clinical documentation there are comments to the effect that there were "dependent" and "histrionic" elements as well. An example of this is in the discharge letter sent by Specialist Practitioner in Psychotherapy 1 to Mr Q's GP on 24 July 2012 (written 10 August – sent 22 August).

> "He showed some personality traits associated with borderline, dependant and histrionic personality types."

Consultant Psychiatrist 1 would have been the "diagnostician" in this case – or at least he would have led on issues of diagnosis. However, we have not seen, what would be considered, a full diagnostic assessment completed by him in the notes. This would have acted as a reference point for the other professionals involved, in particular Specialist Practitioner in Psychotherapy 1. There is an entry by Consultant Psychiatrist 1, dated 21 April 2009, stating:

> *"*Overall, I am unclear about a diagnosis… I have agreed that we will offer him a place in our day unit so that we can make a longer and more detailed assessment of his personality function*".*

Despite Consultant Psychiatrist 1 being open minded about diagnosis, Mr Q's clinical records suggests that the diagnosis was considered to be personality disorder from early on. Not only with Specialist Practitioner in Psychotherapy 1, the key professional involved, but with other professionals who became involved in Mr Q's management on occasion. For example at the beginning of an assessment dated 10 March 2009 the doctor states that Mr Q is:

> *"…* well known to services with a diagnosis of borderline personality disorder with histrionic traits*".*

From there, the assessment goes on to detail Mr Q's experiences under "HOPC" (history of presenting complaint) as:

> *"*Seeing a white ghost in his house… it's the dead tenant… he hears a voice all the time inside his head. The voice is of a female and he talks to her all the time… the voice also comments on whatever he does*".*

This is followed by the "past psychiatric history", which starts off with:

> "He is well known to the team with a diagnosis of borderline personality disorder with histrionic traits".

The doctor does not attempt to come to a conclusions but relies almost entirely on what was perceived to be the definitive diagnosis made by those before.

The documented discussion of Mr Q's diagnosis between involved health professionals is inadequate. It suggests that Mr Q had a personality disorder (and there are certainly many features of the presentation to suggest this), but there is no recorded exploration of whether he had any additional mental health conditions, or whether other conditions developed over time.

Consultant Psychiatrist 1 told us during interview that he remained open-minded about Mr Q's diagnosis throughout and that Mr Q's diagnosis and symptoms were continually reviewed. Consultant Psychiatrist 1 told us that he, Specialist Practitioner in Psychotherapy 1 and the wider team discussed them although the discussions were not documented, in line with good practice. Whilst we acknowledge that Consultant Psychiatrist 1 remained open-minded and that he felt additional work was required to assess Mr Q's personality function, this was not reflected in the care Mr Q received. There is nothing in the clinical records to record that on-going reviews and assessments took place. It also appears that other members of the team, particularly Specialist Practitioner in Psychotherapy 1 who had more contact with Mr Q, were more strongly in favour of a diagnosis of personality disorder.

7.1.1 Finding

It is clear from the information relayed to us during interview that actions that trust staff told us they undertook were not documented in the clinical records in line with good practice.

7.1.2 Recommendation

The trust should ensure that staff understand the importance of thorough record keeping, in line with trust and national policy. This includes the need to record discussions about patients when their symptoms, diagnosis and treatment has been considered and any subsequent action agreed. The trust should carry out six-monthly audits to ensure compliance.

A joint assessment took place on 7 January 2011. The assessment starts: "Diagnosis: emotionally unstable personality disorder". And towards the end of the assessment is written, under "Impression": "History of emotionally unstable PD with histrionic traits".

Although various professionals were involved in the assessment, care and treatment of Mr Q over the years, the doctors referred to above (but possibly with the exception of Consultant Psychiatrist 1) assumed that Mr Q's diagnosis had been confirmed. As a consequence, nothing recorded in the records indicates that attempts were made to re-assess the case with an open mind, focusing on symptoms. This appeared to be a pattern.

In order to make a diagnosis of personality disorder, irrespective of subtype, the assessor needs to establish that the patterns of behaviour being witnessed were in place by late adolescence or early adulthood and continuous since then.

It is impossible to ascertain from the documentation we have reviewed whether Mr Q's patterns of behaviour went back to adolescence or early adulthood. In fact, surprisingly little is known of Mr Q's past. What is documented in the notes, and repeated throughout, is that when he came to the UK in 1999, and when he was living in Cardiff until 2004, he worked as a security guard.

Mr Q's GP records indicate that he first came into contact with mental health services in 2000 when he was admitted to hospital with an acute stress reaction. In 2002 Mr Q went to his GP saying that he was depressed following the death of his father. He was referred to secondary mental health services, who assessed him and recommended counselling. Mr Q was referred to mental health services again in May 2004 but did not attend. He took an overdose in August 2004. He was followed up by mental health services in October 2004 when he described anxiety problems.

Despite his occasional interaction with mental health services (three times in four years), Mr Q appeared to remain in full-time employment, suggesting some degree of stable functioning.

Overall, the impression is that Mr Q was fairly stable mentally at that time and he was well enough to keep a job. If this was the case, then the subsequent breakdown in functioning could point to the advent of a “condition” or an “illness” superimposed on the underlying personality.

It is possible that Mr Q was not forthcoming with information about his past. In our interview with Consultant Psychiatrist 1, he said that Mr Q would avoid answering questions about his past and about his family. However, there is nothing in the substantial documentation to suggest that any serious attempts were made to obtain this information. Any information about his past and family is sparse and is documented early on in the notes and simply repeated either by Specialist Practitioner in Psychotherapy 1 or by other professionals, including medics, who became involved in his care.

We did not find any evidence in the notes to suggest that Mr Q was asked specific questions about his past and that he would not answer or any entries that expressed concern that such information was not available. Such questioning and the obtaining of such personal and social past history are considered prerequisites for making a diagnosis of personality disorder.

Furthermore, little detail was known about Mr Q’s social network, particularly regarding his family. There are entries in his clinical records that state that he had no family in the UK (this is the position taken by the trust’s board level panel inquiry in their final report). However, other entries refer to him having a sister living in the UK and to a “cousin”. His early GP records also refer to a sister living in London.

Such information is critical particularly if the diagnosis is one of personality disorder, where a psychological approach is most appropriate (as opposed to, say, medication). Also, if it was proving difficult or impossible to obtain information, for example regarding Mr Q’s past, interviewing a family member or an acquaintance might have provided missing information.

The documentary evidence suggests that, from very early on, the diagnosis of personality disorder was made and that this diagnosis was the only one being considered. It is not clear why this was the case, especially as Consultant Psychiatrist 1, both in his interview with us and with the trust inquiry panel, stated strongly that, in his view, the diagnosis was never clear, to the very end.

To be unclear about a diagnosis means an open-mindedness in construing the presenting features of the case and constantly adjusting one’s understanding as time passes. Although Consultant Psychiatrist 1 had overall responsibility for Mr Q’s diagnosis and treatment it was Specialist Practitioner in Psychotherapy 1 who took responsibility for the planning of his care and treatment. Specialist Practitioner in Psychotherapy 1’s entries in Mr Q’s clinical records and her interview for this independent investigation would suggest that she considered, early on, that he had a diagnosis of personality disorder.

The fact that the diagnosis was considered to be personality disorder, by Specialist Practitioner in Psychotherapy 1 (and others who became involved on occasion) could explain why no further information regarding Mr Q’s past was pursued, as the

diagnosis was evident (to them) and therefore further information was unnecessary. It also explains the failure in the clinical records of staff trying to make sense of certain clinical findings that could not be easily explained by the personality disorder diagnosis – findings that were generally viewed as reflecting the "histrionic" features of the case or the "dependence" aspects of it.

It would have been Consultant Psychiatrist 1 who had ultimate responsibility for the diagnosis and ultimate treatment of Mr Q as he was the clinical lead. Specialist Practitioner in Psychotherapy 1 was lead specialist practitioner in psychotherapy and would have been managed by the consultant lead nurse in psychotherapy/service manager. It would appear that Specialist Practitioner in Psychotherapy 1 took on ultimate responsibility for the planning of Mr Q's care and treatment over the three-year period and although there were opportunities for team discussion it is unclear from the records how often Mr Q's case was discussed.

When commenting on this report when it was in draft form, Consultant Psychiatrist 1 told us that Specialist Practitioner in Psychotherapy 1 *did* meet with him to reflect on the case but these meetings were not documented in the clinical records.

7.2 Other aspects to Mr Q's presentation

The clinical presentation over the three years that Mr Q was under the care of Consultant Psychiatrist 1 and his team highlighted at least two issues. These were not only significant in themselves at the time of his care and treatment but were made even more significant in the light of the subsequent homicide.

These two issues will be referred to as the "paranoid" and "psychotic" aspects of Mr Q's presentation. The two aspects are intimately related with a grey area in between, with some overlap.

7.3 Paranoid aspects of the clinical presentation

By "paranoid" here we do not mean in its sense of "delusional" (which is one technical meaning of the term) but in its sense of suspiciousness - questioning others' motives and seeing something sinister in them without sufficient cause. Mr Q displayed a great deal of this type of paranoid behaviour as judged by the numerous and frequent entries in the case notes. The following are a selection of examples:

1) Specialist Practitioner in Psychotherapy 1 wrote to Mr Q's GP on 30 August 2009 – by which time Mr Q had been a patient at the Halliwick Day Unit for almost a year, receiving weekly psychotherapy from Specialist Practitioner in Psychotherapy 1. In the letter she writes that Mr Q is:

> "Sensitive to the possible negative feelings of other patients… suspicious of the motives of other people – believing they are acting out of malice towards him… very sensitive to possible inattentiveness in the other…"

2) A doctor recorded in Mr Q's clinical records on 21 August 2009 that Mr Q:

> "Accused me of blaming him for causing an outburst of anger".

3) A nursing entry dated 26 August 2009 states that Mr Q:

> *"*Believes that people are against him and people smile and think he is stupid. He demanded that I should not smile*"*.

4) A medical entry dated 17 November 2009 recorded that Mr Q:

> *"…* is concerned that a man who wanted to have sex with him put something in his drink making him tired*".*

5) A therapy entry dated 6 August 2010 states that Mr Q:

> *"*Found my facial expressions disturbing*".*

6) Specialist Practitioner in Psychotherapy 1 recorded on 26 August 2010 that Mr Q:

> *"*Spoke about his worry that staff here are mind-readers… Spoke about his experience of having inner dialogues which distress him… After the session he was having difficulty breathing*".*

7) There are several consecutive entries in early 2011 made by Specialist Practitioner in Psychotherapy 1 that state that Mr Q was complaining of feeling paranoid. Specialist Practitioner in Psychotherapy 1 recorded that she thought this was to do with his impending court case but Mr Q did not agree with the connection.

8) Following a home visit to Mr Q by one male and one female member of staff on 11 June 2011 the staff record:

> *"*On arrival, he asked us to remove our shoes… the ones worn by the female member of staff took a while to be removed… [Mr Q said this was our] opportunity to block his view so as not to be aware of what the male member of staff has been doing in the house*".*

9) On 24 July 2012, as part of Mr Q's discharge CPA, it is documented that he:

> *"…*continues to experience paranoia about other people and had an on-going problem with a neighbour*".*

Mr Q also commented on one occasion that he did not like the way that a staff member looked at him and felt that people were laughing at him. He repeatedly complained that staff were ignoring him and did not care about him.

This rather pervasive and sustained suspiciousness was a prominent part of Mr Q's clinical presentation, to the point where it could be asked why a paranoid personality type was not considered or, if it was not so prominent as to warrant that status, why this "paranoid" aspect was not emphasised as much as, say, the "histrionic" or the "dependent" aspects.

Considering possible causes of this undue suspiciousness, we note the following:

- Sexual orientation: Mr Q said he was homosexual. In March 2008 it was documented in his clinical records that he said he had been having one-night stands and that "he has been meeting a few gay Somalian friends and has generally been keeping away from the mainstream Somalian community for fear of being abused". On 21 July 2008 it was documented that:

  > "He is finding it difficult to gain support from his friends with regards to his sexuality".

- Culture: Mr Q is from a different culture (Somalia). He arrived in the UK at the relatively late age of 19 when his personality had developed along certain lines. From our understanding he came to the UK alone.

- Religion: Mr Q was a Muslim and in some aspects a practising one (for example, an entry in Mr Q's clinical records on 2 September 2008 refers to him as "fasting"). Nevertheless there is evidence in the notes that Mr Q drank alcohol (an entry dated 31 January 2008 states: "Home visit this evening... [Mr Q] was in on his own drinking beer"): alcohol is prohibited for Muslims. The tensions are obvious.

The "paranoid" aspect of the presentation was not documented as being recognised in its own right and the various factors of culture and religion and sexual orientation do not appear to have been sufficiently explored – if only to ascertain to what extent they might explain the paranoid features of the presentation. This conclusion is reached on the basis of the numerous entries where this particular issue is not addressed and the fact that even the final discharge letter to the GP does not deal with the matter. It is also based on our interview with Specialist Practitioner in Psychotherapy 1 as part of our independent review. Specialist Practitioner in Psychotherapy 1 was clear that all of the aspects of Mr Q's presentation could be explained by the diagnosis of personality disorder.

7.4 Psychotic aspects of the clinical presentation

There were times when Mr Q expressed what appeared to be delusional ideas or described what could be considered hallucinatory experiences. The following examples are taken from Mr Q's clinical records:

> 1) In January 2008 "He saw demons in the garden from his bedroom window. After a little exploration he said he saw them in his nightmare".

2) In March 2008 he said that “people are following him in the street”. He also said that “he felt the trees were attacking him”.

3) On 2 July 2008 Mr Q said “He could hear his mother asking for money”. Later that month it is documented that he was “experiencing auditory hallucinations telling him to kill people”.

4) Mr Q went to North Middlesex A&E department at 4am on 21 July 2008. He told staff he was experiencing auditory hallucinations telling him to kill people. He was transferred to START where he denied having auditory hallucinations but said he was having thoughts of killing his friend who was calling him a faggot.

4) On 17 September 2008 Mr Q reported that he “sees flashes of light from time to time”. Two days later he “reported seeing some flashing lights in his room”.

5) On 21 September 2008 it is documented in Mr Q’s clinical records that he “went on to speak about his ‘ghosting’ experiences… sounded like distorted thoughts…”

6) On 9 February 2009 “He mentioned about the voices which are distressing him; they are worse during the night. They make bad remarks about him… He is trying to ignore them by going for walks and listening to music. He stated that he always has them”.

7) On 27 February 2009 it is documented that Mr Q is “seeing white smoke in his living room… stated that he hears voices… that there is a spirit inside”.

8) On 6 March 2009 Mr Q “reported he has been hallucinating… seeing a white ghost and something crawling on his body”. Three days later it is recorded that Mr Q is “seeing a ghost in his flat, flashing lights going round in the room… insects crawling on his left arm… hearing a voice which has been there for some time… this voice has been with him for many years”.

9) On 13 March 2009 Mr Q “reported hearing a female voice… When I asked [Mr Q] if that could be another way of describing him speaking to himself, he replied that it is rather quite different”.

10) A particularly interesting entry, dated 31 March 2009, mentions “the constant presence of a ghost who he identified as being ‘Christian Catholic’, hence prayers from the Koran would fail to avert the ghost”.

11) A nursing entry dated 11 January 2011 says that “He appeared mentally unwell… observed to be confused throughout our conversation but he said he was experiencing thought disorder. He also said he was experiencing some psychotic symptoms for the past few days. He was asked if he was hearing voices, he said no but some echo in his head commanding him that whatever he does was wrong”.

12) A nursing entry dated 8 February 2012 says that Mr Q was *"*… brought in by police… stated… that he was hearing voices from God about hurting himself and having sex… Police reported him feeling very upset and crying and was hyperventilating*".*

13) Telephone contact between Mr Q and the social worker at Haringey adult commissioning was documented in May 2012. The social worker got the distinct impression that Mr Q was "unwell" – he had spoken to her about the "royal family" and said that he had a "red chest". It is clear from the care coordinator's (Specialist Practitioner in Psychotherapy 1's) notes that she interpreted this "episode" entirely in terms of the PD framework. In fact, she emailed the social worker stating: "I do not think this is a symptom of illness, though he does at times present as if he was unwell".

14) Specialist Practitioner in Psychotherapy 1 recorded on 9 June 2010 that Mr Q "… had a bad night. Experienced what he regards as a ghost in his flat which he confronted and felt slapped by". There is another entry by her dated 24 September 2010: "Came to the view [not made clear who] that the best approach was to accept all these different 'voices' (aspects of himself and his own thoughts)". Another entry dated 22 June 2011 says that Mr Q "feels unsafe at home… fears that a ghost may be wanting to kill him".

In this last entry (point 14), Specialist Practitioner in Psychotherapy 1 goes on to say that Mr Q "is aware that this may not be true and may be his vivid imagination. Agreed to try to rein in his imagination and thus his anxiety". There is also an entry by Specialist Practitioner in Psychotherapy 1 dated 19 July 2011 that states: "He felt let down by the police… as he believed they were following him".

Another particularly interesting entry dated 7 July 2011 by Specialist Practitioner in Psychotherapy 1 combines the paranoid/possibly psychotic features of this case with something of the nature of the relationship that had developed between her and Mr Q. She recorded that he *"*remained adamant that I somehow possess magic powers/am an angel*".*

Another entry by Specialist Practitioner in Psychotherapy 1, dated 8 March 2012 states: "I had my attention drawn to him [through a window, before the session started] because I heard clapping and looked and saw a man who looked like [Mr Q] but behaving more bizarrely than he has done of late".

Specialist Practitioner in Psychotherapy 1 notes Mr Q's clinical presentation but then interprets it as emanating from the personality – in other words, as reflecting the disordered personality. It is further evidence that whatever was presented clinically appeared to be attributed to the personality disorder. This is quite different from the viewpoint expressed by Consultant Psychiatrist 1. He felt that Mr Q's presentation was not only complex but also that it did not fit entirely into any one diagnostic category. His open-mindedness as to what the underlying condition might be did not appear to be shared by Specialist Practitioner in Psychotherapy 1.

At interview Specialist Practitioner in Psychotherapy 1 was asked whether Mr Q talked about ghosts in his flat and the impact it had on him during their sessions together. She replied:

> *"*Yes, a bit. There was also something about his cultural background that I wondered about being significant. He was brought up in a family where he was told that ghosts did exist, and that demons could possess people. It was quite interesting towards the end – I think that I have put it in the notes – that he came and he said that he thought that what he had as anxiety was some sign, as his father would tell him, that he was being possessed, or something. We talked a lot about how he actually preferred the Western view of these things that go wrong, rather than the view that he had taken on in his own Somali culture that was more in belief of ghosts. I don't know enough about that culture. I think that it was possible that he was coming with some different explanations for certain internal experiences that he was having*".*

We also asked Specialist Practitioner in Psychotherapy 1 during our interview whether religious references made by Mr Q seemed to fit inside the box of personality disorder or whether there were other issues that could be attributed to something else. She told us:

> *"*I think that they sat inside that box. They didn't seem to have a delusional quality to them*".*

It must be assumed that, as far as the diagnostic possibilities in this case are concerned, Specialist Practitioner in Psychotherapy 1 and others involved in the care of Mr Q took their cue from Consultant Psychiatrist 1. Consultant Psychiatrist 1 agreed with this assumption during our interview with him.

Consultant Psychiatrist 1 made it clear to us in our interview that, in his view, Mr Q did not have a schizophrenic illness. He said that any apparently psychotic features were not systematised and did not amount to an illness.

This viewpoint is understandable based on the case notes we have reviewed. We would also agree that there was not enough here to support a diagnosis of schizophrenia or a delusional disorder.

This however does not justify the conclusion that these various experiences are not "psychotic" in nature and that they may be attributed to personality disorder. There are in the literature, and memorialized in the International Classification of Diseases (and the American Diagnostic and Statistical Manual), conditions which on the one hand are labelled as psychotic but on the other are seen as fragmented and lacking in any overall coherence or that are not systematised in any way. They are given adjectives such as "polymorphic" and "transient" to reflect these characteristics.

It would appear that symptoms which could have been attributed to a psychotic illness were considered to be symptoms of personality disorder, within a particular treatment model. Rather than having an open-minded and flexible approach, there is a sense that Mr Q's care coordinator interprets his beliefs as anxiety-driven rather than attempting to probe further his internal experiences.

The issue here is not so much what the exact diagnosis was but how these disturbing features and experiences were managed. The documentary evidence is that, led by the one diagnosis of personality disorder, these experiences were not taken as seriously as they should have been. For example, medication should have been considered in dealing with some of these experiences. In this respect, it is significant that the responsibility for prescribing in this case, at least during the latter part of Mr Q's care, was left to the GP.

It is of note that at one point in early 2009 Mr Q was attending a "hearing voices" group. It is not clear if this meant that the "voices" Mr Q mentioned were considered true auditory hallucinations. We could not find any commentary in the notes around this issue and Consultant Psychiatrist 1 was not aware of this fact.

During our interview with Consultant Psychiatrist 1 we asked him for his views on the incident in which Mr Q killed his elderly neighbour and whether he saw his behaviour as an entirely new presentation. He said:

> "I've been through many of the things that you've listed about his symptoms of where he was experiencing things which are simply not normal in terms of either the ghosts or his persecutory feelings or hallucinatory experiences, all of which potentially look like psychotic phenomenon, whether or not this was a psychosis and therefore led to something such as a sudden delusional state where he might have done something. I've discussed it with the people who have seen him subsequently to try to see where it appears and where he was at the time and so on".

Consultant Psychiatrist 1 continued:

> "My own view is that many of those symptoms I still cannot see were related to a psychosis which was present and apparent at the time. I'm not trying to defend myself in any way because there's little point in doing that. They did not hold the quality, the systematisation, the key areas of those symptoms, of psychotic symptoms. The thing that worried me the most about many of his behaviours was whether we'd been drawn down more because of his anxiety and the levels of arousal that seemed to drive so much of his behaviours, whether we'd been duped by that to some degree, because again that is relatively reassurable, you could bring that down, and he responded to that and stopped his contact with others. I still think that his original presentations were interfered with by the drug misuse".

We also asked Consultant Psychiatrist 1 for his view, from what he had read and seen about the incident, about whether Mr Q was psychotic at the time of the incident. He replied:

> *"*I would like to have seen him [Mr Q], I must say, but I thought that the most likely state that he was in was some major affective swing of some sort, which was psychotic, yes*".*

Consultant Psychiatrist 1 was asked to further clarify whether there must have been some process superimposed on top of the personality that that would explain what he did. He replied:

> *"*From his personality function, unless we missed seriously the depth of the narcissism or psychopathy, which I don't think we did, I would think that some of that was there but I don't think it was to the extent that you would have to say to put it all down to personality, no*".*

Consultant Psychiatrist 1 was asked whether there was something that happened over and above that. He replied:

> *"*Something had happened above that, yes. As you know, there was no history that we got of violence, then there were little bits, but he was much more likely to self-harm… and that was much more the theme. We are much more used to dealing with people who make a threat against other people and so on within the personality disorder system. I don't think that his personality functioning, as we saw it, explains him engaging in an act like that. To me, it remains inexplicable on that basis*".*

During our interview Mr Q's care coordinator, Specialist Practitioner in Psychotherapy 1, was asked for her view on Mr Q's diagnosis. It appears that Mr Q was diagnosed with personality disorder, despite being considered a complex case. She told us:

> *"*I think probably that it still seems right to me that that is the diagnosis, primarily. He also had a lot of anxiety, so I suppose that that could potentially have been an additional diagnosis on its own. That seemed to be what would drive him to go and present to other services out-of-hours. He would become flooded by anxiety. I think the things that he would sometimes say would make you wonder if he was psychotic. There was a lot of that in the notes, I think, before he came to us, and also during. I think that either they are manifestations of his anxiety, and sometimes dramatisations of his anxiety, so that he would receive help from people, perhaps*".*

7.4.1 Finding

A combination of paranoid and psychotic features operated at the time Mr Q committed the homicide. Whether or not these features, and in this combination, existed before quite in the same way, there were certainly harbingers of that mental combination. These indicators, referred to as paranoid and psychotic, have been mentioned above in numerous entries in the case notes.

Potentially significant clinical findings were overlooked or their significance missed because the professionals involved focused on a diagnosis of personality disorder. There is nothing in the clinical records to indicate that other diagnoses were being considered but based on the clinical records, insufficient information was obtained to support a definitive diagnosis of personality disorder on sound or solid grounds.

7.4.2 Recommendation

In circumstances where the clinical lead has indicated that there is uncertainty about an individual patient's diagnosis and/or treatment plan, the care coordinator/allocated worker should meet regularly with the clinical lead to discuss the case. These discussions should focus on and agree the plan for risk management, treatment plan and diagnosis.

8. Model of care in Haringey personality disorder service

According to the 2011 operational policy document, Haringey personality disorder service is "committed to providing an evidence-based, accessible psychological treatment service for personality disorder, which is founded on the principles of collaboration with service users in coming to a mutual understanding of their individual difficulties and in agreeing treatment goals that aim to help them function according to their greatest possible potential".

The aims of the service are, among other things, "to enhance service user's capacity to understand and manage intense emotional states, reduce impulsivity and self-harm and suicide attempts, improve interpersonal and social functioning and quality of relationships".

Team roles and responsibilities include "holding a caseload of patients for which they carry CPA care coordinator responsibility". Responsibility for the management of clinical risk is held with the team as a whole, but individual clinicians are responsible for communicating to the team any concerns they have related to risk, "so that a strategy for the management of that risk can be developed by the team and implemented".

Medical staff responsibilities within the personality disorder service include:

> "Conducting psychiatric reviews and mental state examinations of service users as required" and "Providing expert medical diagnostic assessment and advice as required, across the service".

The operational policy for the Haringey personality disorder service states that the treatment programmes offered are compliant with NICE Guidelines. It continues:

> *"*In this regard, they adhere to an explicit and integrated theoretical approach used by the whole treatment team and shared with the service user*".*

It is our view that this suggests a lack of flexibility and openness to the changing needs of the patient. It feels like more of a "one size fits all" approach.

During our interviews with trust staff, Specialist Practitioner in Psychotherapy 1 was asked how much time was devoted into looking into Mr Q's background and his formative years with the treatment model they were using. She replied:

> *"*We do not emphasise that, particularly. We are not hugely proactive about asking for that in terms of believing that that will be where the cure is going to lie. However, he did himself speak quite a lot about his background to me*".*

There appeared to be a greater emphasis on the here-and-now during treatment sessions rather than using them as an opportunity to take a full personal history from the patient in order to undertake a more thorough formulation of his difficulties.

The trust's clinical disengagement/DNA (Did Not Attend) policy: risk management, August 2009, states:

> "When the care coordinator suspects that a service user is out of contact they must:
>
> - make attempts to contact them by telephone and home visits…
> - document any concerns, the reasons for them, and any attempts at contact."

If the service user can still not be contacted then:

> "b) In the case of a person on CPA AND/OR known risk:
>
> - implement the Disengagement follow-up procedure…
> - this decision should be made following discussion in the MDT".

The disengagement follow-up procedure includes the care coordinator taking responsibility for:

- reviewing the risk assessment, advance statement, relapse prevention plan and care plan based on current information; and
- holding an urgent CPA review meeting with all those involved in the person's care.

We asked Specialist Practitioner in Psychotherapy 1 what the process is in the personality disorder service to manage patients who fail to attend appointments. She told us:

> "I think we are quite proactive about making contact with them. We would be ringing them usually if they missed a session, and then if you can't gain contact with them after you have rung, and if they missed another one, you would be writing to them. Ultimately, if somebody is within our service, and they disappeared, we would probably do a home visit. There would be a discussion within the team about whether that was warranted, but for those that were in the more intensive part of our service, you would be thinking about doing that*".*

We asked whether there was a DNA policy in place for the personality disorder service. Specialist Practitioner in Psychotherapy 1 responded:

> *"*There might be. I am sure that it will be in our operational policy what we do. We certainly do not have something where it is rigid in that way. I think that it is relatively flexible*".*

Given that Mr Q was on CPA, in line with the trust policy, staff should have implemented the disengagement follow-up procedure (review risk and hold an urgent CPA review meeting with those involved with his care). A decision about next steps should then be discussed at an MDT. This did not happen in Mr Q's case.

9. Suitability of treatment and care

The Haringey personality disorder service had clear plans to assist Mr Q in developing his relationship and coping skills. It is important to note that there was a great deal of input in this case. In fact, the quantity and intensity of the input are, in relative terms, remarkable. Furthermore, there was "continuity" of care in the sense that one professional (the psychotherapy nurse, Specialist Practitioner in Psychotherapy 1) was involved for more than three years, overseeing the care provided. If the care delivered were to be judged purely on these factors – the continuity of care and its quantity and intensity (that is, the length of time the patient was seen, the frequency of reviews and the length of each review session) – then the care delivered would be considered excellent. However, there are many other factors that need to be considered in order to deliver a high level of care.

We asked Specialist Practitioner in Psychotherapy 1 about how treatment plans are formulated and whether, as the care coordinator, she would have been the main person involved in planning Mr Q's care. She replied:

> *"*It would have been me, particularly when I was seeing him individually, but it would be that there would have been an on-going team discussion in changes or decisions*".*

We asked Specialist Practitioner in Psychotherapy 1 how she arrived at the decision that the mentalisation model might best fit Mr Q and the thinking behind that. She told us:

> *"*I think it was clear from the referral that there was a view that he had a personality disorder. When I first saw him – I don't know whether you have read it yet – it was difficult for me to assess him because he presented in quite a dramatic, theatrical way*".*

She added:

> *"*Therefore, discovering what the problem was took a little time and I asked [Consultant Psychiatrist 1] to see him as well to help with that process. I think that we did end up deciding that he did have enough traits of borderline personality disorder, and with his other dependent traits, that would warrant him coming into the intensive part of our service*".*

Specialist Practitioner in Psychotherapy 1 continued:

> *"*I believed that mentalising would help him to try to have a little more understanding about his own feelings, and the impact he was having on other people. I think there was already at that stage some kind of conflictual relationships with professionals in other teams where he would misunderstand their intentions, he would become paranoid about what they were meaning, and how they're treating him. Our hope, I suppose, was that once he had settled, we could work on some of that with him. This did happen in amongst the treatment with him. He was more able to do that through time*".*

A psychological therapies formulation dated 26 July 2011 (1–51) states that Mr Q:

> *"…*is involved with the treatment programme and feels it to be helpful to him. He attends regularly and shows interest in how he feels and how he relates to others both in the day unit or in his relationships outside. He appears motivated to find a way to have a different life and way of managing things*".*

The report continues by saying that Mr Q:

> *"…*seems to struggle with having negative or angry feelings towards others. At times in his treatment he has felt angry with staff and other patients, but he tends to ascribe these experiences to him being 'ill', as if it is hard for him to integrate his angry feelings into his view of himself.*"*

The report also states that Mr Q:

> *"…*can also sometimes become suspicious of the motives of other people – believing they are acting out of malice towards him.*"*

The summary/formulation fails to mention the frequent calls Mr Q made to services the previous month (he called START team every minute for half an hour on the night of 10 June/early hours of 11 June 2011. He was being abusive and threatened to get staff sacked). He was subsequently accepted by HTT, who visited him daily.

This would suggest that Mr Q could make only limited use of the treatment programme offered as he continued to contact services in crisis rather than access more adaptive coping strategies.

We asked Specialist Practitioner in Psychotherapy 1 if she thought he made use of the treatment. Her view was:

> *"*I suppose that whether he would definitely be able to make use of mentalising at that early stage, I am not sure that we were clear. We knew – because he had had a lot of contact with services outside, and it did seem clear to us – that he needed to come into something that was quite intensive, that would be able to offer him fairly regular contact to try to work on some of that.*"*

We asked Specialist Practitioner in Psychotherapy 1 what would happen to patients who couldn't make use of psychotherapy, and perhaps weren't psychologically minded. She told us:

> *"*They would have been able to be referred to the Complex Care Team if there was a need for community mental health team input. There would have been somewhere outside of our service for those patients to be treated, whereas now, our service will be providing that. We will be receiving extra resource from staff to do that*".*

Due to the complex nature of Mr Q's difficulties he may have benefited more from being under the CCT in order to facilitate a more comprehensive understanding of his psychological, social and health care needs. Mr Q often spoke of difficulties managing his finances and not eating for days. These issues would have been more appropriately addressed within a CMHT framework than within an intensive psychotherapy setting. He frequently presented in crisis and clearly had difficulty coping with day-to-day life. If some of these fundamental stressors had been further assessed and supported then he would have been more likely to benefit from talking therapy.

As part of our independent review, we asked Specialist Practitioner in Psychotherapy 1 to describe her role as care coordinator, outside of their weekly therapy sessions. She replied:

> **"**I suppose at that time I could have probably stopped being his care coordinator. I think he just carried on being on CPA, not necessarily because there were other – I suppose there were other, as initially probation services were involved with him when he first left us. There wasn't a lot of liaison that I was having to do about him, because only as and when somebody phoned me. So when the drug and alcohol service phoned me, I would be doing that outside of the individual sessions*".*

Again, Mr Q may have benefited more from being under the CCT within a CMHT setting as there would have been more emphasis on liaison with other agencies than within a therapy setting.

10. Team roles and responsibilities

The 2011 operational policy for Haringey personality disorder service outlines team roles and responsibilities. Across the service there was a consultant psychiatrist in psychotherapy/clinical lead and a service manager/consultant lead nurse in psychotherapy (Band 8B). Within the psychotherapy day unit there was a lead specialist practitioner in psychotherapy (Band 8A), a senior nurse in psychotherapy (Band 7 – vacant) and an ST4 psychiatrist on rotation. Within the outpatients programmes there were three senior nurses in psychotherapy (Band 7) and one staff grade psychiatrist (vacant).

In addition to core professional discipline, responsibilities included holding a case load of patients for which they carry CPA care coordinator responsibility and holding in mind patients on their caseload and ensuring that they are brought to clinical discussions within the team. Responsibility for the management of clinical risk was held with the team as a whole, but individual clinicians were responsible for communicating to the team any concerns they may have had related to risk.

The service manager‘s responsibilities included ensuring that the staff of the personality disorder service were equipped with the appropriate resources to deliver the clinical service, including training, clinical and management supervision and support. In addition to the responsibilities applying to all clinical team members, the medical staff’s responsibilities within the personality disorder service included conducting psychiatric reviews and mental state examinations of service users as required and providing expert medical diagnostic assessment and advice as required across the service.

11. Staff supervision

The trust's operational policy for the Haringey personality disorder service (undated) states:

> *"*All clinical members of staff will receive at least once weekly clinical supervision of their caseload, and associated individual work, with a senior clinician/specialist in MBT… all clinical members of staff will have a supervision folder, in which a record of each supervision session is made and signed off by both supervisor and supervisee*".*

During interview Specialist Practitioner in Psychotherapy 1 told us:

> *"*We would have a formal weekly clinical meeting where we would talk about patients that we needed to. Outside of my immediate team, I had supervision as well from a clinician who didn't work in the personality disorder service, but he worked in the wider Complex Care Team. I had weekly supervision with him, and I would probably talk about each patient about once a month in rotation*".*

She went on to say:

> *"*It would have been individual supervision weekly. I would have probably talked about him [Mr Q] approximately monthly. I would have been having supervision within my team, which would have been weekly as well. This was not necessarily about that patient, but just to think in general. We would take it in turns to talk about the patient*".*

One of the responsibilities of the service manager was "providing expert clinical and management supervision to the team" (2011 operational policy for Haringey personality disorder service).

12. Use of medication

The trust's review panel raised the issue that it was not clear in the records who had prescribed medication for Mr Q during the period June to August 2011. The panel subsequently established that the GP was prescribing, but this had not been clearly documented on RiO by the Haringey personality disorder service.

As part of our independent investigation, Consultant Psychiatrist 1 was asked if the GP prescribed medication. He told us:

> *"*No, not really. It was in our hands. That is one of our standard practices, which is why we originally had him on antipsychotic medication and then eventually it was changed to antidepressants, and then mostly on an SSRI [selective serotonin re-uptake inhibitor], and I think he had two SSRIs*".*

Consultant Psychiatrist 1 went on to explain that once Mr Q had finished the more intensive day unit group programme the prescribing was subsequently moved to his GP for the remaining two years of his treatment.

Our interview with Specialist Practitioner in Psychotherapy 1 reiterated this. She told us:

> *"*When they were in our service, it was clearer when they were actually in the treatment programme that we take over the prescribing of medication. When they are being seen in follow-up that does sometimes get transferred back to the GP. I think that in his case, when he came out of treatment because of what happened in that group he wasn't on any medication, and I don't think that he was on any for quite some time, so it wasn't something that had been part of what we were providing for him for quite a long time*".*

She added:

> *"*He then received some medication from his GP independently. He went to his GP and asked for medication. The GP thought that it was indicated. It didn't seem to me that it was contra-indicated, because he was coming to me saying that it was helping him. That continued. I think that is an area that we have looked, about needing to be a lot clearer about who is prescribing, when we are reviewing that. I think that came out of the trust's own investigation*".*

Consultant Psychiatrist 1 confirmed for us that he was overseeing the medication and we asked why, if that was the case, Mr Q wasn't given a greater trial of antipsychotic medication. Consultant Psychiatrist 1 told us:

> *"*We didn't think he was psychotic. Our assessment was that, as you've described it, he was all over the place when he first came and we didn't quite know what was going on. We thought he had personality features, we thought he had these fleeting psychotic symptoms, so we tried him on quetiapine for a time, 100mg, but it was primarily because he was terribly aroused… He then requested to stop that because of its side effects, and we agreed to see how things went. We then started on an antidepressant and that's what it shows in

the notes, so that's what we did. That looked to us he was more responsive to that, so his affective states appeared to be a little more stable*".*

13. Khat/cannabis use

Mr Q has a history of substance abuse, namely khat (which contains a monoamine alkaloid named cathinone, an amphetamine-like stimulant, which is said to cause excitement, loss of appetite and euphoria) and cannabis. He had received input from drug and alcohol services on two separate occasions (August 2008 to November 2010 and March to June 2012) but had been variably compliant with this.

When Mr Q was first referred to Haringey Personality Disorder Service in August 2008 he was chewing 6–7 bundles of khat a day, 3 days a week. He reported that he used khat to give him social confidence, reduce his paranoia and psychiatric crises. The START team psychiatrist who assessed Mr Q thought that his khat use somewhat obscured whether or not he was having episodes of hypomania/mania. According to the discharge summary sent by Specialist Practitioner in Psychotherapy 1 to Mr Q's GP on 22 August 2012, *"*It was thought possible at that time that his khat use increased his levels of agitation and led to sudden mood changes or the appearance of ways of being that on first meeting might appear to be psychotic phenomena*".*

During our interview with Consultant Psychiatrist 1 the subject of Mr Q's khat use was discussed. He told us:

> *"*We also put in a policy we wanted to reduce his khat so we could see whether this was an interfering issue, which in my view it definitely was. He was using very heavily. When I reviewed the notes after this [the killing] happened, I had remembered how heavy it was, because it was heavy, and we think that was interfering with those arousal moments and so on.*"*

He also told us:

> *"*I've looked at the literature on that [khat] and it causes agitation, it causes sensitivity, it causes high arousal levels and so on, and I think that confused the whole of the picture.*"*

Mr Q used khat regularly until November 2010, when he significantly reduced his use following help from DASH. He began smoking cannabis in November 2010 and claimed it helped his paranoia and anxiety symptoms and helped him feel calmer. He complained of being addicted to cannabis in March 2012 and said he was spending all his money on it.

On 8 March 2012 Mr Q attended DASH requesting a drug test. He was noted by the duty nurse as reporting to be well and in a good mood but "was clearly unwell". The duty nurse noted that "he was engaged in an earnest conversation with himself". He said he had "gone into my head for a minute". Mr Q tested positive for cannabis but negative for other drugs.

Mr Q was re-referred to DASH and attended a couple of cannabis cessation sessions there but was discharged in June 2012 for not attending.

During our investigation we asked Mr Q's care coordinator, Specialist Practitioner in Psychotherapy 1, how much she felt that cannabis impacted on his presentation. She stated:

> *"*It didn't seem to alter him particularly, to be honest. His own reports were that it helped him. I wasn't seeing any signs that the cannabis was actually increasing any of his symptoms. We warned him about it. I was actively telling him that it wouldn't be good for him, because he was already a bit paranoid and sensitive. He never felt that it made him more paranoid or sensitive. I didn't really see any evidence that it did*".*

Regarding Mr Q's khat use, it states in the risk assessment summary (1–14) that:

> *"*Use of khat had a detrimental impact on his mental health primarily through lack of sleep as well as by stimulating [Mr Q] and increasing his paranoia*".*

Mr Q used khat regularly until November 2010, when he significantly reduced his khat use following support from DASH. He began smoking cannabis in November 2010. He therefore appears to have swapped one drug for another rather than addressed the underlying problem.

There appear to be conflicting opinions among his care team regarding the impact substance misuse had on Mr Q's mental state, behaviour and presentation. It would have been helpful if there was more joint working with the dual diagnosis worker in order to better understand this issue.

Drug use was identified as a factor affecting risk in the risk assessment, which states:

> *"*Client's mood will further deteriorate if he refuses to engage with professionals and continues to smoke cannabis.*"*

14. Risk assessment and risk management

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. The trust's policy says that all service users should have a risk assessment completed as part of their assessment. Risks or safety issues identified should be incorporated into the service user's care plan and reviewed as appropriate for up to 12 months.

Trust policy concerning assessment of risk for all service users subject to CPA states that:

> *"*Risk assessments must include both risk event chronologies and evaluations of potential future risk' and 'Risk assessments and plans must be refreshed as and when appropriate to reflect the changing risks and management of such. As a minimum standard, the Risk assessments must be reviewed on a six-monthly basis*".* (Care Programme Approach Policy 2011).

According to trust policy, it is important that clinical teams consider managing the risk factors identified during assessment. For service users who have had a full assessment of risk completed, their care plan must contain details of the risk behaviours and how they will be managed.

14.1 History of harm to self

Mr Q has a history of deliberate self-harm, the first reported episode being in 2004, when he took an overdose and cut his wrists. A risk assessment summary completed in July 2012 reported three incidents in Mr Q's risk history of risk of harm to self:

- 7 June 2011 – Mr Q reported fleeting suicidal ideas but denied intent/plan.
- 8 February 2012 – Mr Q was brought to the START team by police because he was threatening suicide. Risk was considered low/minimal and he agreed to engage with care coordinator and DASH the following day. There was a lack of detail about him threatening to walk in front of cars to kill himself and telling police that he was hearing voices from God about hurting himself.
- 2 March 2012 – Mr Q presented at the walk-in clinic and reported feeling suicidal in the context that he had no money for food. Added that he would be better off dead and could do this by taking an overdose of his tablets. According to the assessing registered mental nurse (RMN) there appeared to be no clear intent or conviction to carry out this plan.

Other risk-related incidents are recorded in the progress notes but are not reflected within the risk assessment documentation. A progress note dated 18 March 2009 recorded that Mr Q had taken an overdose of 10 paracetamol and 10 zopiclone tablets and an ambulance was called and sent to his home. On 11 March 2012 he was taken to ERC by police on Section 136 after telling police he wanted to kill himself. Neither of these incidents were included in the risk assessment documentation.

14.2 History of violence

There are no reports of violence in Mr Q's clinical records prior to an incident at the Halliwick Day Unit, St Ann's Hospital, on 14 October 2010, when he attacked two fellow patients and was charged with common assault. He was subsequently asked if mental health services had missed any previous violence and he apparently said it had never happened before. There is no information on whether this claim was ever corroborated by any other source.

It is recorded in Mr Q's records in June 2008 that he told his START care coordinator about an incident when he was living in Brent involving a dispute with a neighbour, which resulted in an injunction and him having to pay a fine.

In July 2008 Mr Q was hearing voices telling him to kill people, and said he was thinking of killing a friend.

In September 2008 Mr Q told the police he wanted to kill himself and someone else.

In February 2009 Mr Q told mental health services that he got into an "altercation", although we do not know what this entailed or whether it was violent.

There was additional police involvement in May 2007, March 2009, August 2009, May 2010, August 2010, January 2011, December 2011, February 2012 and March 2012 – which appears to have become more frequent over time.

Risk assessments are usually considered part of a dynamic process and should be regularly reviewed and monitored, particularly when there are changes to a patient's condition or circumstances.

The purpose of a risk assessment is not to predict an incident of violence – it is to plan for what should be done when a patient with a history of violence (and other risk factors) becomes unwell, in order to prevent a similar possible violent incident. The risk assessments in Mr Q's case have not done this.

The trust's internal panel inquiry report says the care coordinator did an "on-going assessment of risk" which apparently entailed her "looking out" for any further risk indicators. The risk does not appear to have been registered or documented in the way that it should have been according to best practice guidance.

A dual diagnosis network brief risk assessment dated 29 October 2008 gives a more comprehensive overview of Mr Q's risk history and outlines a clear risk-management plan. This includes referral to HTT, urgent follow-up by the care coordinator and arranging a professionals' meeting. This plan is one that would have been useful to other professionals coming into contact with Mr Q in crisis, whereas other risk assessment documentation stated that problems were being worked on in therapy sessions and was a less useful source of reference to other providers.

Mr Q's care coordinator (Specialist Practitioner in Psychotherapy 1) carried out an assessment of risk after he attended a session with a screwdriver on 26 July 2012 – three weeks before the fatal assault on his elderly neighbour. Mr Q initially told

Specialist Practitioner in Psychotherapy 1 that he had the screwdriver as a weapon. Specialist Practitioner in Psychotherapy 1's assessment was that she did not view this as an indicator of serious risk to Mr Q or others. However, in accordance with the Trust Risk Assessment Policy the RiO Risk Assessment Form should have been updated to include this incident.

14.3 Finding

During Mr Q's contact with mental health services there had been significant changes in his mental state, including paranoid behaviour and what were very likely psychotic features, threatened and actual violence to himself and others, and at least one period of an in-patient stay in hospital, which do not appear to have resulted in new or updated assessments of the risks he posed. However, there is nothing from his past behaviour to suggest an escalation to the level of violence used in the offence was likely.

It is unclear from the clinical records whether a risk management plan was ever set out for Mr Q and risk event chronologies are patchy and incomplete. The risk overview documentation is of limited use to other providers and does not provide an up-to-date risk history on this client.

14.4 Recommendation

The trust should assure itself that the current process for CPA (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

15. Discharge – planning and appropriateness

The trust's operational policy for the Haringey personality disorder service (undated) states:

> *"*Decisions on the discharge of patients from the PD service will be made on an individual basis, according to the needs of each patient, and informed by an assessment of the risk, both chronic and acute, posed at the time of discharge… Transfer of care out of the personality disorder service will follow the protocols of the trust-wide care programme approach policy.
>
> "In the case of discharging those patients who no longer require a care coordinator back to the GP, a letter will be written outlining the outcomes of treatment within the PD service, assessment of risk, and recommendations for the further clinical management of the case*".*

In Mr Q's case, he was discharged from the PD service on 26 July 2012. However, a discharge letter was not sent to Mr Q's GP until 21 August 2012, six days after the incident occurred. Therefore at the time of the incident on 15 August 2012 the GP was not aware that Mr Q was no longer under the care of the PD service.

We asked Specialist Practitioner in Psychotherapy 1 what the arrangements were (in 2012) in the personality disorder service for discharging patients. She told us:

> *"*The date [of discharge] is set in terms of the timeframe that they are in the treatment. With him [Mr Q], because if he had stayed in the day hospital, that would have been a two-year treatment, but he left after about a year, I think, and I carried on seeing him individually… I continued almost to an extent giving him the individual component of that treatment by seeing him weekly, and carrying on seeing him to monitor his risk, but also trying to carry on doing some treatment with him… In that year that I was working with him individually, I wasn't really working towards him leaving at the end of that year. We would have decided to give him another year, which is the equivalent of what we might offer to patients who have done the two years, which would be another year of follow-up. That was determined, I suppose, that we would work together for another year*".*

We asked Specialist Practitioner in Psychotherapy 1 about Mr Q's readiness to be discharged in July 2012. She responded:

> *"*We did think about whether he was ready. We had to think about if not, what else would we be thinking about putting into place for him. He had begun to show signs that he was accepting that he was not going to be coming to us any more, and that the onus was going to be a bit more on him to go to things that he could attempt more proactively. He was under the Clarendon Centre and he was using some self-help methods to manage his anxiety. We did think that he was as ready as he would be*".*

We asked Specialist Practitioner in Psychotherapy 1 what other options might have been available – other than discharging Mr Q to his GP. We asked whether it would have been possible for him to remain on the consultant's caseload for example. She replied:

> *"*That would have been another option. That happens for some people that they do stay on the clinic caseload, so they would be seen periodically… I think that we probably did talk about it. I think that we felt that it wasn't necessary, partly because he was somebody that would access services if he needed it. You might keep somebody in the clinic because you feel that they are not necessarily going to be very proactive about alerting anybody to the fact that they are needing something. However, because he was someone who would let you know if he needed an appointment, or he needed something, and we believed that he would come back if he wasn't managing*".*

Despite this, when Mr Q did make contact, two weeks after being discharged, he was told by Specialist Practitioner in Psychotherapy 1 that their work together had now finished. There is no evidence in the clinical records that Specialist Practitioner in Psychotherapy 1 tried to establish whether Mr Q needed additional support.

It appears that the onus was placed on Mr Q to get back in touch with mental health services if necessary. Staff working with Mr Q considered that he was someone who could access support when needed. During interview, Specialist Practitioner in Psychotherapy 1 told us:

> "Because he was someone who would let you know if he needed an appointment, or he needed something, and we believed that he would come back if he wasn't managing".

As someone who tended to locate the cause of his problems externally, it is questionable whether he had enough insight into his own condition to recognise when he needed psychiatric help.

Given that Mr Q had built up quite a dependency on Specialist Practitioner in Psychotherapy 1 over the years, saying she was the only one who understood him, Specialist Practitioner in Psychotherapy 1 was asked if she'd considered referring him on elsewhere instead of discharging him back to his GP. Her reply was:

> *"*I suppose that if we would have referred him on, it would have been to the Complex Care Team, rather than the psychosis team, because we weren't thinking of him as having a psychotic illness then. We would have to have been really thinking about why and what for. There weren't any clear indicators that he needed a care coordinator, apart from the fact that he was dependent. That would have been a whole area of focus of our work. We were quite explicit with him about his need for being with somebody. I think that we thought it would probably be counter-productive to involve him with somebody else*".*

It is likely that Mr Q felt "contained" by being care-coordinated at the personality disorder service under CPA. He had reported difficulties when staff have been on leave and not accessible to him. Rather than a complete discharge from the service he may have benefited from remaining on the consultant's caseload or at least from a gradual reduction in frequency of therapy sessions. This would have allowed him (and services) the opportunity to see if he could manage more independently while still being offered some containment.

Mr Q attended his last session with his care coordinator on 26 July 2012 (two and a half weeks before the killing) with a screwdriver and talked about having it as a weapon "because he was scared of a neighbour". Specialist Practitioner in Psychotherapy 1 was not concerned by this event and it did not result in her updating the RiO Risk Assessment Form.

Although Mr Q said the police were "aware" of a situation he had with a neighbour, the care coordinator did not note the conversation in the patient record or consider whether this information should be corroborated with the police.

As part of our independent review we asked the care coordinator (Specialist Practitioner in Psychotherapy 1) about Mr Q bringing the screwdriver to their appointment, and him subsequently phoning her to say that he had been healed by God. We asked whether the situation was reviewed in terms of his discharge in light of those presentations. She told us:

> *"*No. If I take them separately, I suppose that the bringing of the screwdriver to that session didn't make me feel that this was an increased risk, because of the way he spoke of it, and what the whole feel of it was*".*

She was asked to elaborate on this and stated:

> *"*He was somebody that had on-going small clashes with local young men in his neighbourhood, and there was somebody that he was being pestered by. I think it was somebody who used to sell cannabis to him. I think that some of these people also had mental health problems. He came to the session and he just said that he had a screwdriver in his pocket if the guy bothered him again that day. I expressed some concern about that, and told him that that didn't sound like a very good idea, and he responded that he knew it wasn't. He was very quick to say that he knew and that he wouldn't use it… The session then moved on and we continued to talk about his ending. He didn't seem to be in a different mental state, and I suppose that he had a kind of histrionic quality to him. It didn't feel that he had any intent to be using that screwdriver*".*

In relation to the occasion when Mr Q phoned Specialist Practitioner in Psychotherapy 1 two weeks after being discharged from the service (10 August 2012 – five days before the offence) and said that he had been "visited by God and God had totally healed me", Specialist Practitioner in Psychotherapy 1 told us:

> *"*I mentioned it to people in my immediate office, but I suppose I felt that the phone call didn't make me feel that this was a sign of him being unwell, as he

was somebody that would make phone calls like that when I was working with him. He was somebody that would have dramatic dreams and experiences and would want to tell you all about it in quite a demanding way… We thought a little about what the purpose of that phone call might have been, but I don't think I particularly spoke to my manager or [Consultant Psychiatrist 1] about it, because I didn't see it as an indicator that we needed to rethink about it. In some ways, I expected that I would probably receive another phone call the next day, and that this was going to be something I would be having to manage on an on-going basis, about how he was going to manage the ending… I thought that this was him trying to get back in, and wanting to see if he could make contact with me. I thought this was probably going to [be] on-going. There might have been, then, some rethinking about the fact that he had not managed to leave*".*

15.1 Finding

Evidence shows that following his discharge from services Mr Q's first point of contact was the police rather than mental health professionals. Unfortunately, the police did not know that Mr Q had been discharged from mental health services. We accept that it would not be normal practice for mental health services to alert police when a service user is discharged from its care, however in Mr Q's case - as the police were identified as a point of contact for Mr Q if he was in crisis it would have been helpful for them to be briefed. Equally, mental health services were not aware of the extent (and escalating) contact between Mr Q and the police. Had mental health services been alerted to the extent of his police involvement then it is possible that Mr Q could have received an appropriate level of support.

15.2 Recommendation

In instances where a service user has had a long and intensive intervention, a multidisciplinary discussion should take place to discuss the most appropriate way to discharge that individual. The discharge process should be tailored to meet the needs of the service user. This may include a staged discharge to test the service user's readiness to be discharged. Consideration should also be given to whether discharge arrangements should be shared with other agencies, such as the police or the probation service.

16. Crisis planning

Professor Anthony Roth (joint course director, doctorate in clinical psychology, research department of clinical, educational and health psychology, UCL) and Professor Stephen Pilling (director of CORE, director of the national collaborating centre for mental health, research department of clinical, educational and health psychology, UCL) developed a competence framework for psychological interventions with people with a personality disorder[1].

The framework is not intended to prescribe what a clinician should do: it makes suggestions about best practice in the light of current knowledge of the effectiveness of approaches and interventions. It states:

> *"*Clients with personality disorder can be at risk of placing themselves and others at significant risk of harm, and clinicians and services need to be organised in a way that ensures that risk is both monitored and responded to, and that there are plans in place for managing and containing crises when these occur*".*

While under secondary mental health services, Mr Q was frequently seen and assessed in crisis, and staff took responsibility for helping him. He would sometimes be offered HTT involvement for brief periods and was usually discharged back to his care coordinator for follow-up. This approach appeared to be a reactive approach rather than any concerted attempt made to understand what was behind the frequent crisis presentations.

Rather than have a clear and detailed plan for what to do in a crisis, the discharge summary encourages Mr Q to "in the first instance attempt to reduce his anxieties with self-help methods and remembering what he has learnt and developed in therapy*"*. This is inadequate for someone who has made frequent crisis presentations and has a history of harm to self and others.

The trust's internal inquiry team acknowledges that the crisis plan wasn't "clear". It recommends that *"*detailed crisis plans should be developed prior to discharge for service users who have been supported by services over a long period, to ensure that there is a clear plan of action for the assessing team to follow if patients re-present to the service in crisis*".*

The discharge summary stated that Mr Q could contact PCMHT at ERC at St Ann's Hospital if necessary and also the local police if he experienced difficulties with other people in his neighbourhood.

The Metropolitan Police and London Ambulance Service had contact with Mr Q in the days prior to the incident. However, it appears that neither of these agencies contacted mental health services as a result of their contacts with Mr Q in this period.

[1] http://www.ucl.ac.uk/clinical-psychology/CORE/Docs/Working%20with%20Psychosis%20and%20Bipolar%20Disorder%20background%20document%20web%20version.pdf

These episodes were detailed in a report following an internal review into this case conducted by the Metropolitan Police. According to this report, the day before the fatal stabbing incident Mr Q telephoned emergency services to say he had been "killing demons". The operator concluded that the caller was delusional and passed the message to the ambulance service. A request was also made for the police to attend and an information check revealed that the male was very well known to mental health services. However, no details were included.

Four police officers and ambulance crew attended the residence and Mr Q spoke about demons and was behaving in a "strange" manner. He was reading from a bible and making religious references. However, because he was not breaking any laws or in need of immediate 'care or control' no further action was taken.

As the police were included as a point of contact for Mr Q if he was in crisis, it would have been helpful if local police had been briefed by mental health services regarding this client prior to his discharge. Equally, the police and ambulance service should have alerted mental health services that a "*well known*" client required further assessment.

As part of our independent review we asked Specialist Practitioner in Psychotherapy 1 what would happen if a patient under their service presented in crisis. She told us:

> *"*[If they went to ERC for example] they would be told that they were under the care of this service, and would need to go back there. This has created problems for the team because we are not equipped for this. We might all be in sessions with patients. We are not equipped with somebody just turning up and it being an emergency. However, there is now a system to make sure that we are equipped, and there is an available clinician now in the Complex Care Team that would deal with any people that arrive out of the blue. In his case, I don't think that happened. I don't think he was ever told by another service that he couldn't be seen and that he had to go back to his own care coordinator*".*

When Mr Q did contact Specialist Practitioner in Psychotherapy 1 two weeks after discharge, her response was to remind him that their work together had finished. It would appear that Mr Q followed advice about contacting mental health services and police if necessary following his discharge but the response from these services was inadequate and did not identify or contain any crisis that he may have been experiencing.

17. Liaison with other services (police/probation)

As our independent investigation progressed we established that Mr Q had considerable contact with other agencies – namely the police and probation service. We therefore agreed with NHS England, London Region that the terms of reference for this independent review would be widened for us to consider:

> *"*The interface, communication and joint working between the agencies involved with Mr Q. In particular, the extent to which the police, probation service and the trust worked together and communicated effectively.*"*

The purpose of widening the scope was to establish whether agencies individually held information that could have been beneficial for others to know about – both in terms of gaining a fuller picture of Mr Q's care and treatment but also in assessing the risk that he posed.

The information-sharing policy that was in place in the trust at the time of the incident was implemented in April 2011. The purpose and aim of the policy are to:

> *"*Provide a framework for the secure and confidential sharing of information between organisations.*"*

Within the policy there is a template for an information-sharing agreement. Although it is not documented in the policy – and interviewees were unable to confirm – it is likely that an information agreement was in place between the police and the mental health trust. Whether or not such an agreement existed, it is evident that in Mr Q's case information was not routinely shared between the organisations.

Specialist Practitioner in Psychotherapy 1 told us during interview:

> *"*There wasn't a lot of liaison that I was having to do about him, because only as and when somebody phoned me, so when the drug and alcohol service phoned me*".*

There is some evidence that Mr Q's care coordinator liaised with other services (one call to Mr Q's probation officer, one to his solicitor and discussions with the police). However, there is no evidence to suggest that such communications took place in a systematic, proactive way.

Mr Q was known to a number of agencies including:

- police;
- probation;
- drug and alcohol services;
- housing services; and
- Clarendon Centre.

17.1 Police engagement

The police undertook a critical incident review following the incident on 15 August 2012 to examine how the Metropolitan Police Service (MPS) managed contact with Mr Q between 24 July 2012 and 15 August 2012. The review team made seven recommendations – four specifically for Haringey borough operational command unit (BOCU) and three aimed at service level improvement. The review recommended that the MPS:

> *"*Review its information-sharing protocols with regard to mental health agencies to ensure that opportunities are not being missed*".*

The review recommended that whenever a person comes to the repeated attention of police for matters connected with his or her mental health this is brought to the attention of the local mental health trust. This should occur even when there is no suggestion that any person is at risk of immediate harm.

According to the Metropolitan Police internal review, there are records of more than one hundred contacts between police and Mr Q which are connected to his mental health since 2005. The Specialist Crime Review Group report states:

> *"*There is virtually no record of any information being passed back to the mental health trusts. An increase in information sharing where appropriate could ensure that persons receive the appropriate treatment and support, and also importantly prevent tragedies such as this*".*

Mr Q's care team relied on Mr Q to tell them when he was in contact with the police. Towards the end of his treatment (2012), Mr Q told his care coordinator that he was phoning the police less. However, the police report does not support this. There was no system in place for the care coordinator to check this information with the police. It appears that Mr Q continued to contact the police but did not necessarily inform his care team that he was doing so. This demonstrates the need for better communication between agencies to support individuals who are making frequent contact with the police and who are known mental health service users.

17.2 Probation engagement

There are no reports of violence in Mr Q's clinical records before a violent incident involving two other patients in 2010. On this occasion he was charged with two counts of common assault and given a probation order.

Specialist Practitioner in Psychotherapy 1 was asked how much involvement she had with the probation service regarding Mr Q and whether the probation service shared any information about risk with her at the time. She told us:

> ***"***When he first became under the probation officers' service, we had a phone call, and then we had two or three other phone calls just about how he was getting on. There was an idea that we might need a meeting at some point, but then I think we must have concluded that we didn't need a meeting. I didn't receive a formal report, and I suppose I didn't seek it, assuming that

somehow it wasn't needed, and I don't think there was a policy that we should*".*

When a patient is known to the probation service, proactive, regular contact should be made between the probation officer and the care coordinator. Both services will have gathered useful information regarding a person's risk, lifestyle, ability to function in the community and any changes in presentation. All contact should be documented in the patient's clinical record. Having a systematic approach to routinely sharing such information may have proved beneficial in this case.

London probation service shared with us a chronology of its engagement with Mr Q and its involvement with mental health services. The chronology is based on NDelius (probation case records system) and OASys (offender assessment system). Mr Q's supervising probation officer, no longer works for London probation trust so was unavailable for interview.

On 7 March 2011 Mr Q was sentenced at Highgate Magistrates Court to a nine-month Community Order with a supervision requirement for an assault on two females who were part of a group session at St Ann's Hospital. A pre-sentence report was prepared which proposed a community order. The report's author, Mr Q's supervising probation officer, liaised with a doctor at St Ann's for the purposes of the report. Mr Q was assessed as posing a medium risk of harm to the victims, presumably as a result of the offence as the probation service's risk of harm and reoffending static tools indicated he was low risk of both.

Mr Q's risk of harm was assessed as greatest when he was feeling vulnerable, anxious, paranoid, using cannabis or khat and if he stopped having regular contact with mental health services.

Mr Q attended his first appointment with his probation officer on 21 March 2011. They discussed his sentence plan - the objectives of the probation order were:

- monitor Mr Q's mental health and well-being;
- support and encourage structured use of his time; and
- liaison to take place between the probation officer and Mr Q's psychiatric consultant.

Mr Q attended supervision sessions on the following dates:

- 28 March;
- 8 April;
- 15 April;
- 20 April;
- 6 May;
- 13 May;
- 27 May;
- 10 June;
- 17 June;
- 15 July;

- 29 July;
- 1 September; and
- 30 September.

The probation order finished on 6 November 2011. The probation service stated that this was an appropriate level of attendance. Sessions appear to have mainly been led by Mr Q who often brought issues relating to anxiety and paranoia to sessions. Case records appear to indicate that the probation officer worked through these with Mr Q.

OASys (probation's assessment tool) was completed in a timely way at the start of the order and reviewed once during the order and finally reviewed again in a timely way. The sentence plan objectives were worked towards although, on reflection, the probation service considers that there could have been better liaison with mental health colleagues, which could also have informed some of the work the probation officer was doing with Mr Q around his anxiety and paranoia.

There was nothing in the case records to indicate that there was much of a focus on the index offence or offending behaviour generally. The OASys termination assessment indicated that Mr Q still posed a medium risk of harm to "known adults" but there was neither justification nor analysis of this. It appears to be related to his ongoing anxiety and paranoia and misuse of cannabis.

The probation case records do not indicate that there was any actual contact between the probation officer and mental health colleagues (this differs from the mental health records). There are two entries made. Firstly, the probation officer returned a call to "[Specialist Practitioner in Psychotherapy 1] – mental health support worker" on 27 April 2011 but left a message as she was not available. Specialist Practitioner in Psychotherapy 1 then rang and left a message for a doctor on 22 June 2011 (there was no indication why she rang on this occasion).

17.3 Finding

Communication between the trust, the police and the probation service was limited. More could have been done by the agencies involved to establish whether each of the others held any important information about his risk, behaviour or background. If the three agencies, in particular, had shared the information that they individually held about Mr Q it could have enabled staff working with him to have a better understanding of the risks he posed.

17.4 Recommendation

All partnership agencies should work in collaboration with the trust to continue to develop their relationship and processes for joint working. This development should include the trust reviewing the protocols in place with partnership agencies to ensure effective communication and information sharing for the safety of patients and the general public. For example, information sharing arrangements with the police, probation service and London ambulance service. This should take place within the next three months

18. Predictability and preventability

We consider that the homicide would have been predictable if there had been evidence from Mr Q's words, actions or behaviour that could have alerted professionals that he might become violent, even if this evidence had been unnoticed or misunderstood at the time it occurred.

There were occasions where, with hindsight, more could have been done to ensure Mr Q's risk was fully understood and appropriately managed. For example, instances such as Mr Q attending his last session with his care coordinator with a screwdriver should have resulted in action being taken. However, there is nothing in Mr Q's past to indicate that such extreme violence was predictable or likely to occur. As such we consider that while practice could have been improved, based on the information held by the mental health services alone, the homicide was not predictable.

We consider that the homicide would have been preventable if there were actions that professionals should have taken which they did not take. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

In the interviews that we have carried out and in our review of the clinical records we have not identified any words, actions or behaviour that should have alerted staff that this tragedy would occur.

While there is some evidence that Mr Q, at times, had acted aggressively and had described difficulty with neighbours, there was nothing to suggest that it would result in such an incident. Therefore this tragedy was not preventable by actions that the NHS alone should have taken. However, we do consider that more could have been done to support Mr Q and to try to fully understand the risk he posed. This includes taking action when he called to tell his care coordinator that he had been visited by god two weeks after he had been discharged. We are also of the view that his discharge could have been phased and that he could have been offered some alternative support rather than relying on him to make contact if his mental health deteriorated.

While we do not consider that mental health services alone could have prevented the homicide we believe that the police, probation service and mental health service could have worked together to share information in order to manage any risk better. If the police had been aware that Mr Q had recently been discharged from mental health services their response to his calls may have been different.

19. New developments or improvements in services since Mr Q's engagement with mental health services

19.1 Model of care

During an interview with Interim Service Manager 1 we learnt that the model of care delivered by the trust has changed significantly since Mr Q was known to the service. Interim Service Manager 1 described the model of care in place at the time Mr Q was receiving treatment. He told us that the PCMHTs were a:

> *"…* service which offered short-term intervention, mainly referrals from GPs but anywhere within primary care for anyone who needed a follow-up appointment, say a psychiatric medical review or some short-term work within the PCMHT*".*

Interim Service Manager 1 said that during a review of pathways into the trust, they found that there were many entry points, which was confusing. They wanted to try to reduce the number of pathways and a review of adult mental health access pathways began in April 2013.

In November 2013 a single point of entry was introduced per borough for non-urgent routine referrals and the triage service offers a face-to-face assessment for people with non-urgent, routine needs which the previous Intake service did not offer. Interim Service Manager 1 told us that The PCMHT offered short-term work. He said:

> *"*In the new model the triage service is purely an assessment service, 90 percent first assessments and then onward to a treatment pathway, so whether that's a service line or whether that's back to the GP or wherever it may be, but there is no short-term treatment as such in the triage services any more*".*

Interim Service Manager 1 told us that within the trust there are specialist service lines for complex care and for support and recovery – for overlap work perhaps IAPT (improving access to psychological therapies) for short-term intervention. He said that they acknowledged that the PCMHT services contained many service users and, as a result, caseloads could be quite large and the service boundaries were at times unclear, for instance, regarding when to refer on.

Interim Service Manager 1 explained that when a person is triaged, if it is decided that he or she needs some form of intervention (as opposed to a referral back to the GP) then the case will be transferred to the relevant team (e.g., the CCT) within seven days of triage. A plan is also made which might for example entail a service user being assessed as needing to be contacted within one week. Alternatively, it might be that contact is recommended and needed within one month. Ultimately, the service line has seven working days to decide when the service user needs to be seen next and the service lines then respond as indicated for contact. Within these seven days all of the risk assessments, care plans and core assessments have to be up to date and completed.

Interim Service Manager 1 explained that, in the previous model, if someone was in crisis in the community, the trust would suggest he or she attend (perhaps via the acute assessment centre – AAC). It was decided that this was not the best way to manage someone in crisis and the new model enables staff to go to the person in the community – he or she will be seen within four hours. The trust no longer has walk-in facilities. There is a crisis resolution and home treatment (CRHTT) service which was the old home treatment team (HTT).

We asked Interim Service Manager 1 how the trust manages the fact that patients are used to having the option of just turning up if they are unwell. He told us that they have started to develop rapid assessment interface and discharge (RAID) services, enhanced liaison services. The acute hospital local to the trust is North Middlesex, which has a 24/7 RAID service staffed by BEHT staff but commissioned by the acute hospital. Barnet A&E has also commissioned a RAID service and the trust is hoping that this will soon become a 24/7 service.

Interim Service Manager 1 told us that the trust's recommendation is that unless a patient has a medical issue then the trust would prefer to visit the patient in the community (within four hours). If a patient does go to A&E, the CRHT team will become involved. The CRHT team is the gatekeeper for all of the trust's beds – 156 inpatient beds plus 16 psychiatric intensive care unit (PICU) beds.

The manager of the personality disorder service at the time Mr Q was under its care, told us that the personality disorder service has merged with the complex care service, which was a community mental health service with large psychological therapy input for non-psychotic patients. The personality disorder service was separate until they merged, but the personality disorder treatments remain a treatment stream within the broader complex care service.

19.2 Liaison with the probation service/police

An amendment was made to the personality disorder operational policy to state:

> *"*In cases where patients are on probation, the PD Service will proactively liaise with probation services, and document this contact according to normal record-keeping protocols*".*

This amendment was also discussed during a team meeting on 30 March 2013. The minutes record:

> *"*It was recommended that with all patients on probation the team should proactively liaise with probation services to clarify roles and document that this has taken place according to normal record-keeping standards. It was reported that generally this is taking place with most cases*".*

The service has clearly taken steps to ensure that information is shared between agencies in a much more proactive way.

We have not sought to review evidence to substantiate that this new approach is being used routinely or that it is resulting in improved communication between

services. We recommend that the trust carry out a random audit of communication between the service and probation (when a service user is subject to a probation order) to assess whether the new system is being used routinely and whether communication is more effective as a result.

The police investigation into their engagement with Mr Q made a recommendation regarding communication with other agencies:

> *"*That a system be developed that allows the appropriate agency to be informed when a person with mental health issues persistently comes to notice, but are not of immediate risk*".*

The report also recommends:

> *"*The MPS needs to look at providing guidance at an early stage in recognising mental health issues, how staff should respond and what other services are available to assist in the process*".*

The police identified the need for greater communication between themselves and mental health services. We asked the police for an update on progress made in this area, but they did not respond to our request.

In response to the trust's board level panel inquiry report recommendations, the patient safety team manager wrote to a Metropolitan Police borough commander in May 2013 and stated:

> *"*It was agreed at the meeting that a joint quarterly meeting with yourself (or a senior delegate) would be most beneficial so that operational matters can be looked at and joint learning shared…
>
> "Currently the trust holds a joint monitoring group which is chaired by [OT] Director C&E/DCI/SCNP service lines. At this meeting, serious incidents, which involve the London ambulance service, the police (including mental health act matters) are discussed. This meeting currently has police representation. It was felt however that in order to ensure overarching strategic input and joint learning, a quarterly meeting between yourself and the trust to discuss such cases in more detail would be very helpful*".*

The introduction of joint meetings between mental health services and the police will help to ensure that information is shared between agencies.

19.3 Medication/prescribing

Following the findings of the board level inquiry the following amendments were made to the personality disorder service operational policy:

> *"*Decisions on the discharge of patients from the PD service will be made on an individualised basis, according to the needs of each patient, and informed by an assessment of the risk, both chronic and acute, posed at the time of discharge.

> "Transfer of care out of the personality disorder service will follow the protocols of the trust-wide care programme approach policy.
>
> "In the case of discharging those patients who no longer require a care coordinator back to the GP, a letter will be written outlining the outcomes of treatment within the PD Service, assessment of risk, and recommendations for the further clinical management of the case, within 2 weeks of completing treatment…
>
> "In the case of patients with a long history of attachment to staff members within the personality disorder service, consideration should be given to this in the risk and crisis management plan during the phase of disengagement from the service, and a detailed crisis management plan should be developed with the patient, according to the principles of crisis management adopted within the PD service".

During a team meeting on 21 November 2012 the following actions regarding GP prescribing were agreed:

> *"…* to ensure liaison with GPs re: robust guidelines for the prescription of Benzodiazepines. It was noted that the PD service has a general policy, which is written in the service operational policy of not prescribing benzodiazepines in personality disorder. In cases where patients have been put on them by external prescribers, the policy is to liaise with those external prescribers and explain our guidance on this. All clinicians with prescribing responsibility will be reminded to follow this protocol*".*

19.4 Discharge planning

In response to the issues identified by the board level inquiry panel report regarding patient discharge, a team meeting was held on 21 November 2012 and the following actions regarding discharge planning were agreed:

> *"*The final recommendation was to review procedures to ensure crisis plan and discharge planning reflects risk and mitigating action for patients with a long history of attachment to staff members. This was discussed also in the context of the SUI re: Mr Q. It was felt that this should not affect decisions to discharge. Operational policy to be updated to reflect this*".*

It is not clear, from the documents provided, whether this review took place and what subsequent action was taken.

19.5 Drug advisory service, Haringey (DASH)

The board level inquiry panel highlighted that DASH had followed the correct guidelines during its engagement with Mr Q. Although Mr Q's care coordinator was notified of his non-attendance this was not recorded on RiO. A DASH clinical team meeting that took place on 24 July 2013 noted that it is:

> *"…* important for all Keyworkers to note all communications with both clients and anyone involved with the clients' care on RiO at all times but most especially when discharging a client. Please see your manager for clarification*".*

The board level inquiry panel acknowledged that the action taken by DASH to ensure that best practice is followed when patients are discharged from their service – including ensuring joint working arrangements with other services – is in place. The panel recommended that the new procedures are embedded in the DASH operational policy.

The trust sent us extracts from the updated DASH operational policy, which states that:

> *"*Team members are responsible for liaising with other professionals involved with the client*",*

and that:

> *"*Keyworkers are responsible for recording all contacts with clients and other professionals involved in their care, and for recording unsuccessful attempts to contact the client or other professionals, in order to provide a full and accurate record of their treatment*".*

We have not sought to review evidence regarding any impact that the revised operational policy has had on practice.

20 The internal review

The terms of reference for this investigation include assessing the quality of the internal investigation conducted by the trust focusing specifically on the adequacy of its findings, recommendations and subsequent action plan.

In this section we examine the national guidance and the trust's incident policy to consider if the investigation into the care and treatment of Mr Q met the requirements set out in these policies.

20.1 Detection of incident

On 15 August 2012 at 10.30pm police contacted night staff from the Haringey PCMHT and requested information about Mr Q. He was being held in custody on suspicion of murder.

The senior nurse assessor, who took the call from the police, immediately contacted the Section 12 doctor, the approved mental health practitioner and the assistant director on call and a 24-hour report was sent to senior managers.

The following day, the trust reported the incident as a serious untoward incident to NHS London, NHS North Central London and the local authority. The assistant director met with staff in the personality disorder service to inform them about the incident and to provide any necessary support.

The director of nursing, quality and governance subsequently attended a *"*gold meeting" convened by the Metropolitan Police.

20.2 Desktop review

The executive director of nursing, quality and governance commissioned a desktop review and arranged for a meeting to take place. The review team consisted of:

- Assistant director;
- Severe complex and non-psychotic (SCNP) service line;
- Consultant clinical specialist for Barnet complex care service;
- Practice standards lead;
- Psychosis service line and SCNP; and
- Serious incident investigation officer.

The purpose of the desktop review was to document the events that preceded the incident and determine the type and level of inquiry to be undertaken by the trust. The desktop review also considered professional staff practice to establish whether there were any performance management issues that required immediate attention and also to identify any lessons where action needed to be taken immediately.

The desktop review panel found no care or service delivery problems in the care and treatment provided to Mr Q. They concluded that the teams involved – Haringey personality disorder service, Haringey primary care mental health team, the home treatment team and DASH – offered:

> *"*A quality of care and treatment which included clinical assessments taking account of risks, medication treatment reviews, nursing care and therapeutic interventions.*"*

The desktop review panel did not find any predictable causal link to the incident nor find any care or service delivery problems that required immediate action. It made three recommendations. The first related to shared prescribing responsibilities, the second was about DASH contact documentation and the third was for a board level panel inquiry to be commissioned.

The desktop review findings were approved by the trust board on 5 September 2012 and were reported to the Department of Health, Care Quality Commission and NHS London.

20.3 The trust's board level panel inquiry report

A board level panel inquiry was commissioned. The panel consisted of:

- Luke O'Byrne, independent chair;
- Bronwen Tumani, non-executive director, BEH;
- Mary Sexton, executive director of nursing, quality and governance;
- Consultant forensic psychiatrist and clinical director of forensic service line; and
- A panel facilitator.

The board level inquiry panel referred to Mr Q as "*ZZ*". The terms of reference for the board level panel inquiry were:

> "Desktop exercise:
>
> - to review the desktop review report and refer to its findings so that the board level panel is aware of areas which require deeper scrutiny, exploration and analysis.
>
> Care and treatment:
>
> - to investigate the care and treatment received by ZZ from BEH. This to include all involved teams and services from 2008 to 2012 (as identified for the panel via timeline information);
> - to consider the care and treatment by Central and North West London Mental Health NHS Trust from 2007 and the handover of information on transfer to our service in 2008;
> - to assess the suitability of that care and treatment offered to ZZ in the period from 2008 to July 2012
> - to examine the extent to which the care provided corresponded with statutory obligations, such as under the Mental Health Act 1983

(amended 2007), relevant guidance from the Department of Health, trust policies and guidance and any local operational policies;

- to assess whether sufficient attention had been paid by BEH services (key involved service Haringey personality disorder service), drug advisory service Haringey, home treatment team (Haringey), and Haringey PCMHT to support needs of ZZ; and
- to assess whether the discharge planning arrangements were adequate and to review what follow-up arrangements were put in place to support ZZ post discharge.

Risk assessment/risk management:

- to assess the adequacy of risk assessments and risk management plans made by trust services during the period that ZZ was in contact with the trust and the actions consequent upon these assessments.

Liaison with other agencies:

- to review the level and extent of liaison that took place with other involved agencies and impact of said liaison on support for ZZ.

Support to staff and victim's family:

- to review the support provided to team members and the communication (if any) with the victim's family and perpetrator's family. To ascertain if the level of support and communication was appropriate or if more action by the trust is warranted.

Root causes of the incident:

- to identify the root causes of the incident and to make recommendations to address root cause and sharing of lessons learnt.

Recommendations:

- to make recommendations to the board of the mental health trust so that, as far as is possible, in similar circumstances in the future, harm to the public, patients, and staff is minimised and that the quality of care is improved."

20.4 National guidelines

The good practice guidance "independent investigation of serious patient safety incidents in mental health services" (NPSA February 2008) advises that after a homicide, an internal NHS mental health trust investigation should take place to establish a chronology and identify underlying causes and further action needed.

The 2008 NPSA guidance, three levels of RCA investigation, states that a level 2 – comprehensive investigation is:

> "Commonly conducted for actual or potential 'severe harm or death' outcomes from incidents, claims, complaints or concerns";

that the investigation uses:

> *"*Appropriate analytical tools (e.g., tabular timeline, contributory factors framework, change analysis, barrier analysis)";

and that the investigation is:

> *"… normally conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice or specialist investigator(s). Conducted by staff not involved in the incident, locality or directorate in which it occurred".*

The guidance also states that:

> *"*The internal investigation should be completed as soon as possible after the event, usually within 90 days*".*

20.5 Trust policy

The serious incidents management policy that was in place at the time of the incident was dated November 2011; this is the fifth version of the policy (which was first ratified in January 2008).

The policy states that when a homicide occurs following recent contact with mental health services, a board level panel inquiry will take place. The timeframe for completion of the investigation is defined by the trust's policy as 26 weeks/6 months.

The policy also states:

> *"*Board level inquiries will be commissioned by director of nursing. They are established to review the most serious incidents such as homicide/multiple deaths. A board level inquiry will be chaired by an independent chair or the director of nursing/medical director/a non-executive director of the trust. The panel may include professionals external to the trust*".*

20.5.1 Comment

> The investigation into Mr Q's care and treatment appears to have been commissioned in line with trust policy. However, the trust's policy states that board level reviews should be completed within six months. This is contrary to the national guidance, which states that such investigations should be completed within three months.

20.6 Submission of report

The first draft of the board level panel inquiry report was submitted on 29 January 2013, five months after the investigation started.

The trust told us that following the acceptance by the trust board of the internal report, a series of learning events with the service took place and key factors were discussed.

The trust said that since the learning event the whole team had come together to reflect on the incident and changes in practice (and procedures and policies) had been made. In addition, key lessons had been shared with trust staff via risk management training, 'embedding the learning lessons' training; via the trust's Patient Safety News Letter and Take 2. Therefore through training and trust publications learning from the incident was shared with staff throughout the trust.

20.7 Recommendations from the trust's review

The panel identified a number of areas where practice could be improved and made eight recommendations.

20.7.1 Recommendation 1

It is recommended that in any case where a patient is on probation there should be proactive contact with the probation services and this should be recorded appropriately.

20.7.2 Recommendation 2

It is recommended that detailed crisis plans should be developed prior to discharge for service users who have been supported by services over a long period, to ensure that there is a clear plan of action for the assessing team to follow if patients re-present to the service in crisis.

20.7.3 Recommendation 3

It is recommended that the trust discharge policy should be reviewed to ensure there are clear guidelines regarding the timeframe within which discharge summaries should be sent to primary care.

20.7.4 Recommendation 4

It is recommended that the revised procedures regarding the shared prescribing responsibilities between the HPDS and primary care are incorporated within the HPDS operational policy.

20.7.5 Recommendation 5

The panel welcomes the action now taken in DASH to ensure that best practice is followed when clients are discharged and there are joint working arrangements with

other services, and recommends that these new procedures are enshrined in the DASH operational policy.

20.7.6 Recommendation 6

The need to document on RiO; updated risk assessments, mitigations and consequent changes on a patient's care and management plan must be reinforced to all staff in the HPDS and compliance should be established through individual supervision and regular audits.

20.7.7 Recommendation 7

Service leads in all service lines should regularly reinforce to staff in their areas that RiO records must be contemporaneous and descriptive, in accordance with the trust record-keeping policy. Limitations in record-keeping in this case have highlighted the need for routine monitoring and regular audit by managers of the RiO records in the clinical supervision of individuals and teams.

20.7.8 Recommendation 8

The panel is aware that the police are conducting an internal review into this case. It is recommended that both agencies now consider how they can work together and with others such as London ambulance service to support individuals who are making multiple contacts with the police and who are known to mental health trusts.

20.8 Action plan

An action plan was compiled to address the recommendations made by the board level panel inquiry. As part of our independent investigation we met with the manager of the Haringey personality disorder service. He talked us through changes made to the service as a result of the recommendations. A copy of the action plan and evidence to support changes to the service is included in appendix C

20.9 Our view on the findings of the trust's board level inquiry investigation report

While we found the trust's investigation to be comprehensive in a number of areas we identified areas where we considered the analysis and subsequent conclusions did not go far enough. These are outlined below.

20.9.1 Diagnosis

The trust's board level inquiry panel report states that:

> "The records available to the panel strongly suggest that ZZ [Mr Q] suffers from a personality disorder… with mainly emotionally unstable, dependent and histrionic personality traits. Evidence of personality disorder includes

> emotional instability, recurrent threats of deliberate self-harm, impulsivity, the need to have others assume responsibility for many of his difficulties, anxiety and apparent feelings of helplessness. ZZ [Mr Q] received considerable support from mental health services and therapy for his personality disorder…
>
> "There are references in the records to him having heard voices in the past and having been paranoid at times. These symptoms were generally short-lived and probably did not indicate the presence of a paranoid psychotic illness, such as paranoid schizophrenia, but were features of his personality disorder…
>
> "The panel found from a review of the notes and evidence from witnesses that ZZ [Mr Q] often presented with high anxiety but his symptoms often reduced rapidly and he calmed down to the extent that he was able to leave services and return to his home. This strongly suggested to clinicians that his symptoms were not of a psychotic nature".

It is our view that this assessment is inadequate.

We consider that at the time of the homicide a combination of paranoid and psychotic features were present. Whether or not these features, and in this combination, existed before in quite the same way is unknown. However, there were at least harbingers of that mental combination. We describe these indicators, referred to as paranoid and psychotic, in section seven of this report, calling on the numerous entries in the case notes describing them.

Potentially significant clinical findings were overlooked or their significance missed because the professionals involved focused on a diagnosis of personality disorder. The sufficient and necessary information had not been obtained in order to make a definitive diagnosis of personality disorder on sound or solid grounds.

20.9.2 Medication

The trust's board level inquiry panel said that it was not clear from Mr Q's clinical records who had prescribed his medication between June and August 2011. It was subsequently ascertained that Mr Q's GP had been prescribing his medication during this period.

The panel noted in its report that HPDS identified the needs to review the shared prescribing responsibilities between the service and primary care and to ensure that discussions about prescribing for each patient are documented clearly on RiO in line with the trust's recording standards.

The panel subsequently recommended in its report that the revised procedures regarding the shared prescribing responsibilities between the HPDS and primary care are incorporated within the HPDS operational policy.

However, the board level panel inquiry report does not comment on Mr Q's compliance with prescribed medication or the impact of his failure to do so.

From the records, we understand that Mr Q stopped taking his anti-psychotic medication in October 2011. Failure to take medication is a common feature of many mental health homicides, yet the panel report makes no comment on the potentially very serious consequences of this.

20.9.3 Risk

In October 2010 Mr Q attacked two fellow patients and was charged with common assault. He was subsequently asked if mental health services had missed any previous violence and he apparently said it had never happened before. There is no information in the records on whether this claim was ever corroborated by any other source.

It is understood that Mr Q had committed other acts of violence, which were known about by his neighbours, the ambulance service, and the police, but which the trust's board level inquiry investigators did not include in their review of risk/violent acts. The trust has since informed us that they were unaware of these instances at that time.

There was additional police involvement in May 2007, March 2009, August 2009, May 2010, August 2010, January 2011, December 2011, February 2012, and March 2012 – which appears to have become more frequent. The trust's internal panel enquiry noted that "there were a few issues which showed indications of potential violence towards others".

The trust's board level inquiry report only mentions, in any detail, the assault on two other patients in 2010 where Mr Q was charged with two counts of common assault and put on probation. The trust told us that they were unaware of the true extent of his other acts of violence and contacts with the police at that time.

20.9.4 Communication

The trust's board inquiry panel report includes no information from the police, ambulance service or probation service, all three of which it acknowledges had contact with Mr Q and potentially important information about him.

20.9.5 Discharge planning

There is clearly a question about whether Mr Q's challenging attitude to mental health care workers had clouded their judgement, and made them keen to discharge him, rather than deal fully and responsively with his real mental health needs.

The panel do not appear to have considered this. Its only comment about the discharge summary is that it wasn't sent to Mr Q's GP on time.

21 Overall analysis and recommendations

Several important aspects could have changed the way trust services understood and engaged with Mr Q. We have identified the following aspects of care that could have been improved:

- diagnosis;
- treatment model;
- identification of the impact of khat/cannabis use;
- risk assessments;
- discharge from services; and
- communication between agencies.

21.1 Diagnosis

The documentary evidence suggests that, from very early on, the diagnosis of personality disorder was made and this diagnosis was the only one being considered. As a consequence, there is little information in the clinical records that suggests diagnosis and symptoms were continually re-assessed, focusing on symptoms.

Consultant Psychiatrist 1 told us during interview that he remained open-minded about Mr Q's diagnosis throughout and that Mr Q's diagnosis and symptoms were continually reviewed. Consultant Psychiatrist 1 told us that he, Specialist Practitioner in Psychotherapy 1 and the wider team discussed them although the discussions were not documented, in line with good practice. Whilst we acknowledge that Consultant Psychiatrist 1 remained open-minded and that he felt additional work was required to assess Mr Q's personality function, this was not reflected in the care Mr Q received. There is nothing in the clinical records to record that on-going reviews and assessments took place. It also appears that other members of the team, particularly Specialist Practitioner in Psychotherapy 1 who had more contact with Mr Q, were more strongly in favour of a diagnosis of personality disorder.

There are entries in the records that allude to Mr Q experiencing 'paranoid' symptoms but these are in the context of how Mr Q manages his thoughts and not in considering whether they are symptomatic of anything outside of personality disorder.

Mr Q displayed symptoms that could have been attributed to a psychotic illness. However, these were considered by most of the clinicians involved in Mr Q's care as being attributable to personality disorder, within a particular treatment model. The issue is not so much what the exact diagnosis was but how these disturbing features and experiences were managed.

A combination of paranoid and psychotic features operated at the time Mr Q committed the homicide. Whether or not these features, and in this combination, existed before in quite in the same way, there had been harbingers of that mental combination previously.

Potentially significant clinical findings were overlooked or their significance missed because the professionals involved focused on a diagnosis of personality disorder. There is nothing in the clinical records to indicate that other diagnoses were being considered but based on the clinical records, insufficient information was obtained to support a definitive diagnosis of personality disorder on sound or solid grounds.

21.2 Treatment model

Due to the complex nature of Mr Q's difficulties he may have benefited more from being under the CCT in order to facilitate a more comprehensive understanding of his psychological, social and health care needs. He frequently presented in crisis and clearly had difficulty coping with day-to-day life. If some of these fundamental stressors had been further assessed and supported then he would have been more likely to benefit from talking therapy.

21.3 Identification of the impact of khat/cannabis use

Mr Q used khat regularly until November 2010, when he significantly reduced his use following support from DASH. He began smoking cannabis in November 2010 and thus appeared to have swapped one drug for another rather than addressing the underlying problem.

There appear to be conflicting opinions among Mr Q's care team regarding the impact substance misuse had on his mental state, behaviour and presentation. It may have been helpful if there was more joint working with the dual diagnosis worker in order to better understand this issue.

21.4 Risk assessments

Risk assessments are usually considered to be part of a dynamic process and should be regularly reviewed and monitored, particularly when there are changes to a patient's condition or circumstances. The purpose of a risk assessment is not to predict an incident of violence – it is to plan for what should be done when a patient with a history of previous violence (and other risk factors) becomes unwell, in order to prevent a similar possible violent incident. The risk assessments in Mr Q's case did not do this.

The trust's internal panel inquiry report says the care coordinator did an "on-going assessment of risk" which apparently entailed her "looking out" for any further risk indicators. The risk does not appear to have been registered or documented in the way that it should have been according to best practice guidance.

Mr Q's care coordinator (Specialist Practitioner in Psychotherapy 1) carried out an assessment of risk after he attended a session with a screwdriver on 26 July 2012 – three weeks before the fatal assault on his elderly neighbour. Mr Q initially told Specialist Practitioner in Psychotherapy 1 that he had the screwdriver as a weapon. Specialist Practitioner in Psychotherapy 1's assessment was that she did not view this as an indicator of serious risk to Mr Q or others. However, in accordance with the

Trust Risk Assessment Policy the RiO Risk Assessment Form should have been updated to include this incident.

21.5 Discharge from services

After Mr Q was discharged from the personality disorder service, the onus was placed on him to get back in touch with mental health services if necessary. Staff working with Mr Q considered that he was someone who could access support when needed. Since he tended to locate the cause of his problems externally, it is questionable whether he had enough insight into his own condition to recognise when he needed psychiatric help.

It is likely that Mr Q felt “contained” by being care-coordinated at the personality disorder service under CPA. He reported difficulties when staff had been on leave and not accessible to him. Rather than a complete discharge from the service he may have benefited from remaining on the consultant's caseload or at least from a gradual reduction in frequency of therapy sessions. This would have allowed him (and services) the opportunity to see if he could manage more independently while still being offered some containment.

21.6 Communication between agencies

Mr Q’s care team relied on Mr Q to tell them when he was in contact with the police. Towards the end of his treatment (Spring 2012), Mr Q told his care coordinator that he was phoning the police less. However, the police report does not support this. There was no system in place for the care coordinator to check this information with the police. It appears that Mr Q continued to contact the police but did not necessarily inform his care team that he was doing so. This demonstrates the need for better communication between agencies to support individuals who are making frequent contact with the police and who are known to mental health services.

Mr Q was sentenced to a nine-month community order and attended his first appointment with his probation officer on 21 March 2011.

Mr Q’s clinical records show that his care coordinator spoke to Mr Q’s probation officer on 3 March 2011 (sometime before Mr Q attended his first appointment with his probation officer). This is the only documented contact between probation and mental health services.

The police, probation service, mental health service and the ambulance service all held information about Mr Q that would have helped inform risk assessments. Although there is nothing in Mr Q’s past to indicate that such extreme violence was predictable - better joint working between the services could have helped to identify and manage Mr Q’s risk better, particularly if there had been arrangements in place for the police to be notified that Mr Q was known to the personality disorder service and had recently been discharged.

21.7 Predictability and preventability

21.7.1 Predictability

There were occasions where, with hindsight, more could have been done to ensure Mr Q's risk was fully understood and appropriately managed. For example, instances such as Mr Q attending his last session with his care coordinator with a screwdriver should have resulted in action being taken. However, there is nothing in Mr Q's past to indicate that such extreme violence was predictable or likely to occur. As such we consider that while practice could have been improved, based on the information held by the mental health services alone, the homicide was not predictable.

21.7.2 Preventable

In the interviews that we have carried out and in our review of the clinical records we have not identified any words, actions or behaviour that should have alerted staff that this tragedy would occur.

While there is some evidence that Mr Q, at times, had acted aggressively and had described difficulty with neighbours, there was nothing to suggest that it would result in such an incident. Therefore this tragedy was not preventable by actions that the NHS alone should have taken. However, we do consider that more could have been done to support Mr Q and to try to fully understand the risk he posed. This includes taking action when he called to tell his care coordinator that he had been visited by god two weeks after he had been discharged. We are also of the view that his discharge could have been phased and that he could have been offered some alternative support rather than relying on him to make contact if his mental health deteriorated.

While we do not consider that mental health services alone could have prevented the homicide we believe that the police, probation service and mental health service could have worked together to share information in order to manage any risk effectively. If the police had been aware that Mr Q had recently been discharged from mental health services their response to his calls may have been different.

21.8 Recommendations

21.8.1 Record keeping

The trust should ensure that staff understand the importance of thorough record keeping, in line with trust and national policy. This includes the need to record discussions about patients when their symptoms, diagnosis and treatment has been considered and any subsequent action agreed. The trust should carry out six-monthly audits to ensure compliance.

21.8.2 Diagnosis

In circumstances where the clinical lead has indicated that there is uncertainty about an individual patient's diagnosis and/or treatment plan, the care coordinator/allocated worker should meet regularly with the clinical lead to discuss the case. These discussions should focus on and agree the plan for risk management, treatment plan and diagnosis.

21.8.3 Care programme approach

The trust should assure itself that the current process for CPA (including care planning, risk assessment and risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

21.8.4 Discharge planning

In instances where a service user has had a long and intensive intervention, a multidisciplinary discussion should take place to determine the most appropriate way to discharge that individual. The discharge process should be tailored to meet the needs of the service user. This may include a staged discharge to test the service user's readiness to be discharged. Consideration should also be given to whether discharge arrangements should be shared with other agencies, such as the police or the probation service.

21.8.5 Partnership working

All partnership agencies should work in collaboration with the trust to continue to develop their relationship and processes for joint working. This development should include the trust reviewing the protocols in place with partnership agencies to ensure effective communication and information sharing for the safety of patients and the general public. For example, information sharing arrangements with the police, probation service and London ambulance service. This should take place within the next three months.

Appendix A

Team biographies

Amber Sargent

Amber joined Verita as a senior investigator in 2009. Previously she worked at the Care Quality Commission (CQC) where she led on several major investigations into patient safety, governance and concerns around performance. At Verita Amber has worked on a wide range of investigations and reviews, including those into the care and treatment of mental health patients convicted for homicide or murder. She specialises in patient safety systems and benchmarking.

Emily Ewart

Emily is a registered mental health nurse and a cognitive behavioural therapist. She is currently employed in Central London as a CPN and also carries a CBT caseload. During her career she has worked in a range of acute wards and community based positions including work as a Care Coordinator. Emily has gained considerable experience in the identification of patient risks and has been involved in the creation of programs for trainee therapists. In her roles she has taken a proactive involvement in the development of procedures to ensure patients conditions are meet with the correct levels of care and experience. Emily has gained a number of Graduate and Postgraduate professional qualifications.

Mostafa Mohanna

After graduating from medical school with an MB, BCh, Mostafa went on to get his basic training in psychiatry at Leicester and subsequently, after gaining membership of the Royal College of Psychiatrists (MRCPsych), became a lecturer with the Leicester Medical School. From there he went on to become a senior registrar in the Cambridge rotation. Mostafa then took up a consultant post in Lincoln in 1990 and has been in that position since. During his consultant tenure he became the clinical tutor organising the junior doctor rotation and from there went on to become the clinical director for the mental health services. He then became the medical director for the newly formed Lincolnshire Partnership Trust in 2001 but has recently vacated that post. He currently continues to practice as a consultant psychiatrist within the same trust. His role as medical director involved, amongst other things, investigating untoward incidents and complaints and liaising with external bodies coming into the trust to investigate incidents. As medical director, Mostafa was joint lead, with the director of nursing, on clinical governance and quality, and had the lead on research and clinical effectiveness. Mostafa is a Fellow of the Royal College of Psychiatrists (FRCPsych).

Appendix B

Documents reviewed

Clinical records

- Mr Q's pre-incident (July 2012) clinical records
- CNWL clinical records

Polices

- CPA policy
- Discharge policy/protocol
- DASH operational policy
- Home treatment team policy
- Haringey personality disorder service policy
- Haringey primary care mental health team operational policy
- DNA/disengagement policy
- SUI policy
- Information sharing protocols between agencies (e.g. – agreement between trust and probation service regarding sharing information.)

Internal report

- Internal investigation report dated 28 January 2013
- Internal investigation action plan
- Internal investigation transcripts

Other

- Service description Claredon day centre
- Chronology of input from probation service
- MG5 case summary report
- MPS Critical Incident Review report
- CAD correspondence in relation to critical incident review

Appendix C

Internal investigation action plan and evidence

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Board Level Internal Inquiries	HAA	Action plan

	Issue/Area	Recommendation	Action Required	Person Responsible	Review Date	RAG Rated Progress Report Comments / Evidence of implementation Red – Not ompleted Green - completed
01	Liaison with the Probation Service:	It is recommended that in any case where a patient is on Probation there should be proactive contact with the Probation Services and this should be recorded appropriately.	Update PD Service Operational Policy and communicate same to team members through team business meeting.	Manager HPDS	31 July 2013	Operational Policy updated and discussed at team meeting on 20.03.13
02	Planning the discharge of the patient from the HPDS:	It is recommended that detailed crisis plans should be developed prior to discharge for service users who have been supported by services over a long period, to ensure that there is a clear plan of action for the assessing	Update PD Service Operational Policy and communicate same to team members through team business meeting.	Manager HPDS	31 July 2013	Operational Policy updated and discussed at team meeting on 21.11.12

		team to follow if patients re-present to the service in crisis.				
03	Discharge Summary to the GP dated 10 August 2012:	It is recommended that the Trust Discharge Policy should be reviewed to ensure there are clear guidelines regarding the timeframe within which Discharge Summaries should be sent to Primary Care.	Discuss and agree time frame within the Haringey PDS Team meeting and update PD Service Operational Policy accordingly	Manager HPDS	31 July 2013	Discussed and agreed at team meeting on 20.03.13. Operational Policy updated on 01.07.13
04	Medication prescribed for ZZ June-August 2011:	It is recommended that the revised procedures regarding the shared prescribing responsibilities between the HPDS and Primary Care are incorporated within the HPDS Operational Policy.	Discuss with team the importance of documenting where the prescribing responsibility lies between the PDS and GPs, update PDS Operational Policy accordingly, and repeat POMHS audit on prescribing practices within PDS	Manager HPDS	31 July 2013	Discussed at team meeting on 20.03.13, Operational Policy updated on 21.03.13, and POMHS Audit repeated during April 2013.
05	Treatment by Drug Advisory Service Haringey	The Panel welcomes the action now taken in DASH to ensure that best practice is followed when clients are	new procedures are enshrined in the DASH Operational Policy and discussed at teams clinical	Service Manager Dual Diagnosis Services	31 July 2013	

	(DASH) September - December 2010, and February - May 2012:	discharged and there are joint working arrangements with other services, and recommends that these new procedures are enshrined in the DASH Operational Policy.	governance meeting 27/04/2013. – see extracts embedded.			
06	Incident on 26 July 2012 when ZZ came to his last session with his Care Co-ordinator, with a screwdriver in his pocket:	The need to document on RIO; updated risk assessments, mitigations and consequent changes on a patient's care and management plan must be reinforced to all staff in the HPDS and compliance should be established through individual supervision and regular audits.	Reiterate to HPDS team the importance of ensuring that risk assessments and risk management and crisis contingency plans are reviewed and updated according to significant clinical change	Manager HPDS	31 July 2013	Discussed at team meeting on 20.03.13 and monitored through the monthly Quality Assurance Audit process
07	Record Keeping:	Service Leads in all Service Lines should regularly reinforce to staff in their areas that Rio Records must be contemporaneous and descriptive, in accordance with the Trust Record Keeping	Reiterate to HPDS team at business meetings the importance of making contemporaneous notes, not retrospective, and recording all	Manager HPDS	31 July 2013	Discussed at team meeting on 20.03.13

		Policy. Limitations in record keeping in this case have highlighted the need for routine monitoring and regular audit by managers of the RiO records in the clinical supervision of individuals and teams.	interagency communications.			
08	Liaison with other agencies:	The Panel is aware that the Police are conducting an internal review into this case. It is recommended that both agencies now consider how they can work together and with others such as London Ambulance Service to support individuals who are making multiple contacts with the police and who are known to mental health trusts	Report to be discussed at the Inter-agency Joint Monitoring Group (JMG)	Patient Safety Manager	31 July 2013	
	Arrangements for shared learning:	The contents of this report will be shared with staff through the Trust's clinical governance processes.	Trust Presentation of findings by Chair of Panel 17 April, 2-4 pm @ Chase Farm Hospital , Camlet 3	Patient Safety Manager	July 2013	