A review into the care and treatment of DB and AA by South London and the Maudsley NHS Foundation Trust

A report for NHS London

June 2008

NHS London

VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

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Verita is an independent consultancy which specialises in conducting and managing inquiries, investigations and reviews for public sector and statutory organisations.

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Abbreviations and references

This report refers to DB and AA respectively. The full names of DB and AA have been kept anonymous for the purpose of this report, as has the names of the victims.

DB's partner, his children and wider family have also been kept anonymous for the purpose of this report. Otherwise the report generally refers to people by name.

A&E	accident and emergency department
CCS	clinical computerised system
CIAMHS	Croydon integrated adult mental health services
CIPTS	Croydon psychological therapy service
CMHT	community mental health team
CMP	care management problems
CPA	care programme approach
EPJS	electronic patient journey system
ELMHT	emergency liaison mental health team
GP	general practitioner
HCR20	historical clinical risk
HTT	home treatment team
PCT	primary care trust
RMO	responsible medical officer
SHA	strategic health authority
SHO	senior house officer
SIE	serious incident evaluation
SLaM	South London and Maudsley Foundation NHS Trust
SMART	specific, measurable, achievable, realistic and time-limited

1. Introduction

1.1 On 20 April 2003 DB and an accomplice tortured and murdered PG. DB was a patient of the Croydon Adult Mental Health Service, part of South London and the Maudsley NHS (pre) Foundation Trust (SLaM). On 1 April 2005 DB was found guilty at the Old Bailey of PG's murder and jailed for life. He was given eligibility for parole in 18 years minus one year to account for his mental health history and minus the time he had spent in custody on remand (almost two years).

1.2 Fran Bristow, borough-wide services manager at SLaM undertook an initial fact-finding review and completed the management report on 25 April 2003. SLaM commissioned a board-level inquiry to examine the circumstances surrounding the killing. It was chaired by Diana Robbins, a non-executive director at SLaM. The inquiry's report made recommendations for improvements to the trust's services. The report of the internal investigation team was submitted to the trust board on 29 September 2004.

1.3 On 19 January 2005 AA a patient of the Croydon Adult Mental Health Service, stabbed to death her partner. She was a patient of SlaM at the time. On 26 August 2005 AA was found guilty at the Old Bailey of manslaughter and jailed for life. AA will serve two years and 334 days before being eligible for parole. When she is ultimately released she will be subject to conditions on licence which will continue for the rest of her life.

1.4 An internal investigation was commissioned by the director of Croydon Mental Health Services (Steve Davidson) and the assistant director of risk management (Cliff Bean) at SLaM. Karen Cook and Abigail Fox-Jaeger investigated the incident and Dr Siobhan O'Connor facilitated the review. The investigators' report made recommendations for improvements to the trust's services. The report of the internal investigation team was submitted to the trust board on 29 September 2004.

1.5 HSG (94)27 Guidance on the discharge of mentally disordered people and their continuing care in the community (Department of Health May 1994) and the updated paragraphs 33-36 issued in June 2005 states that in serious cases there must be an immediate investigation using structured investigation processes such as root cause analysis (RCA). This approach is used to identify and rectify possible shortcomings in operational procedures with particular reference to the care programme approach (CPA).

The guidance before June 2005 also stated that in the case of a homicide an independent inquiry must be held.

1.6 In March 2006 South West London Strategic Health Authority (South West London SHA), now part of NHS London, consulted Verita on the most appropriate way to review these two cases. It agreed with Verita's advice that an external review into the events and root causes leading up to the two homicides related to Croydon addiction service within SLaM was required. NHS London also wanted assurance that the recommendations of the internal investigations were being implemented and where necessary further advice to be provided to the trust, primary care trust (PCT) and SHA about implementation. The terms of reference for the review are given in full in chapter two of the report.

1.7 This report examines two incidents involving patients with dual diagnoses and drug- or alcohol-related problems. At face value the cases involve patients with similar co-morbidities and use of services but they were in fact quite different in terms of areas of concern with service delivery. We have therefore reviewed each case separately, assessed the trust's own internal investigation, identified further necessary service improvements and made recommendations. The progress the trust has made on their original recommendations for each of these incidents is also reviewed.

1.8 This report provides an independent review of the two incidents. We first outline the systematic investigation and analysis approach we used in this review. We then outline the care and treatment of DB. This begins with a chronology of events leading up to the incident. The findings are then presented, followed by our comments. The same format is adopted for AA. The recommendations and the progress the trust has made on these for both cases are reviewed in the final section of this report.

1.9 Dr Sally Adams chaired the review. She is a psychologist and an expert in systematic incident investigation.

1.10 Malcolm Barnard was the supporting investigator. He is a Verita consultant with a background in mental health and social care.

1.11 Dr Simon Wood, a consultant forensic psychiatrist, acted as an expert adviser to the review team.

1.12 The review began in April 2006 by tracing DB and AA in the prison service. We then obtained their consent to release their medical and associated records for review. We began the interview process after studying the records and documents. We interviewed 19 people in total. Eight people were interviewed for the DB case, six for the AA case and five people had knowledge of both cases.

1.13 This investigation has taken significantly longer than we had planned, largely due to reasons outside our control. This has included delays in getting consent from both perpetrators, locating DB within the prison system and accessing certain key witnesses.

Acknowledgements

1.14 We are particularly grateful to DB's mother and sister for their contributions. They agreed to be interviewed, and gave us valuable background information.

1.15 We are conscious that the deaths of the victims of DB and AA have deeply affected the lives of a number of people, in particular their family and friends. We offer them our deepest sympathy.

1.16 We tried a number of ways to find the family and friends of the victims of DB and AA but without success.

1.17 SLaM has cooperated with our review.

Reading this report

1.18 The remainder of the report is organised as follows:

- Chapter two gives the terms of reference for the review
- Chapter three is an executive summary that identifies the key findings and recommendations of the review
- Chapter four describes the systematic method we used to complete the review
- Chapter five provides details of the incident and care and treatment received by DB
- Chapter six reviews the trust's internal investigation findings and then provides our comments and findings

- Chapter seven provides details of the incident and care and treatment received by AA
- Chapter eight reviews the trust's internal investigation findings and then provides our comments and findings
- Chapter nine reviews progress of recommendations.

1.19 We have included a number of appendices that contain supporting information or evidence and documents referred to in the text of the report.

2. Terms of reference

2.1 The terms of reference for these two homicide investigations were provided by South West London Strategic Health Authority (now NHS London) and are as follows;

2.2 The aim of the review is to provide independent review into the events and root causes of events leading up to the two Croydon addiction service related homicides. In addition, to provide assurance that the recommendation of the internal investigation are being implemented and, where necessary, to provide further advice to the trust, PCT and SHA about implementation.

2.3 The review will:

- Investigate the root causes for both incidents;
- Identify the principal themes and recommendations emerging from the internal report and RCA report;
- Establish what progress has been made implementing the recommendations from the internal investigation and why;
- Identify any recommendations that have not been implemented - either in part or in full – and suggest a course of action to the trust, PCT and SHA;
- Ensure any further recommendations build on this knowledge and take into account what needs to done for appropriate change to take place;
- Provide a written report with recommendations to NHS London, the PCTs and the trust
- Upon completion of the work recommend appropriate ways to ensure the lessons learnt from the review are shared and acted upon.

2.4 The review will not duplicate the earlier RCA investigation; this work is being commissioned to build on the internal investigation.

2.5 Should the reviewers identify a serious cause for concern, this should be notified to NHS London and the trust immediately.

2.6 The review will be undertaken in two phases:

Phase One

This will be an information and fact-finding phase incorporating the gathering and review of relevant pieces of information to establish the scope of the second phase of the review.

Phase Two

This will include interviews with key staff and managers – either individually or in groups. Fieldwork will be carried out on site in the trust.

It is expected the final report will include recommendations to inform the appropriate commissioning of the service by Croydon PCT as the lead commissioner of mental health services.

2.7 The outcome of the review will be made public. The SHA for London will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the review team, relatives and other interested parties.

2.8 The review team will comprise of appropriately skilled members, assisted as necessary by expert advisers with nursing, medical or other relevant experience, and be expected to work promptly and effectively, with the full process completed within four months. The review team will submit regular progress reports to the commissioners.

3. Executive summary and recommendations

3.1 We were commissioned by South West London SHA (now NHS London) to provide an independent review into the events and root causes leading up to two Croydon addiction service related homicides committed by DB in 2003 and AA in 2005. We were asked to build on the trust's internal investigations rather than duplicate earlier work. We were also asked to provide assurance that the recommendations of the internal investigations were being implemented and, where necessary, to provide further advice to the trust, PCT and SHA about implementation.

Executive summary: DB

3.2 On 20 April 2003 DB, a patient of the Croydon Adult Mental Health Service, and an accomplice tortured and murdered PG.

3.3 Fran Bristow, borough-wide services manager undertook an initial fact-finding review and completed the management report on 25 April 2003. A board-level inquiry was commissioned by SLaM to examine the circumstances surrounding the killing of PG. The report of the internal investigation team was submitted to the trust board on 29 September 2004. The recommendations from this report are provided in section 3.31. These recommendations are accepted by us as being appropriate.

3.4 DB was first referred to secondary mental health services in December 1990 after concerns about substance misuse and his mental health. He was admitted to Warlingham Park Hospital in 1991. DB was admitted again to Warlingham Park Hospital in 1993 having stabbed the manager of his bed and breakfast accommodation. In 1994 DB was placed on the supervision register under the category of serious violence. DB lived at a forensic hostel in Croydon when he was not in hospital and remained there until it closed in 1998.

3.5 In June 1998 DB moved into his own flat and continued to receive support from the mental health team. By December 1998 DB had stopped his depot medication and disengaged from services, although he remained in contact with his responsible medical officer (RMO) and social worker until July 1999.

3.6 On 20 August 1999 DB was arrested for attempted armed robbery, but a conviction was not made due to lack of evidence. Later that week DB reportedly acted in a

threatening manner towards his father, demanding money for crack cocaine. He also allegedly assaulted a 15-year-old girl. He was assessed and detained under section 3 of the Mental Health Act 1983 on Gresham psychiatric intensive care unit. He was referred to the Shaftesbury clinic, which is run by South West London and St George's mental health trust for assessment and transfer to medium security facilities. This referral was rejected. Dr Mari Harty, RMO, subsequently referred DB for assessment at Witley 3 ward (forensic rehabilitation ward at Bethlem Royal Hospital). He was again considered unsuitable due to his poor insight of his mental illness and offending behaviour. DB's case was eventually referred to the regional adviser in forensic psychiatry to adjudicate on his needs. She decided DB should be placed in medium security, but no beds were available at the Shaftesbury clinic.

3.7 Between March and September 2000 DB was treated on Gresham 2 ward (acute psychiatric ward for males aged between 18-65), although active treatment was limited due to DB's aggression and poor insight into his mental illness. In August 2000, Croydon Crown Court considered an application by DB's defence solicitors to vary his bail conditions. The new conditions stipulated that he should live at his flat with visits from Croydon community forensic team. A CPA meeting was arranged and DB was discharged to his flat.

3.8 On 30 March 2001 DB saw Dr Harty and told her he was moving to Hastings with his partner. Transfer of care was arranged. However, DB returned to Croydon a month later because of deterioration in his partner's mental health.

3.9 DB was admitted twice more to Gresham 2 ward - in March 2002 and then again in October 2002 due to a deterioration in his mental state, his aggressive and volatile actions. He was discharged on 19 November 2002.

3.10 Between January 2003 and April 2003 DB was seen regularly by his community psychiatric nurse (James Forrester) and Dr Fiona Cowden. DB was generally well, but refused to be screened for drugs.

3.11 DB was last seen by Dr Cowden and the Croydon Forensic team on 17 April 2003, when he appeared euthymic (neither depressed nor elated) with no psychotic symptoms.

3.12 On 20 April 2003 at 9.55am DB attended the Emergency Liaison Mental Health Service at Mayday Hospital requesting a detoxification programme. He returned at 2.32pm complaining of a headache and was given analgesia. At 8pm approximately PG was tortured and murdered by DB and an accomplice. It is alleged that PG was a paedophile and owed drug money to DB's accomplice.

Executive summary: AA

3.13 AA was born in 1955. She began drinking alcohol at the age of 16 in 1971, but by 1991 she was drinking daily.

3.14 In 1992 she was cautioned for being drunk in charge of a car, for assaulting a police officer and for drunk and disorderly behaviour. In 1994 she said she had been fined for obstructing the police. In 1998 she received a two-year probation order for assaulting a police officer, in addition to serving seven days in prison for this offence. In 1998 she received a five-day prison sentence for failing to appear in court. In 1998 she was sentenced to three years and six months for grievous bodily harm and affray after a serious assault while intoxicated. This assault, with several other people was on a woman in Queen's Gardens in Croydon, and occurred as a result of an argument over a cigarette. The victim suffered permanent brain damage. AA was released on licence in February 2002 but the licence was revoked in September 2002 and she went back to prison to finish her sentence.

3.15 On 28 January 2003 AA was released from prison on probation. She initially engaged with substance misuse services and was noted to be "dry" and considering going into rehab. On 18 February 2003 she was admitted to the accident and emergency department (A&E) at Mayday Hospital. She was disturbed and asking those around her to kill her. She went to A&E several times in the next few days. On 23 February 2003 she was admitted informally to Bethlem Royal Hospital after jumping in front of cars. She was discharged a month later on 21 March 2003 after returning to the ward drunk on two occasions. A further brief admission followed over the weekend of 22-24 March 2003, when she discharged herself. On 25 March 2003 she was admitted to hospital following the implementation of section 136 of the Mental Health Act.

3.16 On 5 June 2003 AA was discharged to Mount Carmel residential rehabilitation unit in Streatham. She was discharged in August because she was drunk, was not taking her medication and was getting up late.

3.17 On 1 July 2003 AA was referred to the Cawley Centre at the Maudsley Hospital that specialises in personality disorders. AA was not accepted as a patient because she had no fixed address and had not completed her alcohol rehabilitation programme.

3.18 The Oaks (addictions service) offered AA an appointment in September 2003. She failed to attend this and other appointments so was discharged in October 2003.

3.19 On 12 November 2003 AA's care was transferred from a substance misuse worker (Prema Nazran) to a care coordinator (Pauline LaForge) from North West CMHT. AA was seen on three occasions between 28 February 2003 and 2 February 2004, twice by Pauline LaForge and once by another member of the team. AA cancelled her appointment with Pauline LaForge on 12 February and no further contact was made.

3.20 AA continued to attend her outpatient appointments with Dr Raj Persaud's senior house officer (SHO) in April and July 2004.

3.21 On 21 September 2004 the police contacted the substance misuse team because AA was at the police station. Later that day she went to Mayday Hospital A&E department claiming she was suicidal. The cause of this appeared to be that after a drinking binge, her daughter had left home to stay with her father. Eventually the police removed AA from the hospital premises. North West CMHT were alerted to the situation. A duty worker took the call and planned to make a home visit as Pauline LaForge was absent. Before the visit could be made AA was taken to Bethlem Royal Hospital on a section 136. A few days later she was discharged.

3.22 In the following weeks she attended A&E frequently. On occasions she was informally admitted to a mental health ward, but discharged shortly afterwards for being drunk and abusive. Pauline LaForge was notified, but it is unclear how she responded.

3.23 On 21 October 2004 AA, with her sister, was seen by Dr Persaud at Westways Resource Centre. Dr Persaud told her that countless attempts to help her had failed so she needed to take some responsibility for her own life. He referred her to the home treatment team (HTT). Later that same day AA was assessed at home by HTT.

3.24 AA continued to drink and attend A&E over the weeks and months.

3.25 On 4 January 2005 AA was seen by the addictions consultant. Her request for detox was discussed, she was assigned a key worker and it was agreed that an inpatient detox

appointment would be arranged. Next day she was brought into A&E by London ambulance service after drinking and taking a suspected overdose of Venlafaxine. She stayed in the high-dependency unit overnight for observation. A report was sent to the Oaks and she was given an appointment for February 2005. She was considered psychiatrically fit for discharge.

3.26 On 19 January 2005 AA fatally stabbed her partner, while they were both drunk. She was charged with his murder on 22 January and found guilty of manslaughter at the Old Bailey in August 2005.

3.27 AA has a diagnosis of borderline personality disorder with major depression complicated by alcohol dependency. The diagnosis of borderline personality disorder emerged over time. She has a long history of impulsive acts of self harm, including overdoses and cutting, and violence when drunk.

3.28 An investigation was commissioned by the director of Croydon Mental Health Services (Steve Davidson) and the assistant director of risk management (Cliff Bean) at SLaM. Karen Cook and Abigail Fox-Jaeger investigated the incident and Dr Siobhan O'Connor facilitated the trust's internal investigation and review. The final report made recommendations to improve the trust's services.

3.29 The following are the main areas of concern identified by the two internal investigations:

- The management and care co-ordination of patients with dual diagnosis
- The management of people with personality disorder
- Improving and strengthening CPA implementation
- Team management and leadership
- Child protection
- Risk management of complex cases.

3.30 Our independent investigation corroborated these findings. We identified two further areas of concern:

- The electronic patient record system
- Conduct of investigations.

3.31 The recommendations from each of the two investigations are provided below. Recommendations from DB's case are followed by his initials, from AA's case (AA) and where we have identified further recommendations these are preceded by (II).

The management and care co-ordination of patients with dual diagnosis

- A joint protocol should be agreed between substance misuse services and mental health services outlining joint working procedures and lead responsibility for dual diagnosis clients. (AA)
- Care co-ordination by the most appropriate service for dual diagnosis clients must be made clear particularly in cases involving drug addiction and severe mental illness. (DB)

Management of people with personality disorders

- Local guidance should be provided on the long-term management of people with anti-social personality disorder. (DB)
- Training should be provided to help clinicians assess and manage patients with personality disorders, and substance misuse problems during times of crisis. (DB)
- The trust should review its policy on hospital discharge for patients with borderline personality disorder and related personality difficulties to consider a better system for patients who are drunk and therefore in breach of conditions for remaining in hospital. (II/AA)

Implementation of CPA

- CPA policy must be followed by all staff. (AA)
- The role of the care co-ordinator must be clearly understood by all members of the team allocated this role. (AA)
- The trust should reconsider its decision to put further CCS (clinical computerised system) training on hold until the implementation of the 'Patients Journey' electronic record system. This is because staff are unable to access information previously recorded on CCS. (DB)

- The trust board should make sure systems and protocols are implemented and audited so appropriate standards of care coordination and competency of care coordinators are in place in CMHTs. (II/AA)

Team management and leadership

- The team leader must follow the supervision policy and manage caseloads effectively. The team leader must ensure performance management systems are followed when under-performance is identified. (AA)
- The trust should consider a review of the caseload and staffing levels in the Croydon Forensic Team. (DB)

Child protection

- A joint protocol should be developed between Children's Services and Mental Health Services to enable better communication and shared practice for children whose parents have mental health problems. (AA)

Risk management of complex cases

- It needs to be made clear how differences in opinion should be resolved when patients are referred to medium secure services. (DB)
- A clinician providing a second opinion should be of a similar or higher competency level than the referring clinician. (DB)
- Access to secure beds should be improved in the local catchment area. The trust should pass this recommendation to the PCT responsible for commissioning secure placements. (DB)
- Staff should be given clear guidance in the form of an escalation policy on what to do if a patient continues to refuse to give blood or urine samples. (II/DB)
- For patients with an identified risk factor of drug use, testing should not only be random but an expected part of their care. This should be clearly explained. Patients should also be told that an adverse inference will be drawn if they fail to give a sample, or otherwise circumvent the testing process. It should be explained that in such circumstances the team might not be prepared to maintain them in the community and might resort to a hospital admission. (II/DB)
- Criteria should be developed or reviewed to ensure consultants and other senior members of staff take a more active role in the care and management of patients with complex issues. (II/AA)

The trust's electronic patient record system

- The trust should review where patient risk factor information is located on the electronic patient journey system (EPJS) to make sure it can only be placed in one area or field and ensure that this information is provided to all staff. (II/AA)

Investigations

- A tabular timeline, or similar methodology, should be used in all local incident investigations so a more complete chronology is established. (II/DB)
- The trust should communicate with the victim's and perpetrator's families immediately after an incident to offer condolences, explain the trust's investigative processes and, if appropriate, offer an apology and support. (II/DB/AA)
- The trust should develop intelligent and targeted support strategies for staff after serious untoward incidents. (II/DB)
- When independent reviews are commissioned, the trust should tell the commissioners/review team of any specific personnel issues as soon as possible. (II/DB)

3.32 In general SLaM had made good progress implementing the recommendations from the DB and AA internal investigations. However with regard to specifying the minimum staffing grade able to undertake the Appropriate Adult role, this had not been completed.

4. Approach: systematic incident investigation and analysis

4.1 The guidance for internal investigations by mental health trusts was issued by the Department of Health in HSG (94)27. The guidance requires them to conduct formal internal reviews of critical incidents. In the case of homicides and other exceptional events the SHA is required to commission an independent investigation into the circumstances of the incident. In June 2005 the guidance was amended and required trusts to conduct an investigation into the circumstances surrounding any critical incident and to use a structured investigation process such as root cause analysis (RCA).

4.2 RCA is a structured and systematic approach to incident investigation and analysis for healthcare incidents. RCA is composed of five main steps:

1. Getting started
2. Gathering and mapping evidence
3. Identifying the problems
4. Analysing the problems
5. Generating recommendations and solutions.

4.3 Our review began with an examination of key policies and procedures and case notes for DB and AA. A list of all the documents we reviewed is in appendix A.

4.4 We examined the case notes for DB and AA in detail and produced timelines as appropriate. For DB, we produced a new tabular timeline (see appendix B) and extended the narrative chronology (see section five). For AA we added to the trust's internal investigation timeline (see appendix B). Both timelines highlight the main events associated with care and treatment along with the names of staff involved. The timelines are in appendix B and C.

4.5 Each witness interview was conducted by Dr Sally Adams and Malcolm Barnard. Dr Simon Wood attended the witness interviews with all clinical staff, as we felt a psychiatrist needed to lead the clinical related questions. This approach gave a sense of proportion and streamlined the review process.

4.6 Before the interview, each interviewee received a letter explaining:

- the nature of the review and the purpose of the interview
- the name of the interviewer
- the date, time and location of the interview
- their option to bring a friend or colleague for support

4.7 In most cases the interview was transcribed by a stenographer. After each interview, the staff member was given a copy of the transcript and encouraged to correct any errors or add anything they felt had been omitted. Very few corrections were made, with the exception of one transcript. Corrected transcripts were returned to the Verita review administrator (Johanne Sondergaard). The transcripts were then sent to us for review. The list of formally recorded interviews with resultant transcripts, along with the date of the interview and the names of the interviewers is in appendix D.

4.8 The evidence was reviewed to establish the care management problems (CMPs – acts of omission or commission) in each incident. This verified the CMPs identified by the trust's internal investigations, and identified new CMPs.

4.9 For each new CMP identified we used the CRU/ALARM Protocol (Vincent, Taylor-Adams et al 1999, see appendix E) contributory factor frameworks to identify the reasons why the CMP had occurred. As part of this process we were able to identify good practice which is summarised in paragraph 9.33. Relevant fishbone/five why diagrams associated with each CMP are in appendix F.

4.10 The final stage of the analysis involved a further review of SLaM's recommendations to see if they resolved the identified problems. We then reviewed progress in implementing recommendations and, where appropriate, the effectiveness of the recommendations themselves. The review team has identified further recommendations for the trust to consider.

4.11 Each case is described separately; the DB case in chapter five and the AA case in chapter seven. Both cases start with a chronology of the incident and give relevant historical details and context. The CMPs, contributory factors, root causes and recommendations are then discussed from both a SLaM and an independent perspective.

DETAILS OF REVIEW

5. DB

Family history

5.1 DB is the youngest of four children. He has an older brother, who is a half sibling, and two older sisters one of whom died when he was five. DB's father was an accountant who originated from Guyana. His mother, who originates from Ireland, was a teacher and is now retired.

5.2 DB started school in Purley then went to a private boarding school in Kent until he was 14. Because of family financial difficulties he then moved to a local state school. He found the transition difficult, but gained several qualifications. DB then went to a local college where he studied for a B.Tech in construction. He started a degree course at Nottingham University, but left in the first year. That coincided with his first presentation to mental health services.

5.3 DB's parents divorced when he was 14. DB lived at his father's house. Shortly after the divorce his father's accountancy business went bankrupt and the family home was repossessed.

5.4 DB's brother had previously been diagnosed with bi-polar disorder and his aunt and cousin have schizophrenia.

Personal history

5.5 DB was born in Purley on 20 February 1972. There is no documented history of obstetric or perinatal problems. He had measles at the age of 16 months, followed three weeks later by German measles. DB's mother reported that after this second illness DB's *"gentle personality and affability as a baby completely altered and he became very difficult to handle"*. He has no history of developmental delay in motor or social functioning. His educational history has been outlined above. DB worked as an estate agent, but left because he found the job too stressful. He also worked as a temporary electrical installation engineer, but has been unemployed and receiving state benefits since 1999.

5.6 DB is an intelligent, articulate man.

Drug and alcohol history

5.7 DB used cannabis on a regular basis since he was 18. He has admitted to regular use of crack cocaine since the age of 22.

Psychiatric history and summary of incident chronology

5.8 DB first came into contact with psychiatric services in December 1990, aged 18 years, after concerns from his family and general practitioner (GP) about substance misuse and his mental health.

5.9 DB was first admitted to Warlingham Park Hospital in 1991. He was taken there by police who had arrested him for climbing into a woman's bedroom. He had been in police custody on four previous occasions. He was noted to be aggressive and irritable. He said he experienced auditory hallucinations, that he had exceptional intelligence and could read people's thoughts. DB's symptoms were considered to be the result of drug induced psychosis. He was discharged from hospital into bed and breakfast accommodation.

5.10 In 1993 DB was admitted to Warlingham Park Hospital after stabbing the manager of his bed and breakfast hotel, as he believed he was a child molester. DB suffered a relapse of his mental illness and was assessed in hospital under section 35 of the Mental Health Act 1983. He was volatile, explosive in mood and had clear psychotic symptoms. He was diagnosed with schizophrenia. He responded well to antipsychotic medication while he was treated under section 37 of the Mental Health Act 1983. He was discharged to a forensic hostel in Croydon.

5.11 DB was placed on the Supervision Register in 1994 under the category of serious violence.

5.12 In August 1995 DB moved to a semi-supported hostel. He demonstrated good independent living skills, but quickly became demotivated. Within two months there were two separate incidents of concern. The first involved damage to property at the hostel while he was drunk. The second incident involved criminal damage to a playground. He was picked up by police, taken to Warlingham Park Hospital, and re-admitted. On

discharge he was returned to the forensic hostel in Croydon, as it was thought he needed a higher level of observation and a semi-supported hostel.

5.13 DB stayed at the forensic hostel until it closed in June 1998. He had a three-day admission to Warlingham Park Hospital in 1997, after an apparent reaction to his depot medication. He had been compliant with treatment since 1994 and there were no reported concerns about his mental health after the aforementioned incidents in 1995.

5.14 At a CPA meeting in May 1998 DB said he wanted to live independently. His mother supported this decision. DB was open, co-operative, compliant and appropriate in his views regarding substance misuse. He accepted his diagnosis of schizophrenia and the detrimental effects of stressful situations on his mental state. He also acknowledged the negative effects of drug misuse on his mental health.

5.15 In June 1998 DB moved into his own flat. He continued to receive support from Croydon's Forensic Outreach Team but within a couple of months he indicated a wish for less frequent monitoring. He also become more resistant towards continuing engagement with services.

5.16 In December 1998, he stopped depot medication and disengaged from services. He refused to restart treatment but did agree to renew contact with his RMO and his social worker Mark Fletcher. Mark Fletcher reported concerns about a deterioration in DB's mental health characterised by paranoid ideas, threatening and aggressive behaviour. DB continued to be seen by his RMO as an outpatient until July 1999. He also continued to see his community psychiatric nurse on a weekly basis but declined depot medication. His mental state continued to deteriorate with threatening and aggressive behaviour, expression of paranoid and delusional beliefs and increasing concerns about his self care. DB denied using any illicit substances during this period.

5.17 On 20 August 1999 DB was arrested for attempted armed robbery at a bookmakers. He appeared at Croydon Crown Court and was bailed to his home address.

5.18 On 27 August 1999 he reportedly acted in a threatening manner towards his father, demanding money for crack cocaine. It is also alleged that he assaulted his father's partner. His father did not pursue criminal charges, but said he intended to seek an injunction against his son.

5.19 In the evening of 27 August 1999, DB allegedly assaulted a 15-year-old girl demanding money. The girl was with her mother. He was arrested and taken into police custody. He was assessed and detained under section 3 of the Mental Health Act 1983 on Gresham psychiatric intensive care unit. He was not charged after this incident due to lack of evidence. On admission to hospital his mental state was described as guarded and threatening in manner with evidence of pressure of speech, loosening of associations, agitation, paranoid ideation and lack of insight. He was given oral antipsychotic medication (Haloperidol) and mood stabilising medication (Lithium).

5.20 On 6 October 1999 DB was assessed by Dr Mari Harty, locum consultant forensic psychiatrist. He presented as hostile, guarded and evasive. He was recorded as lacking insight into his mental illness, his offending behaviour, or the need for hospital treatment. Depot medication was reinstated and he was referred to the Shaftesbury clinic for assessment for transfer to medium hospital security. The RMO (Dr McDonald) and DB's social worker all agreed with Dr Harty's assessment that a medium secure placement would benefit him.

5.21 On 29 November 1999 DB was assessed by Dr Claire Diamond, senior registrar in Forensic Psychiatry to Dr Vince. She did not support his transfer to the Shaftesbury clinic.

5.22 On 30 December 1999 Dr Harty saw DB again. DB said he was sorry about the alleged assault on his father's partner. Dr Harty still thought DB would benefit from rehabilitation on an open forensic ward to address his offending behaviour and to gain insight into his mental illness. She referred him to Dr Paul Gilluley, locum consultant forensic psychiatrist, Witley 3 Open Forensic Ward at Bethlem Royal Hospital.

5.23 On 8 January 2000 DB was assessed by Dr Humphrey Needham-Bennett, senior registrar to Dr Gilluley. Dr Needham-Bennett thought DB was unsuitable due to his poor insight into his mental illness and offending behaviour. He recommended that DB be treated in conditions of medium security. He also recommended holding a case conference with the clinicians at the Shaftesbury clinic.

5.24 On 25 January 2000 Dr Elizabeth McDonald wrote to Dr Vince requesting an urgent review of DB by a member of his medical team. It was documented that DB remained hostile towards staff and patients. He made veiled threats towards Dr McDonald and she noted that he continued to minimise the violent events that led to his hospital admission.

5.25 DB was reviewed by Dr Vince on 31 January 2000. Dr Vince did not support his transfer to medium security and recommended more extensive psychological assessment to see if DB had a personality disorder.

5.26 DB's case continued to divide psychiatrists so it was referred to the regional adviser in forensic psychiatry (Dr Philip Sugarman) to adjudicate on his needs. Dr Sugarman decided he should be placed in medium hospital security. Unfortunately a bed was not available at the Shaftesbury clinic. His details were circulated to find a private medium secure bed. DB remained on Gresham psychiatric intensive care unit until a Mental Health Review Tribunal discharged him from section 3. He was subsequently moved to Gresham 2 open ward at the Bethlem Royal Hospital in March 2000.

5.27 In May 2000 DB did not spend much time on the ward and staff found it impossible to work with him in a meaningful and constructive way.

5.28 On 31 May 2000 Dr Harty wrote to Dr Annie Bartlett (consultant forensic psychiatrist, Hume Ward Low Secure Unit, Springfield Hospital) about the referral of DB by Dr Vince to her for assessment and treatment.

5.29 On 7 June Dr Bartlett wrote to Dr Harty to say the medical team on Hume Ward had put DB's assessment on hold because he was an informal patient and it was more appropriate that his court case be resolved with his current treatment team.

5.30 On 14 August 2000 Croydon Crown Court considered an application by DB's defence solicitors to vary the conditions of his bail. He was given new conditions, which stated he should live at his flat and receive a visit from the Croydon Community Forensic Team. In light of this decision a CPA meeting was arranged for 22 August 2000 where his discharge plans were discussed.

5.31 In September 2000 DB was discharged to his flat with support from the Croydon community forensic team.

5.32 On 5 October 2000 DB was admitted to Mayday Hospital with cuts to his arms after falling from a window in his flat. Apart from his physical problems he appeared well mentally and agreed to a urine drug screen to confirm an absence of illicit drugs.

5.33 On 1 November 2000 DB appeared in court on the attempted armed robbery charge. The case was dismissed due to lack of evidence.

5.34 DB continued to attend outpatient appointments with Dr Harty at Tamworth Road Resource Centre (the forensic team base), as well as appointments with his community psychiatric nurse and social worker. On 6 November 2000 he was reviewed by Dr Harty. He did not exhibit any psychotic symptoms and said he was unhappy with his medication. Dr Harty agreed to change his medication. He started on oral antipsychotic medication (Olanzapine 10mg daily). He was advised to continue to take Lithium and Procyclidine as required at a maximum of 5mg three times daily.

5.35 On 22 December 2000 DB failed to attend an outpatient appointment. He was next seen by Dr Harty on 3 January 2001 and again on 10 January 2001 at Tamworth Road Resource Centre.

5.36 On 28 February 2001 he was again reviewed by Dr Harty.

5.37 On 7 March 2001 DB attended a CPA meeting at Tamworth Road Resource Centre. It was noted that his mental state remained stable and his mood was settled.

5.38 On 30 March 2001 he was reviewed by Dr Harty. DB said he had formed a relationship with N, the mother of his child. Because of N's disapproval, he was motivated to stay off drugs. He wanted to be considered a suitable partner and father to N's daughter, M. During this period in the community, his son was conceived and DB moved to live with N and her daughter in Hastings. It was agreed by the forensic mental health team that Hastings forensic services would be contacted in due course to arrange a transfer of care.

5.39 On 19 April 2001 DB was invited to attend an outpatient appointment with Dr Wapner, consultant psychiatrist of Ashen Hill Medium Secure Unit, Hastings. DB did not attend that appointment, or one scheduled for 3 May 2001.

5.40 DB's relationship with N was characterised by conflict and domestic violence. He told Dr Harty that on one occasion he had hit N, leading to a temporary return to Croydon. He also said that N self-harmed in front of him which he found particularly distressing. DB and N lived together for several months in 2001 until the breakdown of their relationship in May when DB returned to Croydon. This led to his admission to the Bethlem Royal Hospital in October 2001.

5.41 After his discharge from the Bethlem Royal Hospital in January 2002 DB was made the subject of a Supervised Discharge order. He attended outpatient appointments with

Dr Harty. DB was distressed at not being given contact with his children and his ex-partner.

5.42 Dr Harty reviewed DB on 13 February 2002. He appeared subdued. He was particularly pre-occupied with access to, and the welfare of, his son. He did not present as overtly depressed and no psychotic symptoms were seen. DB was due to see clinical psychologist, Dr Susan Young for anger management. DB attended the first appointment, but did not attend the follow-up appointment.

5.43 On 1 March 2002 he was seen by Dr Harty at Tamworth Road Resource Centre. He was argumentative, irritable and verbally aggressive. He was angry about events concerning his son. He was preoccupied with the fact that he was a forensic patient and held Dr Harty responsible for this. An informal admission to hospital was discussed, which he declined. Due to his level of arousal during the consultation, Verona Edwards (forensic social worker) and Chris McKay (forensic community psychiatric nurse) tried to calm him down. They were unsuccessful. He became increasingly aroused and left the building. In light of this presentation, papers for his detention under section 4 of the Mental Health Act 1983 were completed. The police, DB's mother and the Children & Families Department of Hastings Social Services were informed. N's mental health team were also told about the situation. DB did not come to the attention of the police or other agencies over subsequent days and section 4 of the Mental Health Act lapsed.

5.44 On 13 March 2002 DB was assessed by Dr Harty at a home visit when section 3 of the Mental Health Act 1983 was completed. DB expressed paranoid beliefs, irritability and hostility. He was admitted to Eden Ward psychiatric intensive care unit at Lambeth Hospital as a bed was not available on Gresham psychiatric intensive care unit at the Bethlem Royal Hospital. He was subsequently transferred to Gresham psychiatric intensive care unit and eventually to Gresham 2 open ward.

5.45 On the weekend of 26-29 July 2002 DB went absent without leave from Gresham 2 ward. When he returned he was involved in an altercation with another patient. This involved verbal abuse and physical threats. Staff intervened to prevent a violent episode.

5.46 On 29 July 2002 a drug screen proved positive for cocaine, cannabis and benzodiazepines. He was referred to Westway's rehabilitation service for ongoing treatment of his mental illness and rehabilitation before discharge to the community. He was not offered a place as his presentation was considered too unstable. The verbal

feedback from the rehabilitation service also indicated that he appeared unwilling to engage with them.

5.47 On 31 July 2002 DB was interviewed by Dr Harty and another member of staff on Gresham 2 ward. He minimised his fluctuating mental state and his use of drugs. As the interview progressed he became increasingly argumentative and aroused and expressed paranoid ideas towards Dr Harty and the Croydon forensic team. Because of the previous altercation with another patient on Gresham 2 ward, DB was moved to Alexandra house ground floor ward. Also at this time his case was considered by a manager's hearing and his detention under section 3 of the Mental Health Act 1983 was upheld.

5.48 In August 2002 Dr Harty attended a child protection case conference in Hastings. A decision to remove DB's children from the at-risk register was made. On 15 August 2002 DB was seen by Sam Edfe (social worker from Hastings children and families social services department) and Teresa Mullaney (Croydon community forensic team leader). Sam Edfe told DB she would not support supervised access to the children. After this meeting Teresa Mullaney said DB expressed further paranoid ideas in relation to the Croydon community forensic team and Dr Harty specifically. DB's medical records show that he screened positive for cannabis the day after the visit with Sam Edfe and Teresa Mullaney.

5.49 On 21 August 2002 DB was referred to Dr Vince for possible transfer to Hume Ward, low secure unit at the Springfield Hospital.

5.50 DB remained on Alexandra ground floor ward between August and October 2002.

5.51 On 13 October 2002 DB was admitted to Gresham 2 ward after an appointment with his psychiatrist. He was described as aggressively aroused, argumentative, irritable and extremely volatile in his actions. This was seen as an indication that his mental health was relapsing.

5.52 On 24 October 2002 DB was admitted to Gresham psychiatric intensive care unit on section 3 of the Mental Health Act 1983, after allegations that he had assaulted a female (stranger) in a public place. No charges were made.

5.53 On 19 November 2002 he was discharged from Gresham 2 ward.

5.54 On 30 December 2002 DB collected his medication from the community team base.

5.55 On 8 January 2003 DB went to the base to collect his medication. It could not be dispensed at that time so it was delivered to his home by his new care coordinator James Forrester (community psychiatric nurse and care coordinator).

5.56 On 21 January 2003 DB went to the community base to collect his medication. He told staff he had been smoking cannabis and had also consumed alcohol on a regular basis for some time.

5.57 On 28 January 2003 Dr Fiona Cowden (locum staff grade psychiatrist) and James Forrester (community psychiatric nurse and care coordinator) visited DB at home. His behaviour was described as appropriate and he was given one week's supply of medication. He complained of physical discomfort and there was a discussion about his substance misuse and the link between this, his health and offending. His care plan was also reviewed at this meeting.

5.58 On 12 February 2003 DB did not attend his outpatient appointment with Dr Cowden, and another appointment was arranged for 26 February 2003.

5.59 On 26 February 2003 he attended his outpatient appointment and said that he was re-establishing relationships with his family, but had broken up with N. He also said he felt unwell due to a recurrent urinary tract infection. He refused to provide a urine sample. He was given one weeks supply of medication.

5.60 On 19 March 2003 he attended another outpatient clinic and was seen by Dr Cowden and James Forrester. DB complained of abdominal discomfort and weight loss. A urine sample was requested, but due to lack of sample pots in the clinic this was not possible. Instead, a letter was sent to DB's GP (Dr Cutting) requesting that a urine sample be taken together with tests for DB's serum Lithium level. His risks were assessed as unchanged. He did not provide a urine sample to the GP as requested.

5.61 On 27 March 2003 DB was seen in outpatients by Dr Fazia Mufti (consultant psychiatrist) who reduced his Clonazepam medication from 1mg to 0.5mg daily. Dr Harty was on leave so Dr Mufti became DB's RMO.

5.62 On 9 April 2003 DB cancelled his outpatient appointment with Dr Cowden.

5.63 On 17 April 2003 DB attended his outpatient appointment with Dr Cowden. Verona Edwards (approved social worker) was also there. DB refused to give a blood sample and said he had given one a couple of days previously. He would also not give a urine sample.

He reportedly made derogatory remarks about Dr Cowden. DB was considered to have been euthymic with no psychotic symptoms. After the meeting, a check with the biochemistry department revealed that DB's last blood test was in November 2002.

5.64 On 20 April 2003 at 9.55pm DB attended the emergency liaison mental health service at Mayday Hospital's A&E department and requested a detoxification programme. When we interviewed DB he suggested that he was aggressive and violent when he attended A&E, but we can find no evidence of this. He was seen by the triage nurse who referred him to the psychiatric nurse Joseph Lordes. DB said that he lied to his consultant psychiatrist, was in fact using cocaine daily, had run out of funds and was requesting a detoxification programme. Joseph Lordes said DB presented *"as coping generally well"*. Therefore the plan was to discharge DB to his home address, refer to the Oaks Resource Centre and for DB to utilise the helpline if he needed further advice.

5.65 At 2.32pm the same day he attended the A&E department at Mayday Hospital complaining of a headache. He was given analgesia.

5.66 At approximately 8pm the same day PG was tortured and murdered by DB and an accomplice. It was alleged that PG was a paedophile and owed drug money to DB's accomplice.

5.67 On 21 April 2003 DB went to the A&E department at Mayday Hospital complaining of assault and head laceration, but left before being seen. At approximately 11pm he went to Croydon police station and confessed to the murder of PG.

5.68 On 22 April 2003 DB was interviewed by the police regarding the murder of PG. Teresa Mullaney acted as the "Appropriate Adult" for DB at this interview. At some point during this interview she became aware that she knew the victim of the homicide.

5.69 Later on 22 April 2003 DB was charged with the murder of PG.

5.70 At the time of the homicide DB's diagnoses were schizoaffective disorder and a mental and behavioural disorder due to multiple drug use (cannabis, crack cocaine and alcohol).

DB's relapse indicators

5.71 DB's relapse indicators in January 2003 (available in Medical Notes and letters from Dr Cowden to Dr Cutting [GP]) were identified as:

1. Non-compliance with medication
2. Disengagement with aftercare arrangements
3. Escalating substance misuse, in particular crack cocaine
4. Chaotic lifestyle
5. Conflict in close interpersonal relationships
6. Elevated mood with pressure of speech and uninhibited behaviour
7. Persecutory delusions with a homophobic content
8. Delusions regarding paedophiles
9. Delusions of reference regarding the general public
10. Threatening or aggressive behaviour
11. Auditory hallucinations
12. Carrying weapons
13. Self harm – lacerations.

6. Findings

SLaM's board-level inquiry

6.1 Fran Bristow, borough-wide services manager, carried out the initial fact-finding review and completed the management report on 25 April 2003. A board-level inquiry was subsequently commissioned by SLaM. This was chaired by Diana Robbins a non-executive director at SLaM. The panel consisted of Elaine Rumble (deputy director of nursing, SLaM) and Dr Eleanor Cole (consultant psychiatrist, SLaM). The board-level inquiry was held on 19 February 2004. Key staff associated with the care of DB gave evidence. Other documentary evidence was considered. The final report was produced on 29 September 2004.

6.2 The board-level inquiry report provides this information:

- Process of the inquiry
- Terms of reference
- Overview of the incident
- How the incident was initially investigated
- Information on DB's personal and psychiatric history (chronology of main events in his care)
- Issues discussed at the board-level inquiry
- Conclusions
- Recommendations.

6.3 The board-level inquiry report does not:

- Provide a systematic analysis using a RCA or similar methodology
- Clearly outline good practice in the report, as stated in the terms of reference.

6.4 The board-level inquiry report provides information on eight issues and is provided here as it appeared in SLAM's own internal investigation report:

1. Compliance with treatment
    - The panel asked about DB's personality and how well the staff knew him. His case was complex with input from the trust's mental health services since 1999, when he first became unwell.
    - Staff said he was a difficult client to manage in the community. They said he was clever and articulate but challenging when unwell. Staff thought he was able to work the system and knew how to present himself to receive the services he needed at any particular time. Staff also thought he was occasionally dependent on the team particularly regarding his partner's children and care orders. On these occasions, staff felt their support was appreciated by him.
    - Several staff said that while he was generally charming, there were odd occasions when they felt extremely threatened by him even when they thought a relationship had been established.
    - Staff said DB did not wish to be monitored by the forensic team and would often question staff regarding his treatments and the professional knowledge of staff. He did not want to see junior staff and demanded that only senior staff manage his care.
    - It was known that he held strong views about paedophiles.
    - Staff said he was generally compliant with his treatment although there were occasions when he did not attend appointments to get his medication and staff would have to visit him at home. At other times he would apparently deliberately arrive at his appointment early and then create a disturbance by pressurizing staff regarding the time and speed at which they worked.

2. Forensic service provision
    - The internal investigation panel wished to be clear about the forensic service provided to DB, and how this service was developing.
    - The forensic team working in Croydon provides an assertive outreach service for their clients. This was part of the service provided to DB. The service was able to provide a level of support to meet the individual's needs. This could be daily if required.
    - Over the three years prior to the incident the team's caseload had increased to almost double without any additional staff. It was becoming

difficult for the team to adequately provide the service necessary to their clients particularly in view of the diversity of needs and level of deprivation in the local area. It was recognised by management that staff stress levels were increasing.

3. Accident and emergency liaison team
    - The internal investigation panel was interested in the liaison service provided by the trust and the events that took place when DB presented in A&E just before the incident. Of particular interest was DB's mental state.
    - The emergency liaison mental health team (ELMHT) covers the A&E department at Mayday Hospital and provides a service to clients who deliberately self harm and who are referred via A&E for a mental health assessment.
    - The trust intended to change the role and function of the ELMHT from 1 April 2004 when the HTT was to incorporate the ELMHT. This was to streamline the service and reduce the number of assessments of individual clients. It was proposed that all referrals via A&E be made to the HTT would provide ongoing support to clients after they leave the hospital.
    - DB was well-known to the team. When he presented on 20 April 2003 they were able to access his updated records via CCS. Although DB was asking for help at this time the team thought he did not appear unwell, that he was looking for work, and seemed to be more concerned about getting money for drugs than getting help with any deterioration in his mental state. The team compared his behaviour with his previous assessment and did not think he should be detained under section of the Mental Health Act 1983, nor admitted as an informal patient.
    - DB asked for detoxification and was referred to the addiction team. Although he was irritable about not being given drugs or money it is reported that he appeared to be resigned to this fact.
    - The team was asked if their view had changed with the knowledge of the incident. The team was adamant that they would still make the same decision. This is supported by the panel.

4. Medium secure service
    - The panel identified several issues in relation to the medium secure service available in the Croydon area: availability and access to the service, the

relationship with the local services and commissioners, and whether it was considered that a Shaftesbury clinic placement would have helped DB.

- The services are currently provided by the Shaftesbury clinic and commissioned by the PCT as part of South West London and St George's mental health trust. As this is not part of the South London and Maudsley NHS trust services it has been difficult for the local team to build up a relationship with the service. This has improved since DB was first referred for a medium secure placement in 1999, but the team believed there would be advantages if the trust could be commissioned by the PCT to provide these services to the Croydon area.
- The local management enquiry report recommended that better links should be established with the PCT in relation to the inpatients secure services but this work has not progressed.
- The staff team thought DB would have benefited from a long-term placement in a secure unit, but this was not possible because a place in the Shaftesbury clinic was not available.
- The team suggested that DB had a secondary diagnosis of personality disorder, which might have been more obvious if a long admission with a planned therapeutic programme had been available to him. An open ward would not be able to provide such a programme.

5. Appropriate Adult role
    - There were questions about how this role was undertaken, and whether there was a policy for staff taking on the role to follow.
    - The panel heard that the role of the Appropriate Adult had not been clearly defined at the time of the incident. The local management report recommended that an Appropriate Adult policy was developed, but nothing had been progressed.
    - As well as clearly defining the role, it was considered that the policy should include guidance on the grade of staff chosen to take on the role. It was the opinion of the panel and team manager that they should be a 'G' grade or over.

6. Dual diagnosis
    - There was a question about how adequate the liaison was between the forensic teams and the drug addiction team.
    - In cases of dual diagnosis, the forensic team has access to the drug addiction team who co-work cases. However when a case is referred to the drug addiction team, case management is provided by the addiction service. The emphasis is then on drug addiction, not the clients mental state.

7. Record-keeping
    - The panel found the team's record keeping to be excellent. Staff trained to use ECS had easy access to client's records. There were concerns about the trust's decision to stop further staff training until the Patient Journey System was in place. This means new staff are not easily able to use CCS to get information about their clients or to update the system after providing treatment.

8. Staff support
    - All staff said they had received good support from the trust over the incident but that its horrendous nature had left those who had a lot of contact with DB badly affected.

6.5 The board-level inquiry report provides nine recommendations:

1. The trust should consider a review of the caseload and staffing levels in the Croydon forensic team.
2. Access to secure beds should be improved in the local catchment area. The trust should pass this recommendation to the PCT responsible for commissioning secure placements.
3. It needs to be made clear how differences in opinion should be resolved when patients are referred to medium secure services.
4. A clinician providing a second opinion should be of a similar or higher competency level than the referring clinician.
5. The trust should consider developing an Appropriate Adult policy for CMHT staff, which sets out the process to be undertaken and specifies the staffing grades appropriate for this role.
6. The trust should reconsider its decision to put further CCS training on hold until the implementation of the 'Patients Journey'. This is because staff are unable to access information previously recorded on CCS.
7. Care co-ordination by the most appropriate service for dual diagnosis clients must be made clear particularly in cases involving drug addiction and severe mental illness.
8. Training should be provided to help clinicians assess and manage patients with personality disorder and substance misuse during times of crisis.
9. Local guidance should be provided on the long-term management of patients with anti-social personality disorder.

6.6 An action plan was generated for the DB case on 14 April 2005.

6.7 There is evidence that the recommendations identified as part of the board-level inquiry have been acted upon. Chapter nine of this report reviews SLaM's progress on implementing the recommendations.

6.8 There is no indication that the board-level inquiry panel made contact with DB or his mother.

6.9 There is no indication that the board-level inquiry panel made contact with PG's next of kin.

Independent systematic review findings: issues and comments

C1 ***The terms of reference are concise and appropriate for this type of investigation.***

C2 ***An appropriately skilled and multidisciplinary investigation panel was convened for this incident. The panel was chaired by a non-executive director and so possessed necessary authority and credibility.***

C3 ***In broad terms the information and people that the panel had access to seem acceptable. However the documentation reviewed has not been formally specified, therefore it is difficult to track exactly what has and has not been reviewed.***

C4 ***A narrative chronology which identifies the main care provided to DB has been used. This is appropriate for a board-level inquiry report. His psychiatric history is usefully summarised, but some of the issues identified are not then adequately explored. For example, there is reference to DB being considered unsuitable for admission to a forensic rehabilitation ward but the report does not say who took that decision.***

C5 ***The chronology is not complete. This is a flaw in the investigation approach as key areas of concern can be easily missed. It is considered good practice to generate a tabular timeline or something similar to map the case fully. This provides a good working document in which areas of concern can be fully examined.***

Comment – new recommendation

C6 ***We suggest that a tabular timeline or similar should be used in all local incident investigations so a more complete chronology is established.***

C7 *We identify a number of key areas for consideration. These do not follow the CMP definition, but they do represent the key areas of concern. We agree that the essential issues have been identified in this incident.*

C8 *We believe however that other issues could have been identified as part of this internal incident investigation:*

1. *The Croydon forensic mental health team did not take random urine and blood samples from DB, or take any action when he refused testing.*
2. *The trust did not adequately involve and support DB's mother with his care and treatment, including after the incident.*
3. *The trust did not support its staff appropriately.*

C9 *Each of these issues are outlined from paragraph C14. Points 1 to 3 resulted in further recommendations being made.*

C10 *We are aware that SLaM had investigated the issue of DB being assessed in A&E by the ELMHT at Mayday Hospital on 20 April 2003 but we felt that we needed further assurance that these assessments were complete and provided appropriate help and support for DB. On balance we felt that care and treatment had been appropriate at the time.*

C11 *Formal identification and analysis of contributory factors did not take place in this incident investigation. However, we do not feel this prevented the panel from identifying areas for future improvement, through targeted recommendations.*

C12 *Overall this case was managed well and the record-keeping of staff is of a high quality, though we criticise the manner in which those records were then filed. However there were some omissions in care and treatment which should be identified in this section of the report. It is important that the report's conclusion is balanced, and does not give stakeholders reason to question the trust's judgement.*

C13 *Nine recommendations are outlined in the report, which link well with the issues identified. It is useful that the trust has a reasonably small number of recommendations to focus its attention on. We believe that some of the recommendations could be merged to provide more specific and targeted*

recommendations. It would be helpful for the trust if they put timeframes or completion times on recommendations.

C14 *We suggest an additional component to recommendation five which says the trust should consider developing "an Appropriate Adult policy for CMHT staff which sets out a process to be undertaken and specifies the staffing grades appropriate for the role" This recommendation should be extended to make it clear when it is appropriate for a member of staff taking on the role of Appropriate Adult to relinquish that responsibility, and what they should do in this situation. Our reason for making this addition is the situation which faced Teresa Mullaney, the team leader for Croydon community forensic team, when she took on the role of Appropriate Adult for DB when he was interviewed at the police station regarding the homicide. At that time it was usual practice for either the patient's care co-ordinator or the team leader to take on the Appropriate Adult role. Because of things DB said during the interview, Teresa Mullaney realised that she knew the victim. The probability of the Appropriate Adult knowing the victim of a homicide is remote and was probably not an issue that either Teresa Mullaney or SLaM had considered. We do not criticise them for this. However, it is important that SLaM now make sure staff know what to do if they believe they have any connection with a victim(s) of a mental health patient.*

C15 *The action plan was developed two months after the board-level inquiry meeting. This is a significant time delay, which prevented the trust from dealing immediately with its failures. The staff and other stakeholders involved in the care of DB were not involved in the development of the recommendations or subsequent action plan. It is considered best practice to engage all stakeholders involved in service delivery (including patients and their care-givers and victims care providers if they are amenable) in the development of recommendations and action plans. These individuals are at the centre of the service and are likely to have a view as to what solutions will work most effectively. Engaging them also increases the likelihood of sustained action after the immediate tragedy.*

1. *Care management problem: Failure to undertake random urine and blood sampling from DB.*

C16 *We do not fully agree with the board-level inquiry's finding that DB was "generally compliant" with his treatment. One of DB's main risk indicators was "taking crack cocaine". We found that in the six months before the incident DB did not have his urine or blood tested and analysed for illicit drugs. Dr Fazia Mufti and Dr Cowden both requested these samples (see table below), but on each occasion DB either refused or provided mis-information.*

Date	*Detail*
12 November 2002	*Blood sample provided for analysis. DB inpatient on Gresham 2 ward (result unknown).*
28 January 2003	*Request for urine screen made - DB refused*
26 February 2003	*Request for blood and urine sample - DB refused and when questioned said he would bring a specimen at a time specified by him*
8 April 2003	*Request for urine sample - no bottles at the forensic team base*
17 April 2003	*Request for urine sample - DB said he had given blood 2 days earlier, which in fact had not occurred*

C17 *SLaM has a clear drug testing policy of which staff had a good working knowledge. In a letter dated 27 February 2003 to Dr Cutting from Dr Cowden locum staff grade psychiatrist "… I then asked him to give a specimen for a urine drug screen, which is a normal procedure with many patients under the care of the CCFT. The nature of our screening policy is that specimens should be taken at random times specified by us in order to monitor illicit substance use and compliance effectively."*

C18 *DB often got defensive and angry when asked for urine and blood samples, particularly with Dr Cowden who he considered to be junior due to her staff grade status. This was one way in which DB manipulated situations to his advantage.*

C19 ***DB is an extremely intelligent, effective communicator who knows how to manipulate people and systems. In our interview with DB we asked him about the blood and urine testing he received. He knew they were trying to get samples from him and he worked around SLaM's testing*** **"… I used to skirt around it. One thing about cocaine is that it stays in the system for about 3 days. So if I had an appointment on let's say Wednesday, I would turn up on a Friday and wash it out with water, so it wouldn't be in the blood or urine system….. I was totally non-compliant".**

Comment – new recommendations

C20 ***We recommend that staff should be given clear guidance in the form of an escalation policy on what to do if a patient continues to refuse to give blood or urine samples.***

C21 ***We recommend that for patients with an identified risk factor of drug use, testing should not only be random but an expected part of their care. This should be clearly explained. Patients should also be told that an adverse inference will be drawn if they fail to give a sample, or otherwise circumvent the testing process. It should be explained that in such circumstances the team might not be prepared to maintain them in the community and might recourse to a hospital admission.***

2. Care management problem - failure of the trust to adequately involve and support the victim or perpetrators family after a homicide.

C22 ***DB's mother and her family were significantly involved in the care and treatment of DB when he was a patient of Dr Annear's at Warlingham Park Hospital from 1991. Yet from about 1998/9 their involvement with SLaM's mental health services became virtually non-existent. We are sure this had much to do with DB wanting to control the situation and limit the involvement of his family. But after the homicide, trust representatives should have met with DB's family to offer sympathy, and to explain options for support, and the local investigation procedure.***

C23 ***We could find no evidence that the trust tried to make contact with PG's family after his murder, which we consider poor practice. We have not spoken with PG's family, but this was not through lack of effort. PG was a previous user of mental health services (for over six months before the incident) and the next of kin***

specified in his records were not family. The individuals we wrote to did not reply to our requests. When we interviewed Teresa Mullaney, who had a personal connection with a friend of the deceased, we asked if she might be able to provide a contact address, but she could not.

Comment and recommendation

C24 ***We recommend that the trust should communicate with the victim's and perpetrator's families immediately after an incident to offer condolences, explain the trust's investigative processes and, if appropriate, offer an apology and support.***

3. Care management problem - failure of the trust to support some of its staff.

C25 ***When DB was interviewed at the police station following the murder of PG, Teresa Mullaney acted as the Appropriate Adult. DB's description of what happened to PG was horrific and at some point during this interview Teresa Mullaney realised she might have had personal knowledge of the victim of DB. SLaM provided a de-briefing session after the incident. An incident review meeting a couple of months later was led by a psychologist so that people involved in the incident could share and learn from their experiences. This was a commendable support strategy which would have met the needs of most staff. However, due to the nature of the homicide and its personal resonance with Teresa Mullaney due to knowing the victim, these meetings caused huge amounts of further distress to Teresa Mullaney. When we interviewed Fran Bristow (Teresa Mullaney's line manager) we asked what she knew about Teresa Mullaney's connection with the victim and about the support offered to her. Fran Bristow had become aware that Teresa Mullaney knew the victim and she realised that Teresa Mullaney was upset by what she had heard and the effect this had had on her personal life. We felt confident that Fran Bristow had done as much as she could offering a number of support options to Teresa Mullaney, which she refused. Whilst we appreciate that Teresa Mullaney has to take some individual responsibility for her own psychological needs, we do not feel that SLaM as an organisation did as much as they needed to support her.***

C26 ***We appreciate the sensitive and confidential nature of Teresa's knowledge of the victim. This emerged as our investigation progressed. We would have expected someone at SLaM to have given us this information before we caused further upset to Teresa Mullaney by sending a letter asking her to attend a witness hearing. We would have approached Teresa Mullaney in a more sensitive way.***

Comment – new recommendations

C27 ***We recommend that the trust develops intelligent and targeted support strategies for staff after serious untoward incidents.***

C28 ***We also recommend that when independent reviews are commissioned the trust should tell the commissioners/review team of any specific personal issues as soon as possible.***

4. Care management problem - We were concerned that the A&E department did not provide effective help and support for DB when he presented on two occasions immediately before the incident. However, this has to be taken in the context that DB was aggressive on presentation.

C29 ***DB presented at A&E on two separate occasions on 20 April 2003 requesting a detox and later analgesia for a headache. On both occasions he became verbally abusive and physically threatening when he did not get what he wanted. DB was seen by the ELMHT which covers the A&E department of Mayday Hospital. It provides a service to clients who deliberately self harm and who are referred via A&E for a mental health assessment. It is important to note that DB was not a patient who usually self-referred to A&E, therefore it was out of character for him to do so on 20 April 2003. Greater weight should have been placed on this although we recognise that relevant information may not have been available to the service.***

C30 ***Medical records were only partially computerised at this time and it would not have been easy to establish DB's specific risk factors and respond accordingly. However, since 2003 the CCS system has been replaced with the EPJS. EPJS is meant to record all interactions and data associated with a particular patient and is therefore a more complete resource. Overall we were impressed by this system when we reviewed it and felt that if it had been available in April 2003, the A&E department might have had more robust information to assess DB. However, while risk information would be contained in EPJS, we found it could be stored in a number of different places, making searches and information correlation more difficult and reducing the effectiveness of clinical decision-making in certain circumstances.***

C31 ***We feel that the ELMHT dealt appropriately with DB on 20 April 2003. However a more responsive system of follow-up and support in a crisis could have helped DB. We are pleased to learn that the trust has developed a HTT, which is able to provide on-going support to patients when they leave hospital.***

7. AA

Family history

7.1 AA was born on 25 March 1955. Her mother suffered from depression and took a number of overdoses before her death in 1995 from non-Hodgkin's lymphoma. AA suffered physical and emotional abuse from her father who was an alcoholic and died in 1997 from myocardial infarction. When AA left school, she worked as a shop assistant and cleaner. She left to care for her baby daughter and has not worked since.

7.2 AA was married between 1987 and 1994, but is estranged from her ex-husband, the father of her daughter. She reports that she lost custody of her daughter in 1994 when she was three years old. AA's daughter moved back in with her mother in May 2004. Her daughter was 14 years old at the time of the incident on 19 January 2005. AA had contact with social services at intervals between 1989 and 2002.

7.3 AA has a diagnosis of borderline personality disorder with major depression complicated by alcohol dependency. The diagnosis of borderline personality disorder emerged over time. She has a long history of impulsive acts of self harm, including overdoses and cutting, and violence when drunk. She stopped drinking between 1995 and 1997 but started again in January 1997.

7.4 AA's early warning signs of relapse are: alcohol misuse, deliberate self harm (primarily cutting but also overdoses and other risk-attended behaviours), social isolation, withdrawal and self-neglect, together with presentations to A&E departments in apparent crisis when she would say she had taken an overdose, or ask to be admitted.

Forensic history

7.5 In 1992 she was cautioned for being drunk in charge of a car, for assaulting a police officer and for drunk and disorderly behaviour. In 1994 she was fined for obstructing the police. In 1998 she received a two year probation order for assaulting a police officer. She also served seven days in prison for this offence. In 1998 she received a five day prison sentence for failing to appear in court. Later in 1998 she was sentenced to three years and six months for grievous bodily harm and affray after a serious assault while intoxicated. This assault, with several others on a woman in Queen's Gardens in Croydon, was the result of an argument over a cigarette. The victim suffered permanent brain damage. AA was released on licence in February 2002 but the licence was revoked in September 2002 and she went back to prison to finish her sentence.

Psychiatric history and summary of incident chronology

7.6 AA first started drinking when she was 16 years old.

7.7 AA began drinking daily in 1991. She had her first period of detoxification in Warlingham Park psychiatric hospital in late 1991.

7.8 AA's relationship with her husband had become physically violent on both sides. He left with their daughter in early 1992. The couple were divorced in 1994.

7.9 Between 1991 and 1997 AA had nine admissions to various alcohol units for detoxification.

7.10 She received outpatient treatment for bulimia nervosa between 1994 and 1996.

7.11 On 5 March 1998 AA was admitted to King's College Hospital with an alcohol withdrawal seizure. She discharged herself three days later from the detox programme she had been placed on.

7.12 On 10 March 1998 AA self presented at the emergency clinic as she had lost her medication, Thioridazine 25mg four times daily. The medication was considered beneficial by her doctor for patients who have borderline personality disorder. AA's diagnosis of borderline personality disorder emerged over time.

7.13 On 10 April 1998 AA and several accomplices attacked a woman when she refused to give them a cigarette. They punched and kicked the victim and left her with serious neurological problems that required hospital treatment and rehabilitation.

7.14 In late December 1998 AA was admitted to the Maudsley Hospital under the care of Dr Davies for depression and suicidal ideation. She was discharged in early February 1999 because she returned to the ward when drunk.

7.15 On 20 October 2001 AA was reviewed by Dr J Sauer at HMP Holloway (SHO to Dr Travis consultant psychiatrist) and assessed for suitability and possible transfer to ES1 Ward. This followed five suicide attempts.

7.16 On 15 February 2002 AA was released from prison on licence. This was revoked in September 2002 when she returned to prison to continue her sentence.

7.17 On 28 January 2003 AA was released from prison on probation. She initially engaged with substance misuse services and was noted to be "dry" and considering going into rehabilitation. An assessment was arranged for 11 February 2003. At this point AA was on enhanced CPA.

7.18 On 18 February 2003 she was taken to Mayday Hospital A&E by ambulance as she was very disturbed, asking those around her to kill her. AA claimed that she tried to set fire to her hair. This was followed by further presentations over the next five days.

7.19 On 23 February 2003 AA was admitted informally to the Bethlem Royal Hospital after she was found jumping in front of cars. Dr Raj Persaud (consultant psychiatrist) became responsible for her care. She was discharged four weeks later on 21 March 2003 because she had returned to the ward drunk on two occasions. A further brief admission followed over the weekend of 22-24 March 2003, when she discharged herself.

7.20 On 25 March 2003 AA was admitted to hospital after the implementation of section 136 of the Mental Health Act. This section permits a police officer who, finding a person in a public place who s/he thinks may be mentally disordered, can detain them and take them to a place of safety for an assessment by mental health professionals. The place of safety varies, but it is usually a police station or hospital. The mental health professionals

must invoke other provisions of the Act if they believe it necessary to make the person stay in hospital. On this occasion AA was drunk, and saying she wanted to kill herself.

7.21 Two weeks later on 7 April 2003, AA's substance misuse worker (Prema Nazran) was told of her admission. The substance misuse worker started to attend ward rounds from 16 April 2003. A plan was made for AA to complete an alcohol detoxification programme. She was told she would be discharged if she left the ward.

7.22 On 23 April 2003 an application was made for detention under section 2 of the Mental Health Act. It was noted that her behaviour gradually improved and she appeared more settled.

7.23 On 22 May 2003 she was assessed and accepted by Mount Carmel rehabilitation unit in Streatham and placed on the waiting list for a bed. There was a discharge CPA meeting and AA remained on enhanced CPA but documentation was vague. Early warning signs were identified as:

- alcohol misuse
- deliberate self harm (primarily cutting, but also overdoses)
- social isolation, withdrawal and self neglect
- presentations to A&E departments reporting overdose or requesting admission to hospital.

7.24 On 5 June 2003 AA was discharged to Mount Carmel residential rehabilitation unit in Streatham. The plan was to continue seeing her as an outpatient. She was reviewed by Dr Persaud's SHO, Dr Ogakwu on 27 June 2003. She engaged well with her allocated worker Prema Nazran from Croydon social services substance misuse team who was assisting with AA's social and housing needs. Prema Nazran was listed as the care coordinator at this time.

7.25 On 1 July 2003 AA was referred to the Cawley Centre at the Maudsley Hospital that specialises in personality disorders. AA was not accepted as a patient at the Cawley Centre because she had no fixed abode and had not completed her alcohol rehabilitation programme.

7.26 On 13 August 2003 she was discharged from Mount Carmel because she had drunk alcohol, was getting up late and was not taking her medication.

7.27 AA moved into bed and breakfast accommodation and kept in touch with Prema Nazran, who reported that she had not drunk alcohol for some time.

7.28 On 21 August 2003 AA self referred to the Oaks (addiction service) by telephone. An assessment was offered for 22 September 2003.

7.29 On 23 September 2003 Prema Nazran telephoned AA as she had missed her appointment at the Oaks the previous day. Prema Nazran discussed the referral to Cawley Centre with the duty worker at Westways. An appointment was made for AA to attend the Cawley Centre in November 2003.

7.30 On 16 October 2003 a letter was sent to the substance misuse service telling them the Oaks had discharged AA for failing to attend two pre-arranged appointments.

7.31 On 23 October 2003 AA was seen by the SHO. She was abstaining from alcohol and was undertaking voluntary work in South Norwood.

7.32 On 3 November 2003 Prema Nazran contacted Dr Persaud's secretary to advise that AA was soon to be housed and her case closed by the substance misuse team. At this time the substance misuse team were leading on AA's care and treatment. AA took up a new tenancy on 10 November 2003. On 12 November 2003 Pauline LaForge from North West CMHT at Westways Resource Centre became her care co-ordinator.

7.33 On 21 November 2003 Pauline LaForge saw AA for an assessment at Westways. It was noted that AA was in touch with her daughter, who was very attentive to her. AA was still abstaining from alcohol and coping well. Pauline LaForge reviewed AA's CPA (where she assumed AA was on standard CPA) and updated the documentation on CCS on 26 November 2003. The level of contact was agreed at one to three contacts per month.

7.34 Between 28 November 2003 and 2 February 2004 AA was seen on three further occasions, once by a duty worker as Pauline LaForge was off sick.

7.35 On 12 February 2004 AA phoned to cancel her appointment with Pauline LaForge as she was feeling physically unwell. It was agreed that AA would phone the week after to make the appointment. No further appointments were arranged and Pauline LaForge did not follow this up.

7.36 On 6 April 2004 AA attended her outpatient appointment with the SHO. She said her daughter had been living with her since March 2004. During this period Prema Nazran

maintained infrequent telephone contact with AA, until the case was completely closed on 27 August 2004.

7.37 On 1 July 2004 AA attended her outpatient appointment at Westways CMHT with Dr Persaud's SHO.

7.38 AA began to drink again in September 2004, becoming increasingly abusive to healthcare staff. On 21 September 2004 the police contacted the substance misuse team because she was at the police station. They were told she was now under the care of the North West CMHT. Later that day AA was seen at Mayday A&E department claiming she was suicidal. The cause of this appeared to be that after a drinking binge, her daughter had left home to stay with her father. She also admitted to regular use of cannabis (up to 15 joints per day). Eventually the police removed AA from the hospital premises. She was taken to South Norwood police station and the A&E liaison team contacted North West CMHT to alert them to the situation. A duty worker took the call and planned to make a home visit as Pauline LaForge was absent. Before the visit could be made, AA was taken to Bethlem Royal Hospital on a section 136. She was assessed by a doctor and Dr Persaud was contacted. He advised that she should be offered admission, observed for withdrawal symptoms and he should be notified before benzodiazepines were prescribed.

7.39 She was admitted informally to Alexandra ground floor ward and a detox regime was agreed, but two days later she went absent without leave (AWOL). She was returned to the ward from A&E the next day, where she had presented herself. She tested positive for morphine. On 9 September 2004 it was agreed to discharge her as she was drinking and taking illicit drugs. When she was told, she became abusive.

7.40 On 30 September 2004 AA presented at A&E in the early hours of the morning demanding to know the whereabouts of her daughter, who had been missing for three days. Her daughter was in fact safe and staying with her father. The A&E liaison staff made contact with the substance misuse team, who advised that AA had a care coordinator from the North West CMHT. It is unclear whether the CMHT were contacted.

7.41 AA began to attend A&E frequently and became increasingly abusive to staff. She was reported to be drinking daily. A&E contacted her allocated care coordinator Pauline LaForge on 7 October 2004 about the frequent presentations, but it is unclear what the response was.

7.42 On 8 October 2004 she was brought to the A&E department of Mayday Hospital by ambulance, due to suicidal ideas. On 9 October 2004 she was admitted to Gresham 2 Ward for detox and was reported to be experiencing chronic and extreme levels of distress and anxiety. She also complained of auditory and visual hallucinations. Her appearance was increasingly unkempt and chaotic and she proved difficult to manage. It was agreed to transfer her to Alexandra ground floor ward. Her management plan was discussed with Dr Persaud who agreed that if she wished to leave she should not be stopped as she was not detainable under the Mental Health Act, and if she returned intoxicated she should be discharged.

7.43 On 19 October 2004 she was discharged from Alexandra ground floor ward as she was drunk, abusive and threatening to staff when she returned to the ward. Following a case conference with social services about her daughter, staff were told they should not assist AA to make contact with her daughter, as she could face an injunction. She had also threatened to kill her ex-husband (father of her daughter) and his mother.

7.44 On 20 October 2004 AA presented at the A&E department of St Thomas's hospital, saying she was suicidal. Contact was made with Dr Persaud, who agreed that AA should make an appointment to be seen the next day at Westways Resource Centre.

7.45 On 21 October 2004 AA and her sister were seen by Dr Persaud at Westways Resource Centre. AA was agitated and verbally abusive. Dr Persaud told her that countless attempts to help her had failed, and she needed to take some responsibility for her own life. He referred her to the HTT. Later that same day AA was assessed at home by the HTT. Several implements and sharp objects were found in the house during the assessment which AA said were for self defence. She was still requesting admission for detoxification. It is not clear from the notes what proactive involvement HTT had in AA's care after this.

7.46 In the early hours of 22 October 2004 she presented at Mayday A&E asking for help with alcohol detox. Her behaviour when she attended A&E was deteriorating and she was verbally abusive and hostile to staff, which required the police to be called to remove her. She was reminded that she had an appointment at the Oaks at 9am that morning, but she did not attend. A further appointment was offered for 10am on 28 October 2004. AA did not attend this appointment either and was discharged back to her GP, as she had not attended two appointments. AA remained on enhanced CPA at this time.

7.47 On 15 November 2004 she presented to the social services substance misuse team in an agitated state. She was told her case was closed and she should attend the initial contact service.

7.48 On 25 November 2004 she was seen by Dr Persaud. He observed that she was still depressed with alcohol problems but not suicidal, and that she should continue on medication.

7.49 At the beginning of December 2004 she did not attend a pre-arranged outpatient appointment, but continued to present at A&E demanding admission for detox. She was often in the company of her victim, a former SLaM patient. They were often drunk, verbally abusive, using foul and racist language and behaving in a threatening way towards staff. They would refuse to leave the A&E department and the police would be called.

7.50 On 16 December 2004 AA was seen by Dr Persaud's SHO and given a prescription for Venlafaxine (an antidepressant) and lactulose (a laxative).

7.51 On 20 December 2004 AA was assessed at the Oaks and was noted to be "*drinking daily, type and amount vary; suicidal; paranoia leads to aggression.*" A referral to the addiction service was made.

7.52 On 4 January 2005 AA was seen by the addictions consultant, Dr Ball. Her request for detox was discussed, she was assigned a key worker and it was agreed that an inpatient detox appointment would be arranged. AA was advised to contact social services regarding follow-up appointment. The next day she was brought into A&E by ambulance after drinking and taking a suspected overdose of Venlafaxine. She stayed in the high dependency unit overnight for observation. A report was sent to the Oaks and AA was given an appointment for February 2005. She claimed to have suicidal thoughts but denied any current plans to kill herself. She was dishevelled yet calm and pleasant. She was considered psychiatrically fit for discharge.

7.53 On 11 January 2005 she was allocated a case worker by social services substance misuse team.

7.54 On 13 January 2005 AA did not attend her appointment with the SHO at Westways. A further appointment was offered for 1 February 2005. The next day she presented at Taberner House (substance misuse). She was drunk and abusive and was therefore spoken with over the telephone, rather than being allowed into Taberner House. She asked for admission to a psychiatric unit because there was a four-week waiting list for rehab detox

and she needed support with her mental health. It is reported that Pauline LaForge informed AA that she no longer came under Westways because she had moved house and had been discharged. She was told to go to Tamworth Road CMHT. AA said she could not go back to her flat and was staying with a male friend, who ended up being her victim.

7.55 Later on 13 January 2005 the substance misuse worker arranged an appointment to see AA and called Pauline LaForge for clarification on AA's current care. Pauline LaForge said she had contact with AA in the past when she was more stable but that she did not have an active role with her at present. She went on to say that AA had moved, no longer came within the North West catchment area, and therefore should be referred to Tamworth Road CMHT. She also confirmed that there had been no formal handover of the AA case to that team. She said AA was on standard CPA, but could not say whether a consultant was seeing her. She agreed to find out further details including: name of consultant(s), any future appointments and medication.

7.56 On 19 January 2005 at 8.15pm, AA was taken to St George's A&E department from police cells after her arrest with two other people in connection with the fatal stabbing. She was assessed then discharged into police custody. On 22 January 2005 AA was charged with the murder of her partner. She pleaded not guilty. He was fatally stabbed in the chest, and received 15 minor stab wounds to the face. AA and her victim were both drunk at the time of the incident. AA was found guilty of manslaughter at the Old Bailey in August 2005 and sentenced to life imprisonment. The two other people arrested at the time of the incident were released without charge.

8. Findings

SLaM's report on the investigation into the circumstances surrounding the death of AA's victim

8.1 Abigail Fox-Jaeger and Karen Cook formed the investigation team and collected evidence about both AA and her victim from social services, addictions and adult mental health services. The information was collated into a timeline, which was considered at a serious incident evaluation (SIE) meeting on 30 June 2005. The SIE facilitator was Dr Siobhan O'Connor. People who attended the meeting were Dr Persaud (consultant psychiatrist), Pauline LaForge (care co-ordinator), Iqbal Surfraz (community psychiatric nurse), Jeanette Nixon (approved social worker), Anita O'Shea (student nurse), Abigail Fox-Jaeger (risk and Mental Health Act complaints co-ordination manager), Mark Carroll (Oaks resource centre), and Michael Larkin (team leader). The SIE meeting considered the events in the timeline and corrected any errors. Recommendations were made. The investigation team then reviewed the timeline, identified CMPs and good practice, and developed root causes and recommendations. The investigation report was made available on 4 October 2005.

8.2 The investigation report contains:

- An executive summary
- Introduction
- List of contributors
- Patient history (background, key events before the incident, information on the incident)
- The methodology
- Problems and good practice
- Conclusions including root causes
- Recommendations and action plan
- Appendices (timeline and SIE meeting notes)

8.3 The investigation report identifies seven main CMPs. The bullet points below outline the specific areas of concern which have been abstracted from SLAMs original investigation report.

1. Fragmented knowledge of patient forensic history
    - No concise ongoing history of AA.
    - Brief risk screens were completed on a number of occasions. There was only one risk assessment that gave details of first index offence, although these were incorrect.
    - There was no evidence that any of the teams knew the details of her previous offence. Some information was in the notes but was not formulated or shared between teams.
    - Teams were aware that she had served a prison sentence for a serious assault, but the details were incorrect.

2. No referral to forensic services for assessment
    - No advice was sought from forensic services. The only mention is in a letter in 2002 from a liaison doctor, referring her to the Community Team, which makes reference to the possibility of the forensic team being involved but leaving the decision up to the CMHT. AA was never seen by this team as her licence was revoked and she went back to prison.
    - Presentations in October 2004 to A&E and Westways were much more aggressive and confrontational.
    - AA makes threats to kill her ex-husband and his mother.

3. Child protection issues not widely understood or investigated
    - None of the teams involved were aware that AA's daughter was on the child protection register.
    - There was some awareness of AA's daughter moving in with her, but it did not appear to be considered important.
    - The risks that a breakdown in her relationship with her daughter could cause her to start drinking again do not appear to have been appreciated even though it was highlighted in her care plan as a relapse factor.
    - There was no contact between care coordinator and Children's Services to support the re-established relationship. AA's daughter was as keen as AA to make the relationship work and initially stay with her.

- AA's daughter was living with her from March 2004. No checks were made with Children's Services about these arrangements or to alert them of risks.

4. Care planning
   - Other services were not informed of AA's hospital admissions and her substance misuse worker was not told immediately.
   - Between February and April 2003 there was a chaotic pattern of admission where AA discharged herself, or was discharged because of drinking and disruptive behaviour. There were also numerous presentations to A&E during this time.
   - The only evidence of a CPA meeting was during an inpatient episode in June 2003.
   - There is some evidence that her CPA was updated after an initial assessment by her care coordinator in November 2003, but this was not as a result of a review meeting.
   - There was no CPA meeting after this. The care coordinator believed her involvement was short term. Even though AA remained on enhanced CPA, the only services offered by her care coordinator were regular outpatient appointments and a response if she was on duty when AA presented in crisis.
   - AA relapsed in September 2004 when her daughter left. She re-established the same pattern of chaotic admission, discharge, then presentation at A&E as had happened the previous year. No consideration appeared to have been given to a rehab replacement, and/or a referral to substance misuse as she was described as "unsectionable".
   - On 5 October 2004 there was no clear plan of intervention if AA did not attend her seven day follow-up appointment.

5. Communication between teams
   - On 13 August 2003 there was no communication about discharge from rehab to the CMHT.
   - There was some ambiguity about the substance misuse team's involvement between November 2003 and August 2004. They said they were closing the case but remained involved until August 2004.

- In August 2004 the substance misuse team did not tell other services they were closing the case. There was an assumption that support was being offered by the CMHT.
- The care coordinator believed she had closed the case in February 2004 but this was not documented or passed to other teams.
- In January 2005 the care coordinator informed as the substance misuse team that she had no active role with AA, and that AA no longer came under North West community mental health team because she had moved. No transfer or CPA had taken place. Inaccurate information was given to substance misuse worker concerning the ongoing involvement of the consultant/CMHT and CPA status
- The care coordinator told the substance misuse worker that she had been told not to see AA again as she had been abusive at their last meeting. There is no evidence to support this statement and no indication of alternative arrangements. There is also no evidence that this matter was discussed in supervision.

6. Referral to Cawley Centre turned down
    - There was no challenging behaviour or personality disorder service in Croydon. This may have been beneficial to AA.
    - Her referral seems to have been dropped and there was no alternative plan in place in case she was turned down. She carried on being followed up by SHOs in the outpatients clinic.
7. Enhanced CPA protocols were not followed **(IDENTIFIED AS THE PRIMARY PROBLEM)**
    - A care co-ordinator from mental health services was not allocated to a patient on enhanced CPA.
    - No formal review of AA's care plan took place.
    - Misinformation was given to the substance misuse team about the team's involvement and the level of CPA.
    - No formal handover took place when it was suggested that AA came under a different CMHT.
    - Discussions were not recorded on CCS.
    - The care co-ordinator continued to be the named worker who had no active involvement for 10 months.
    - The care co-ordinator had a large caseload.

- Limited supervision records were found and there does not appear to have been any system for effective monitoring and supervision
- The care co-ordinator was not required to account for the management of her caseload to her line manager.

8.4 SLaMs investigation report identifies the following four root causes.

1. A care co-ordinator from mental health services was not allocated to a patient on enhanced CPA (the care co-ordinator wrongly believed AA was on standard CPA).
2. The care co-ordinator showed a lack of competence in carrying out her responsibilities for a client on enhanced CPA.
3. The care co-ordinator Pauline LaForge did not manage her caseload sufficiently. There is no evidence that a caseload review took place as part of her supervision.
4. The organisation underestimated the complexities of managing a dual diagnosis patient.

8.5 The investigation report provides four recommendations.

1. CPA policy must be followed by all staff.
2. The role of the care co-ordinator must be clearly understood by all members of the team allocated this role.
3. The team leader must follow the supervision policy and manage caseloads effectively. The team leader must ensure performance management systems are followed when under-performance is identified.
4. A joint protocol should be written and agreed between substance misuse services and mental health services outlining joint working procedures and lead responsibility for dual diagnosis clients.

   There is a further recommendation in the executive summary, which is identified in point five, below. The action plan in the investigation report only deals with the first four recommendations.
5. A joint protocol should be developed between Children's Services and Mental Health Services to enable better communication and shared practice for children whose parents have mental health problems.

8.6 An action plan was generated for the AA case on 4 October 2005.

8.7 There is evidence that the majority of the recommendations in the investigation report have been acted upon. This is reviewed in section 9 of this report.

8.8 SLaM has produced documents for us to review containing information on the progress the trust have made on the recommendations. The fifth recommendation from the investigation report has been added to the recommendation list in these documents, but changed to: "ensure that all staff are conversant with SLaM child protection policy".

8.9 On 24 July 2006 Steve Davidson, Croydon borough director, provided an update on the recommendations made after the investigation into the death of AA's victim and conviction of AA for Homicide. A further update with detailed information on policy developments and evaluation information was provided to the independent review team on 2 August 2007, for both the AA and DB incidents.

8.10 There is no indication that the investigation team sought contact with either AA or the family of AA's victim.

Independent systematic review findings: issues and comments

C30 ***The terms of reference are concise and appropriate for this type of investigation.***

C31 ***The investigation team was helped by a senior member of SLaM staff and the investigation team had some knowledge in conducting an investigation.***

C32 ***In broad terms the members of staff the panel spoke to seem acceptable for an internal inquiry. However including the victim's family, the perpetrator and her GP could have provided greater clarity on the incident. The investigation report does not specify exactly what medical notes or procedures were reviewed as part of the investigation. It is therefore difficult to comment on the completeness of this part of the investigation process.***

C33 ***A narrative chronology which identifies the main care provided to AA has been used in the report, which is considered to be entirely appropriate for an internal investigation report. A more detailed tabular timeline has been provided as an appendix. The tabular timeline provides information on the details of the event, supplementary information, data source and any data gaps. It would be advisable in future investigations to include information on the care management and causal factors. This would make the timeline a more useful tool in problem identification and analysis.***

C34 ***The investigation identifies a number of CMPs or themes. Each problem is then broken down to give specific examples. For example:***

- ***No communication about discharge from rehab on 13 August 2003 to the CMHT***
- ***Not all contacts were recorded e.g. telephone calls between substance misuse and CMHT etc***

C35 ***This type of theming of problems under a main heading is highly effective in an incident investigation report and should make the causal analysis part of the process more effective.***

C36 ***Some of the key CMPs are not phrased appropriately for analysis. For example the problem of "care planning" was identified, but what was it about the care planning that was a problem? It is only when you analyse the sub issues that the CMPs become clear.***

C37 ***The staff involved in the incident did not take part in care management problem identification or validation.***

C38 ***The staff involved in the incident did not take part in any causal analysis of the CMPs.***

C39 ***The staff involved in the incident did participate in forming recommendations, which constitutes good practice in incident investigation. However this is difficult before the completion of significant causal analysis work.***

C40 ***The investigation report suggests that a human error classification framework, and fishbone diagrams were used to analyse the problems to produce the root causes. There is, however, no evidence of this analysis in the report or other documents received from SLaM. It is considered good practice (NPSA 2004 Root Cause Analysis Training) to include this information (or examples) in the report appendices.***

C41 ***The investigation team identified good practice as part of the investigation process, but it is unclear how this information was communicated back to staff. It is suggested that the clinical governance or risk management departments could feedback through the action plan part of the investigation process.***

C42 ***Any robust and accurate investigation centres on data gathering to produce a timeline, identification of CMPs, then analysis of CMPs for causal factors. The causal analysis allows root causes to be found. Recommendations and associated action plans are produced to deal with the root causes. This process was not followed as recommendations were generated before the CMPs had been identified and causal analysis completed. We do not consider this to be good practice.***

C43 ***There is some ambiguity in the investigation report as to the final set of recommendations and associated action plan. For example the recommendation concerning safeguarding children was omitted from the Trusts internal investigation report, but picked up again in the progress on recommendations created by S Davidson (0206)***

C44 *The investigation report and its associated action plan was produced 10 months after the incident. This delay limits early organisational learning and reduces the likelihood of preventing similar incidents in the future.*

C45 *The action plan template in the internal investigation repost is robust and links the recommendation with the action. The actions themselves are based on the premise of being Specific, Measurable, Achievable, Realistic and Time-limited (SMART). The template then provides spaces for information on the partner agency involved, named responsible person, completion date, evidence of completion and traffic light priority system. None of this latter information was provided and in subsequent updates on progress, this specific template has been lost to show just progress and timescale.*

C46 *On the progress of recommendations document dated 24 July 2006 it is difficult to ascertain the validity of some of the progress made. For example, for the recommendation "CPA policy to be adhered to by all staff", the progress was stated to be "All clients receiving care under enhanced CPA are allocated a care co-ordinator". The timescale was identified as "achieved". Several of the other recommendations at this stage were recorded as work in progress. The progress on recommendations will be further reviewed in section 9.*

C47 *We agree with the main themes (CMPs) identified by the trust's own internal investigation. However we believe there are two other CMP themes that are relevant in this case. 1. Lack of multidisciplinary team input and leadership in the care and treatment of AA; and 2. Failure to manage the discharge of patients with borderline personality disorder, who are in crisis, to keep them safe.*

1. Care management problem: lack of multidisciplinary team input and leadership in the care and treatment of AA.

C48 *This CMP problem has been further analysed to determine its causal or contributory factors. We completed a "five why analysis" for the "lack of multidisciplinary team input in the care and treatment of AA". This is in appendix D. This analysis is quite simplistic and identifies the main contributory factors. Pauline LaForge was the care coordinator for AA from 12 November 2003. From this period until 12 February 2004, she saw her two or three times. Their appointment on 12 February 2004 was cancelled by AA and it was agreed that AA would make an appointment the next week. This did not happen. We have seen no evidence that*

Pauline LaForge then followed AA up. Pauline LaForge's view was that she had discharged AA but her recollections as to when this might have happened, and the process adopted, are vague. Normal procedure in the team for discharging a patient on standard CPA would be to have a multidisciplinary meeting before deciding whether to discharge. If a patient was on enhanced CPA, there would first be a meeting to downgrade them to standard CPA and then a further multidisciplinary meeting to discharge. AA was on enhanced CPA, so should not have been discharged anyway, but irrespective of that a multidisciplinary team meeting was not held for AA before her discharge. This was a deviation from protocol.

C49 *We are concerned that a care coordinator can take on this role for a patient, but then fail to develop even a basic understanding of their criminal history, diagnosis, RMO, or CPA status. We are aware that Pauline LaForge had a large caseload at the time but we believe that the care co-coordinator should take responsibility for this lack of knowledge.*

C50 *The substance misuse team was involved early in AA's care but this ended in November 2003 when she was transferred to North West CMHT. However Nazran Parem maintained infrequent contact with AA until 27 August 2004. It is commendable that the substance misuse team continued to provide support for AA, but it may have contributed to a lack of clarity about which team had overall responsibility for her.*

C51 *We found that from 8 October 2004 to 19 January 2005 AA went to the A&E department of Mayday Hospital 43 times including 10 occasions in the 16 days before the homicide. The A&E department made many attempts to get further support for AA, but the inadequate crisis planning for AA meant an appropriate response was not made. Further to this the HTT told us that "AA presented so frequently and the staff's intention was never to admit her, it was to just try and keep her out, there were many referrals".*

C52 *Patients with borderline personality disorder often know when they are escalating out of control and can take steps, albeit commonly ineffective, to signal that fact and their distress. A properly coordinated multi-agency approach is necessary to better manage the patient and their risks. It is necessary to communicate the relevant risk information, and to proactively plan care interventions and respond to the crises presented by the patient. This was lacking.*

C53 ***The lack of care co-ordination, care coordinator competency and supervision of the care coordinator had a significant impact on the lack of care AA received. Whilst care coordination and supervision policies were available in the trust, we believe that on this occasion the systems and protocols to ensure these processes occurred failed. Responsibility for ensuring that robust systems and protocols are in place and complied with rests with the trust board. Therefore the trust needs to ensure its supervision policy is adhered to through its professional assurance framework and management structures.***

New recommendation

C54 ***The trust board should make sure systems and protocols are implemented and audited so appropriate standards of care coordination and competency of care coordinators are in place in CMHTs.***

2. Care management problem: failure to manage the discharge of patients with borderline personality disorder who are in crisis to keep them safe.

C55 ***On the 7 April 2003 AA's substance misuse worker (Nazran Parem) was informed of her admission. The substance misuse worker started to attend ward rounds from the 16 April 2003. A plan was agreed for AA to complete an alcohol detoxification programme and she was advised that if she left the ward she would be discharged. This prompted the review team to question the approach to discharge patients in such circumstances. It is our opinion that people with borderline personality disorder and related personality difficulties, often signal their crisis and seek intervention. That was part of the pattern of behaviour for AA. Many do so as a result of intoxication, at which times their inhibitions are reduced and risk behaviours increase. It is a common policy for mental health units to discharge people who get drunk, or who leave the unit. The latter creates an illogical situation for informal patients who are free to leave. They are essentially told*** "You are free to leave but if you leave, don't come back". ***We recognise that dealing with drunk patients puts an enormous strain on healthcare staff, and increases the risks to them and to property in the hospital. But it seems strange to us to admit a person whose problems include adverse behaviour (potentially with risk to self and others) when intoxicated, then discharge them if they do get drunk. Often the reason they sought help is because they recognise they have lost control. To discharge them in those***

circumstances could increase the risk to themselves and others, and gives them no reassurance that they will be helped if they present again. We think the implications of this policy should be reviewed. We do not say that it should change, but further exploration is necessary perhaps with a view to differentiating between categories of people to whom such a rule might apply.

C56 *On 13 August 2003 AA was discharged from Mount Carmel because she was drinking, getting up late and was not taking her medication. This again troubles us, for the reasons outlined above. Rehabilitation patients have problems which need solutions including rehabilitation. Common issues include motivation, compliance and alcohol abuse. The questions of how such patients can be engaged, what form of agreement about behaviour can be made, and what sanction can be imposed, are outside the scope of this report but they do need consideration.*

Comment and recommendations

C57 *We recommend that the trust review its policy on hospital discharge for patients with borderline personality disorder and related personality difficulties to consider a better system for patients who are drunk and therefore in breach of conditions for remaining in hospital.*

C58 *In our view the case of AA was complex, though not necessarily unusual. We recognise that it is impossible and inappropriate for senior medical staff to have a personal caseload including every patient, but we are equally convinced that it is not in the best interests of either the patient or the wider service and community for immediate responsibility for complex individuals with multiple needs to be devolved regularly to junior staff. We think there should be criteria whereby consultants or other senior members of staff take a more involved role in the management of complex people to maintain an overview and an expertise of input. We recommend such criteria should be developed or reviewed.*

9. Review of SLaM's progress with recommendations

9.1 Since the two incidents happened, SLaM has identified 14 recommendations to reduce the likelihood of similar incidents in the future. In July 2007 we asked SLaM for an update on progress made with each of the recommendations. SLaM provided a summary document outlining areas of practice in Croydon they felt needed strengthening after the incidents, along with supporting evidence. They identified six priority areas (which are denoted in italic text). Below this we have specified the original recommendation related to the priority areas, so we can assess whether the recommendation has been followed completely. Each priority area and associated recommendations will be reviewed separately.

1. The management and care co-ordination of patients with dual diagnosis

- A joint protocol should be agreed between substance misuse services and mental health services outlining joint working procedures and lead responsibility for dual diagnosis clients. (AA)
- Care coordination by the most appropriate service for dual diagnosis clients must be made clear particularly in cases involving drug addiction and severe mental illness. (DB)

9.2 Croydon's dual diagnosis service is provided by Croydon's social services and is based at the Croydon Substance Misuse Service. Therefore initiatives were implemented to build effective working relationships with services providing care for clients with addictions and mental health problems. Local health and social care commissioners have been involved in this process.

9.3 The dual diagnosis service has delivered structured training to mental health staff over the last three years in an effort to aid understanding and joint working between the two areas. Croydon Integrated Adult Mental Health Services (CIAMHS) staff have also attended a five-day course. To complete the course, participants must attend at least four out of the five days and present a dual diagnosis case study on day five. Participants who failed to complete the course could attend a following course covering any missed days including day five. One-hundred-and-seventeen staff have completed the dual diagnosis training and only 10 staff have failed the course. It has operated since

September 2006 and has continued through 2007. The course has been provided to these wards and teams:

- Assertive outreach team
- Westways inpatient unit
- Westways recovery and rehabilitation team
- Forensic team
- COAST team
- Mental health homeless support service
- Selhurst Road hostel
- West CMHT
- Central CMHT
- East CMHT
- South CMHT
- North CMHT
- The women's service
- Gresham one and two
- Alexandra house ground floor
- HTT
- Psychiatric liaison team

9.4 We were pleased by the trust's commitment to this training and to see that so many staff had passed the course. We were particularly pleased that the forensic team and the north CMHT, who were involved in the two incidents, had good numbers of staff attending and passing the training.

9.5 An inter-agency mapping event was attended by mental health, addiction services, probation and the PCT. A local group chaired by the PCT has been set up. This group is developing and maintaining a strategic overview of the relationship between the adult mental health service and addiction services. Terms of reference have been agreed and the group is also responsible for steering the dual diagnosis service. The group is currently engaged in:

- identifying the interface/pathway between adult and addiction services through a review of the national Models of Care policy;

- piloting ward-based alcohol assessment workshops based on the electronic patient journey alcohol assessment;
- reviewing the current dual diagnosis service with a view to targeting future investment to areas of known risk and need;
- reviewing the different service interfaces in clinical cases.

9.6 The 'Models of Care' policy which describes the pathway between substance misuse and adult mental health for clients requiring access to mental health services has been developed, piloted and has been in use since June 2007.

9.7 This pilot will identify any inconsistencies in the pathway and will provide the information needed to agree a multi service/system protocol. Progress of the pilot was reviewed on 18 October 2007 between the pilot coordinator and the mental health service director. The development of a wider protocol was agreed at the adult mental health/substance misuse partnership working group on 23 November 2007.

2. *Management of people with personality disorders*

- Local guidance should be provided on the long-term management of people with anti-social personality disorder. (DB)
- Training should be provided to help clinicians assess and manage patients with personality disorders, and substance misuse problems during times of crisis. (DB)

9.8 Clients with a diagnosis of personality disorder receive care from the CMHT and in-patient services. Psychological therapy is provided by the Croydon psychological therapy service (CIPTS).

9.9 CIPTS provides direct intervention, delivers training to non-psychological therapy staff, and provides a complex case forum at which clinicians from all CMHT's can discuss psychologically challenging or complex patients. Croydon's integrated adult mental health services updated their existing local psychological therapy provision specifically for individuals with a diagnosis of personality disorder in July 2007. The provision looks comprehensive but still requires CMHT and other staff to access these services appropriately. An evaluation of take-up and a review of other incidents involving clients with dual diagnoses must be part of this analysis. A complex case pilot protocol has been

developed, which appears comprehensive. The trust is keen that the pilot protocol becomes standard protocol once it has been fully tested.

9.10 Workshops on assessing and working with patients with a diagnosis of personality disorder for CMHT staff have taken place. The training uses a "hands on" interactive approach to look at areas including assessing, engaging, moving on and discharging patients who are disturbed and disturbing. The training consisted of five, one-and-a-half-hour workshops in June 2007. Originally two members of each CMHT and other community-based teams were invited. The course was attended by 15 people including staff from North and West CMHTs, the forensic team, the assertive outreach team, COAST (the early intervention psychosis team) and representatives from the rehabilitation and recovery teams. Once again we were pleased that staff from the North West CMHT and the forensic team attended this training because of their involvement in the AA and DB incidents. The course was oversubscribed within a few days of being advertised, but not all CMHTs attended. It has been recommended that the course should be repeated. We endorse the need to run further training in this subject area on an intermittent basis through the year to allow new staff to become better trained.

9.11 SLaM has not been commissioned to provide a specific service to clients with severe personality disorder. The PCT fund occasional placements to the Cawley Centre, a psychotherapeutic day hospital provided by SLaM specialist directorate, or to the Henderson Hospital. This does not meet identified local need particularly for people who need effective evidence-based interventions earlier on in the course of their disorder. SLaM is currently working with their commissioners to develop a strategy for delivering care to people with a diagnosis of personality disorder. Business cases have been developed but have not currently received funding. SLaM suggests that if additional resources are not made available, they will restructure the service so specialist intensive psychological input for people with severe difficulties can be developed. They are also working with the Institute of Psychiatry on a research programme which may increase their capacity to provide psychological therapy treatments to this group.

9.12 We are satisfied that SLaM has made good progress on recommendations associated with the management and treatment of people with a diagnosis of personality disorder. The issue of commissioning new services was not identified as a recommendation with either of the two incidents, but we feel SLaM's work in this area is important given the identified client need.

3. Implementation of CPA

- CPA policy must be followed by all staff. (AA)
- The role of the care co-ordinator must be clearly understood by all members of the team allocated this role. (AA)
- The trust should reconsider its decision to put further CCS (clinical computerised system) training on hold until the implementation of the 'Patients Journey' electronic record system. This is because staff are unable to access information previously recorded on CCS. (DB)

9.13 SLaM has implemented a CPA and EPJS practitioners group which is currently carrying out a local audit and raising issues that will help CPA operations as the process is experienced by patients. They have developed terms of reference for the CPA group, a summary of need and a CPA flow chart. We are satisfied with the work SLaM has undertaken in this area, but are keen for them to consider how EPJS can be refined to provide more intelligent ways of providing data. For example, in both DB and AA's cases it was difficult for the A&E departments to determine the early warning or relapse indicators, and the service and/or person responsible for the patient. When we were provided with an overview of how EPJS worked, we looked at where this information would be located and the risk tabs associated with this data. We found that the information was not always readily available nor in the place where one might expect to find it. Therefore we are keen that work in this particular area is attended to.

New recommendation

9.14 We recommend that the trust reviews where patient risk factor information is placed so it can only be placed in one area of EPJS even if a patient presents to another part of the service.

9.15 The need to follow CPA standards was emphasised to all teams as part of the reorganisation in May 2006 and is contained in core objectives for the practitioner managers, care coordinators, clinical charge nurses and support time recovery workers. We have found these documents to be clear, concise and comprehensive. We are content that SLaM has improved the understanding of CPA in the core objectives, but we are not convinced that the service has a detailed understanding of compliance with CPA.

New recommendation

9.16 We suggest that an evaluation is carried out to establish with greater certainty that compliance to CPA is improving.

9.17 SLaM has reviewed standards in CMHT's and identified the need to strengthen the assessment skills of staff. Initial training was held on 9, 16 and 23 February 2006 for half a day. This is currently being followed up in partnership with the Royal College of Psychiatrists to provide assessment training for community staff. We are pleased that SLaM is continuing this training in partnership with another organisation, as staff need regular updates in this area.

4. Team management and leadership

- The team leader must follow the supervision policy and manage caseloads effectively. The team leader must ensure performance management systems are followed when under-performance is identified. (AA)
- The trust should consider a review of the caseload and staffing levels in the Croydon Forensic Team. (DB)

9.18 Significant issues in the AA investigation were the ineffectiveness of supervision and caseload management. These issues have been addressed in the recent restructuring of the CMHTs and through various leadership initiatives.

9.19 In the service restructure, practitioner manager posts were developed in each CMHT to provide clinical leadership and to work with the team managers in providing supervision to staff. The trust have provided evidence of the work they have completed in this area, which includes:

- the management of staff affected by service change (September 2005)
- the management of community mental health staff affected by change (13 November 2005)
- the job description of the community mental health practitioner manager.

9.20 This has been accompanied by the review and re-launch of local supervision guidelines (February 2007). SLaM has also reviewed management roles, particularly those of team managers and ward managers. These members of staff have been provided with leadership development and support. This was done initially during the service reorganisation but has been extended through a formal programme designed by the general managers and run in partnership with SLaM partners. This training was started in May 2007 and continues until 11 September 2008. After this, action learning sets will start to increase the leadership capability in these staff groups. We are satisfied that SLaM has new organisational arrangements in place to give leadership and clinical supervision to staff. We are also satisfied that local supervision guidelines are clearer about how supervision will be provided. It would be useful for SLaM to assess compliance with this approach.

9.21 All client records are held on an electronic case record (EPJS). Performance reports are taken from this system for further questioning and scrutiny by SLaM staff. Reports are made available in a service summary form, which is reviewed by the management team at monthly information meetings. Team leaders also monitor and review individual care co-coordinator caseloads in supervision sessions. The electronic record allows the supervisor to monitor when the patient was last seen, whether they have had a CPA review in the last year (minimum standard) and whether a care plan has been sent to the patient. Supervisors also use the electronic system to work with a clinician on the standard and content of the case records, risk assessments, crisis and contingency plans and summary of need.

9.22 Croydon inpatient services audit the data on EPJS for current inpatients each week. In relation to CPA the audit gathers information on availability of brief risk screen, date of CPA discharge meeting, and copy of care plan given to patients.

9.23 Croydon has also carried out small scale local audits measuring performance of CPA and risk assessment in areas such as Inpatient Rehabilitation Service (June 2007), Early Intervention team (July 2007) and Recovery and Rehabilitation team (June 2007).

9.24 The trust nursing directorate carried out a trust-wide CMHT practice audit in May 2007. The audit required the production of evidence against a number of standards designed to check compliance with Healthcare Commission standards. In relation to CPA standards the audit focused on evidence of caseload review systems and systems for

allocating care co-ordinators and evidence that all patients have an allocated care co-ordinator.

9.25 The trust has also completed a records audit (February 2007). 1,864 case records were audited. The results were:

- Enhanced CPA -summary of need completed - 86%
- All relevant staff invited to CPA meeting - 82%
- CPA care plans complete - 82%
- CPA review meeting - note of meeting 80%
- Relatives invited to review meeting – 77%
- Revised care plan - 76%
- Multi-disciplinary report - 68%
- Evidence of clinical outcomes recorded - 65%
- Carers assessment complete - 47%

We would suggest that in future SLaM also audits the frequency with which the CPA form is shared with the patient. However, overall we are happy with the progress SLaM has made in the area of team management and leadership.

5. Child protection

- A joint protocol should be developed between Children's and Families Services and Mental Health Services to enable better communication and shared practice for children whose parents have mental health problems. (AA)

9.26 When we reviewed the AA case we were particularly concerned that child protection issues were not managed appropriately within SLaM. We appreciate lack of care coordination was a major area of weakness in this case, but we felt this was not the only area of weakness. For example, when she was an inpatient AA was allowed to make phone calls to her daughter during which she used abusive and foul language. She also made threats to kill. When we interviewed Sue Lewis, the assistant director of nursing and child protection lead for SLaM, we were concerned that her team had reviewed over five years of trust action plans, recommendations and themes from incident investigations, but the recommendation concerning child protection in the AA case had not featured as part of that review. This may have been because the child protection

recommendation in the AA case was added at a later stage and it was not clear in the investigation report that child protection was an issue. We are pleased that Steve Davidson and his team have made sure this recommendation has been accepted in Croydon and the wider SLaM organisation.

9.27 Child protection training is now mandatory for all trust staff working in clinical services and is monitored through the trust education and training committee.

9.28 We have evidence to support the work that Croydon has carried out to increase the profile and understanding of staff awareness of children within their care and contact with adults. A local safeguarding group was set up in July 2006. This group has defined terms of reference and a comprehensive and varied membership. The group produces a report for the SLaM child protection clinical governance committee and the area child protection committee safeguarding board. Meetings are held bi-monthly, agendas are circulated before the meeting and minutes after the meeting. This team has trained local teams and signposting staff about available training in partnership organisations.

9.29 A local safeguarding mental health protocol has been developed and is currently in use. This is a joint service protocol to meet the needs of children and the unborn, whose parents or carers have mental health, substance misuse problems or a learning disability. This protocol was developed in September 2006 and appears comprehensive. A date for review of this protocol would be useful. This safeguarding group has also developed two posters, which have been widely distributed through the organisation. One is designed to help staff understand who to contact if they have concerns, the other is displayed in patient areas. Both the posters are informative and easy to understand.

6. Risk management of complex cases

- It needs to be made clear how differences in opinion between doctors should be resolved when patients are referred to medium secure services. (DB)
- A clinician providing a second opinion should be of a similar or higher competency level than the referring clinician. (DB)
- Access to secure beds should be improved in the local catchment area. The trust should pass this recommendation to the PCT responsible for commissioning secure placements. (DB)

9.30 The complex case forum, mentioned in paragraph 9.9, is a system that allows difficult and complex cases to be discussed. It has been piloted for two months. The trust has found this forum difficult to implement and SLaM plan to extend the pilot by four months. A forensic risk forum has been available since 2004 and a medical risk forum has also been established. In our view the two might usefully merge, since risk management is not the province of any one staff group. It is important that efforts do not take place in isolation and that a multidisciplinary approach to risk management is adopted. An inpatient complex management forum was started in March 2007. It was proposed to pilot this forum for two months, carry out a management team review, then continue for one year. All of these forums give staff the opportunity to discuss and manage difficult cases. One would hope this would provide opportunities to treat and manage patients in different ways. In the DB case it was well known by the Croydon community forensic team that DB was articulate, intelligent and very capable of manipulating situations and discussions with staff who did not know him. Consequently when he was assessed by Dr Diamond and Dr Vince from the Shaftesbury clinic, they concluded that a medium secure placement for DB would not be appropriate. We do not know to what extent, if any, their view was moulded by his ability to project a different persona from the one seen by those who knew him well. The regional adviser, Dr Philip Sugarman became involved in the case when it went to arbitration, and it was agreed that DB should take up a medium secure bed. A manager's hearing at this time allowed DB to leave hospital. We have commented elsewhere on the difficulty encountered by those responsible for his care over the issue of a medium secure placement. We are not in a position to determine whether he should, or should not, have been offered such a place. To do so would only be possible with the use of hindsight. What is clear, however, is that his case was complex and therefore any clinical solution is unlikely to have been simple. There was undoubtedly delay caused by the dispute regarding his suitability for medium security. Therefore we upheld the trust's recommendation that clarity was needed about how to resolve differences of opinion when patients are assessed for a medium secure placement. The trust has introduced formal liaison arrangements between SLaM and South West London and St George's Forensic Services. This arrangement includes access to the PCT for arbitration should there be a difference in opinion concerning a patient's suitability for medium secure care. We note, and consider as positive, that these substantial changes have taken place since the incident occurred.

9.31 We do not know how robust the managers' consideration of the case was or what led to the decision that DB was entitled to leave hospital. It seems unusual for a patient

to be discharged when there was an active debate about his need for medium security. We would expect that the lessons from this case be used in the training of managers who perform Mental Health Act functions in the trust.

9.32 The Historical Clinical Risk (HCR 20) risk management approach has been used in the community forensic team since December 2006. The HCR20 is currently being considered for use with selected cases in the assertive outreach team. It is good that using a formal risk management instrument has been considered, but it is important that staff do not place excessive reliance upon it, since it is an aid to clinical judgement rather than a replacement for that judgement.

9.33 SLaM did not provide us with a progress update on the development of an Appropriate Adult policy for CMHT staff that specifies the staffing grades appropriate for the role. Following our review of Appropriate Adult documentation received from SLaM, we find that SLaM and the Borough of Croydon have had an Appropriate Adult service since March 2003, updated in October 2006. The documents specify that the duty officer, in conjunction with the team leader or duty senior, should decide on the need to refer to the Appropriate Adult service. The documents do not outline the staffing grades considered appropriate for the role. We believe this recommendation has not been acted on. We understand that the local authority is responsible for providing this service, but we would suggest that SLaM work with them on this specific issue.

9.34 It was recommended in the DB investigation that access to secure beds should be improved in the local catchment area and a recommendation to that effect should go from the trust to the PCT responsible for commissioning secure placements. We are aware from discussions with SLaM staff, that there have been significant developments in the commissioning of secure beds. SLaM is currently constructing a medium secure building, which will open in 2008. This development will significantly improve the provision of services for those patients requiring a medium secure placement.

9.35 During the analysis of these two cases, both by SLaM and ourselves, a number of instances of good practice have been identified. Some of these are outlined below:

- Effective and efficient communication with DB's GP (Dr Cutting) after every contact with him. (DB)
- Effective implementation of CPA for DB. (DB)

- Good communication and handover of DB's case to Dr Wapner in Hastings. (DB)
- Effective interaction between Croydon community forensic team and child protection services. (DB)
- Complete and thorough risk assessments completed for DB. (DB)
- Excellent team working and communication in the Croydon community forensic team. (DB)
- Patients were always seen by at least two members of the team, unless a really good risk assessment was completed or the case was to be handed over to the CMHT. This not only aids consistent and clear communication, but the safety of staff. (DB)
- Addictions consultant (Dr Ball) saw AA quickly after the referral had been made from Dr Persaud. (AA)
- Comprehensive notes were maintained by the clinical team when AA was in hospital. (AA)
- The SHO's maintained comprehensive notes of all consultations with AA. (AA)

9.36 We have found no evidence that SLaM has actively commended aspects of care provided by individuals and teams in the DB and AA cases. We believe this is a significant omission by SLaM. Reinforcing aspects of care and treatment that are exemplary motivates staff to maintain high standards of care, many having demonstrated such standards during their involvement in these cases.

9.37 In both cases, the board-level enquiry reports were not produced in a timely way. For example by the time the Croydon community forensic team had access to the report, a large proportion of the staff involved in the incident had left. This inhibits individual and organisational learning, which is not considered good practice. We are aware that systems and processes have improved to make sure investigations are carried out more immediately and reports are passed quickly through relevant committees to the board. It is important for SlaM to maintain their progress in this area.

APPENDICES

Appendix A

List of all documents reviewed

Documents reviewed as part of the AA and DB review

1. Appraisal and Personal Development Review Policy Version 2, June 2006
2. Appraisal and Development Meeting Record, June 2006
3. Croydon Inpatient Services Operational Policy, August (draft)
4. Core Objectives Care Co-ordinators 2006/2007
5. Core Expectations for Teams within Croydon Integrated Adult Mental Health Services 06/07
6. Draft for Obtaining a Forensic Team Assessment, 6 September 2006
7. Adult Protect Policy, Guidelines and Procedures
8. Clinical Governance 2001/2
9. Croydon Community Forensic Team Protocol, January 2004
10. Croydon Integrated Adult Mental Health Services Operational Policy, Community Mental Health Teams, November 2004
11. Home Treatment, Duty Liaison and Bed Management Team Operational Policy, January 2006
12. Emergency Liaison Mental Health Service (ELMHS) Interim Operational Policy 21 August 2002
13. Croydon Home Treatment Team Operational Policy, April 2004 (includes a number of other useful documents as appendices)
14. The Process of Admission and Discharge from Hospital – Staff Roles, Nov 2006
15. Croydon Integrated Adult Mental Health Service – Specialist Day and Outpatient Service for People with Personality Disorder, Draft 5
16. Full Business Case for Bethlem Royal Hospital Secure Unit (Draft) Secta, 15 February 2005
17. General Manager Community Care Job Description, printed July 2006
18. Community Mental Health Team Manager Job Description, printed January 2006
19. Croydon Council Multi Agency Adult Protection Policy, Guidelines and Procedures, Version 2, October 2003
20. Framework for Clinical Risk Assessment and Management of Harm, May 2001 (Amendments to Appendices December 2003)
21. Risk Management Strategy, April 2004 – March 2007

22. Risk Management Strategy, To April 2004
23. Appropriate Adult Service, March 2003
24. Appropriate Adult Service, October 2006
25. Final Draft Croydon Appropriate Adult Service Level Agreement 2004/2005
26. Local Supervision Guidelines, Dec 2006 (which includes South London & Maudsley and Croydon Council Croydon Adult Mental Health Services Supervision Record)
27. Risk Management and Assurance Policy 4 July 2006
28. Risk Rating Matrix, date unknown
29. Framework for Clinical Risk Assessment and Management of Harm, version 3 Reviewed and amended July 2005
30. Clinical Governance Strategy 2004-2006 Version 4, Nov 2004
31. Child Protection Policy Safeguarding Children and Young People, version 2 14 July 2005.
32. Home Treatment, Duty Liaison & Bed Management Team Operational Policy, January 2006.
33. Croydon Council Multi Agency Adult Protection Policy, Guidelines and Procedures, May 2002
34. Croydon Forensic Outreach Service Protocols 2000
35. Croydon Community Forensic Team Protocol, January 2004
36. Draft protocol for obtaining a Forensic Team Assessment, date unknown
37. Formal Consultation on proposed changes to the Croydon Integrated Adult Mental Health Services, date unknown
38. Croydon Integrated Adult Mental Health Service: summary of results from Service Review Consultation, May 2005
39. Adult Mental Health Service Review: the management of staff affected by service change, September 2005
40. Croydon Integrated Adult Mental Health Service (Organisational Structure), date unknown
41. General Manager Community Care Job Description, date unknown
42. General Manager Crisis and Inpatient Care Job Description, date unknown
43. General Manager Complex Care Job Description, date unknown
44. Assistant Service Director Job Description, date unknown
45. Croydon Integrated Adult Mental Health Service Evaluation of 2005/6 Service Review, 27 June 2006
46. Primary Care Referrals to East Croydon Community Mental Health Team, date unknown

47. Terms of Reference for the Croydon Governance , Quality and Risk Executive, Sept 2006
48. Service Review Work Plan: community mental health teams 2006/7
49. AF1 Preparation Checklist for Appraisee (August 2000)
50. AF2 Appraising Manager's Checklist (August 2000)
51. AF3 Appraisal and Development Meeting Record (August 2000)
52. Staff Appraisal and Development Scheme: Staff Guide, date unknown
53. Staff Appraisal and Development Scheme: Managers Guide, date unknown

Appendix B

DB tabular timeline

Key to initials used in timeline

DB	DB	Patient
FB	Fran Bristow	Borough wide service manager
Dr FC	Dr Fiona Cowden	Consultant psychiatrist
VE	Verona Edwards	Approved social worker
JF	James Forrester	Community psychiatric nurse/ Care co-ordinator
MF	Mark Francis	Social worker
PG	Peter Greenfield	Victim
Dr M	Dr MacDonald	Consultant psychiatrist
Dr MH	Dr Mari Harty	Locum consultant forensic psychiatrist
Dr FM	Fazia Mufti	Consultant psychiatrist
Dr W	Dr Weppner	Consultant psychiatrist
Dr CR	Christine Ross	Community psychiatric nurse
MK	Martin King	Community psychiatric nurse
AP	Annette Patterson	Occupational therapist
AB	Alan Bailey	Staff Nurse
CMcK	Chris McKay	Community psychiatric nurse
Dr NO	Dr Nicola Omru	Registrar to Dr Mari Harty
Dr V	Dr Vince	Consultant psychiatrist
JS	Julie Steel	Psychologist

Event Date / Time					
	13-Jun-95	**13-Jun-95**	**13-Jun-95**	**15-Jun-95**	**15-Jun-95**
Event					
	DB burgled mother's house.	DB caught climbing into a woman's bedroom.	DB admitted to Warlington Park Hospital.	DB stabbed B&B Manager.	DB admitted to Warlington Park Hospital.
Additional Information					
	Verbally threatening towards mother.		Transferred from police station due to bedroom incident. DB was aggressive, irritable and reported he had experienced auditory hallucinations. Symptoms considered to be a result of drug induced psychosis.	DB thought he was chatting him up and had abused children.	Felt that the offence had been committed in the context of a relapse of his mental illness. Assessed on a section 35 of the Mental Health Act, at which time he was volatile, explosive in mood with clear psychotic symptoms. Responded well to medication.
Good Practice					
Data Source					
			Board Level Report - check notes	Medical Notes	Board Report - check records

Event Date / Time					
	15-Jun-95	**16-Jun-95**	**August 1995**	**October 1995**	**01-May-98**
Event					
	DB discharged to a forensic hostel (Selhurst Rd).	DB placed on the supervision register under the category of serious violence.	DB moved to a semi-supported hostel.	DB admitted to Warlington Hospital following police arrest.	CPA meeting held to discuss DB's move to independent living facility.
Additional Information					
			Reported to demonstrate good independent living skills, but became quickly demotivated.	DB had allegedly damaged property in his hostel and to have caused criminal damage at a playground.	DB expressed a wish to live independently. It was decided that DB should move to a flat where he could live independently, but with careful monitoring by the community team. DB very compliant and insightful about drug use and impact on his mental health.
Good Practice					
Data Source					
	Board Report - check records		Board Report	Board Report	Board Report

Event Date / Time					
	01-Jun-98	**01-Jun-98**	**01-Dec-98**	**20-Aug-99**	**27-Aug-99**
Event					
	Discharged back to Selhurst Rd as it was considered DB did not need a higher level of observation and he remained here until it closed in June 1998.	DB moved to his own flat and continued to receive support from the mental health team.	DB stopped his medication and disengaged with services and refused to recommence his treatment.	DB arrested for attempted robbery.	DB threatened father and demanded money for crack cocaine.
Additional Information					
		After a short period DB requested a reduction in the frequency of monitoring and had become more resistant towards continuing engagement with services.	Although he did agree to maintain contact with his RMO and his then social worker MF. He was seen on a regular basis at the outpatient clinic by his RMO and CPN until July 1999. Medical notes state continued deterioration with threatening and aggressive behaviour, paranoid delusional beliefs and increasing concerns about his self care. DB denies using illicit substances during this period.		He also allegedly assaulted a 15 year old girl who was with her mother from whom he demanded money. He was arrested and taken into police custody. He was assessed and detained under section 3 of the mental health act on the Gresham psychiatric intensive care unit. On admission his mental state was described as guarded and threatening in manner. DB was reported to have had pressured speech and been agitated in mood. DB also lacked insight and was uncooperative with a voluntary admission.
Good Practice					
Data Source					
	Board Report	Board Report	Board Report - check records		Board Report

Event Date / Time			
	?	**01-Oct-99**	**01-Mar-00**
Event			
	Convicted of GBH with intent and placed on S37 hospital act.	DB assessed by locum consultant forensic psychiatrist (MH).	DB transferred to Gresham 2 ward for therapeutic treatment.
Additional Information			
		DB noted to be hostile, guarded and invasive. He lacked insight into his illness, offending behaviour and the need for continued treatment in hospital. He was referred to the Shaftesbury clinic for assessment for transfer to medium security. However despite agreement by his social worker, Dr MH and DBs treating responsible medical officer he was not considered appropriate for transfer to a medium security hospital. DB was subsequently referred for an assessment by Whitley 3 Ward - which is a forensic rehabilitation ward at the Bethlem Royal Hospital. he was considered unsuitable due to his poor insight into his mental illness and offending behaviour. Again concerns were raised as to his need for medium security and longer assessment. The panel heard that Mr DB's case was eventually referred to the regional adviser in forensic psychiatry to adjudicate on his needs, who decided that Mr DB should be placed in medium security, however there were no beds available at the Shaftesbury clinic.	
Good Practice			
Data Source			
		Board report	Board report

Event Date / Time					
	01-May-00	**14-Aug-00**	**22-Aug-00**	**01-Sep-00**	**05-Oct-00**
Event					
	It is documented that DB did not spend much time on the ward and that staff were finding it impossible to work with him in a meaningful and constructive way.	Croydon Crown Court considered an application by DBs defence solicitors to vary the conditions of his bail.	CPA meeting arranged.	DB discharged to his flat with support from the Croydon community forensic team.	DB was admitted to Mayday Hospital after being seen in A&E for lacerations to his arms, following a fall from a window in his flat.
Additional Information					
		This meant that DB was given new conditions, which stipulated that he should live at his flat and receive visits from the Croydon community forensic team. As a consequence of this a CPA meeting was arranged for 22nd of August 2000 where DBs discharge plans were discussed.			Seen by TM (team leader and CC), DB alluded to the fact that his flat had been broken into by someone he knew. DB requested that TM contact the housing officer to ensure the place was made safe.
Good Practice					
Data Source					
	Board report	Board report	Board report	Board report	Board Report TM Witness statement

Event Date / Time					
	06-Oct-00	**09-Oct-00**	**10-Oct-00**	**11-Oct-00**	**18-Oct-00**
Event					
	TM receives a phone call from DBs brother. He wants DB to be transferred to Poole, as he is concerned that he is not getting proper care and would be taken out. Arranged to meet DB's brother at Mayday the next day with the keys to the flat.	TM picks up keys from Talbot house flat, DB's brother met TM there.	DB's brother rang West ways saying he wanted DB to be taken into hospital straight away as he believed him to be paranoid and his life was in danger from the Yardies.	DB gave his depot at Westways.	Domiciliary visit with Dr Harty and TM.
Additional Information					
		DB was concerned that by going to Bournemouth he would be in breach of his bail conditions.	DB was taken to Mayday Hospital by one of DB's brothers employees who had apparently been a driver for the SAS. TM and Dr Owen reviewed DB on his arrival at Mayday he was found to be well on examination and able to account for his actions.	DB reported feeling safe and had just wanted to relax over the weekend. Apparently his brother had an expectation that DB should always be on the go and DB felt he was unreasonable.	He appeared well, flat was in a state, little furniture. DB informed them that his girlfriend was pregnant and that he wanted to move to Hastings to be with her.
Good Practice					
Data Source					
	TM Witness statement	TM witness statement	TM witness statement	TM witness statement	TM witness statement

Event Date / Time					
	25-Oct-00	**26-Oct-00**	**27-Oct-00**	**06-Nov-00**	**15-Nov-00**
Event					
	DNA outpatient appt.	DB called to say he had been unable to get back from Bournemouth for his appointment and arranged to see TM the following day.	DB attended West ways and TM gave him his depot injection and provided a urine specimen.	DB was reviewed by locum consultant forensic psychiatrist (MH).	DB CPA held.
Additional Information					
			Depixol 60mg. Spoke about his worry concerning his court case which was due in November.	It is documented that DB did not elicit any psychotic symptoms and also explained that he was unhappy with his medication. Dr MH agreed to change DBs medication and he was commenced on all oral antipsychotic medication (Olanzapine 10mg daily). DB was advised to continue to take lithium and procyclide as required at a maximum of 5mg three times daily.	
Good Practice					
Data Source					
	TM witness statement	TM witness statement	TM witness statement	Board Report	TM Witness statement

Event Date / Time					
	22-Dec-00	**03-Jan-01**	**10-Jan-01**	**28-Feb-01**	**07-Mar-01**
Event					
	DB DNA outpatient appointment.	DB seen by Dr MH, consultant psychiatrist at Tamworth Road Resource Centre.	DB seen by Dr MH, consultant psychiatrist at Tamworth Road Resource Centre.	DB reviewed by Dr MH locum consultant forensic psychiatrist.	DB attended a CPA meeting at Tamworth Road Resource Centre.
Additional Information					
					DBs mental state remained stable and his mood was settled. DB had denied suffering from auditory hallucinations.
Good Practice					
Data Source					
	Board Report	Board Report	Board Report	Board Report	Board Report

Event Date / Time					
	30-Mar-01	**19-Apr-01**	**24-Apr-01**	**03-May-01**	**16-May-01**
Event					
	DB was reviewed by Dr MH.	DB DNA an outpatient appointment with Dr W consultant psychiatrist of Ashen medium, secure unit Hastings.	T M receives a phone call from Pauline Westcott, CPN Hastings, advising that DB now back in London having split up with his girlfriend.	DB DNA an outpatient appointment with Dr W consultant psychiatrist of Ashen medium, secure unit Hastings.	Dr MH reviewed DB with Dr H and his community psychiatric nurse.
Additional Information					
	At this meeting DB informed Dr MH that he had recently moved to Hastings to live with his partner and her daughter. It was agreed that a forensic services responsible for the Hastings area would be contacted in due course, in order to arrange the transfer of DBs care.		Girlfriend has been admitted to hospital with the baby. TM phones DB which he did not appreciate. Sounded well but difficult to assess properly due to interruptions on the line. Asked his CPN to follow-up.		DB reported that he had returned to Croydon from Hastings approximately 1 month earlier and that his return was instigated by deterioration in his partner's mental health which required her readmission to hospital.
Good Practice					
Data Source					
	Board Report	Board Report	TM witness statement	Board Report	Board Report

Event Date / Time					
	04-Jul-01	**27-Nov-01**	**04-Jan-02**	**17-Jan-02**	**06-Feb-02 - 12.30pm**
Event					
	CPA at Tamworth Road.	TM completes DLA form with DB in PICU, Bethlem Royal Hospital.	Domiciliary visit with AP (occupational therapist).	DB discharged from a supervised discharge order.	DB came in at 12.30 for his four o'clock appointment. Picked up his medication and re arranged his appointment for the following day.
Additional Information					
	Dr MH, CR(CPN), MK (CPN) were present and his mental state was stable at this point.	Co-operative with the procedure.	Girlfriend was present. Showed receipts for items he was going to buy his flat. Wanted to start courses.		
Good Practice					
Data Source					
	TM witness statement	TM witness statement	TM witness statement	Board Report	TM witness statement

Event Date / Time					
	06-Feb-02, 4pm	**07-Feb-02**	**12-Feb-02**	**20-Feb-02**	**27-Feb-02**
Event					
	DB came back to Westways, looked at the DLA forms and left a message for his solicitor about getting parental responsibility for his son.	DB attends with his girlfriend.	DB attends outpatient with staff nurse AB.	TM accompanies DB to Parchmore medical centre by car.	DB collected a week's supply of medication.
Additional Information					
		Presented as being well and happy. Discussed early warning signs in particular aggressive behaviour. Discussed contraception. Went through further benefit forms.	DB has bruises on both eyes and bridge of nose. Had been at a rave in Middlesex with a friend where he alleged he had been attacked and his money stolen. DB reported feeling a little down, and requested help with steam clean but didn't want to go to Thornton health (he had been referred to the Cranstoun project at Parchmore community Centre.	Dr directed questions towards TM rather than DB, which was not appropriate. TM went for coffee with DB he had decided to cool things with his girlfriend as it was important to sort his own life out. Concerned about the welfare of his son. Admitted to having been violent towards his ex-girlfriend and mother of his son at the end of their relationship.	Admits to feeling sad but not depressed. Spoke about being excluded from the children's case conference, he was aware that allegations were made against him for making threatening phone calls to ex-girlfriend. He was concerned about her behaviour and presented to Croydon police informing them that she was harming herself and not looking after the children. He found the police unhelpful which he attributed to his own criminal history. Allowed him to phone solicitor to seek advice on how he should proceed in relation to his children. Advised him to have a physical review of his health.
Good Practice					
Data Source					
	TM witness statement	TM witness statement	TM witness statement	TM witness statement	TM witness statement

Event Date / Time					
	22-Mar-02	**16-Apr-02**	**01-Aug-02**	**06-Aug-02**	**15-Aug-02**
Event					
	DB was admitted to Gresham 2 psychiatric intensive care units under section 3 of the mental health act ward.	CPA in PICU.	TM sees DB on Alex ground floor ward, Bethlem Royal Hospital with CMcK (CPN) for purposes of preparing a report for the manager's hearing on 6 August 2002.	Managers hearing.	TM shows DB the case conference reports from 7 August 2002 and gave him the opportunity to make a comment on them.
Additional Information					
			Feeling tired due to medication he was on. He wanted TM to inform the hearing that he cared for his children and he would financially support them when he could.	TM writes Re: not disclosing minutes of case conference.	
Good Practice					
Data Source					
	Board report	TM Witness statement	TM Witness statement	TM Witness statement	TM Witness statement

Event Date / Time					
	21-Aug-01	**13-Oct-02**	**21-Oct-02**	**24-Oct-02**	**25-Oct-02**
Event					
	Dr MH writes letter of assessment to Dr V regarding low secure bed for DB.	DB was admitted to Gresham 2 ward following an outpatient appointment with his psychiatrist.	Letter from Dr NO (Registra to Dr V) to Dr MH regarding non agreement to accept DB into a minimum secure bed.	DB admitted to Gresham Psychiatric Intensive Care Unit on section 3 of the mental health act.	Risk assessment completed.
Additional Information					
	Dr MH in final paragraph of letter states I am of the opinion that he would benefit from rehabilitation in a less secure setting. Such placement would offer an opportunity to address his substance misuse in a more contained setting in addition to ongoing treatment of his mental illness.	DB was described to have been aggressively aroused argumentative, irritable and extremely volatile in his actions, which it was felt was an indication that his mental health was relapsing.		Following allegations that he assaulted a female (stranger) in a public place. No charges were made.	
Good Practice					
	comprehensive letter				
Data Source					
	Dr MH medical records/statements	Board Report	Letter from Dr NO	Board Report	TM Witness statement

Event Date / Time				
	12-Nov-02	**15-Nov-02**	**18-Nov-02**	**19-Nov-02**
Event				
	DB provided blood sample for analysis.	Letter to Dr MH from Dr V further stating why a secure bed would not be appropriate for DB.	TM writes to tribunal.	TM attends tribunal.
Additional Information				
		In this letter Dr V states that he felt there was very little if anything that could be achieved from further detention. It is clear that DB represents a difficult clinical management problem particularly when he is discharged, although there have been periods of relatively prolonged stability in the past so long as he is compliant with his medication and refrains from illicit substance abuse. Therein lies the principal problem. It is strongly felt by our team that the substance abuse problem is the overarching problem and this is one of the main reasons why we felt that admission to hume ward would be of little value. It does seem very clear that the relationship between DB and yourself has broken down and it is unlikely that of follow up by yourself as RMO would be successful. It was strongly felt that DB does not warrant a forensic involvement and the problems he presents are not at all dissimilar to the problems that such difficult patients present to general adults CMHT. It was suggested that an assertive outreach team would be more appropriate than a forensic mental health team in maintaining compliance and engagement of this patient.		
Good Practice				
Data Source				
	Dr FC Witness statement	Letter from Dr V	TM Witness statement	TM Witness statement

Event Date / Time					
	19-Nov-02	**30-Nov-02**	**05-Nov-02**	**12-Dec-02**	**19-Dec-02**
Event					
	DB discharged from Gresham 2 ward.	DB collected his medication from the community team base.	DB came into see TM and of VE.	DB came in for appointment and to pick up his medication.	DB DNA appointment.
Additional Information					
			Spent most of his time in Leicester, seeing a professional girl, a few details provided. Reported being mentally stable and realised he needed to keep taking his medication. Agreed to be referred for psychology sessions. Informed that he was due in court the following week with matters relating to his children. Reluctant for VE or TM to do a home visit as the place was a mess.	Reported being happy enough with the outcome of the court proceedings in relation to his children. Admitted to spending most of his time away from home but would not give details. Appeared well. Further appointment arranged for 19 December.	
Good Practice					
Data Source					
	Board Report	Board Report	TM Witness statement	TM Witness statement	TM Witness statement

Event Date / Time					
	23-Dec-02	**30-Dec-02**	**07-Jan-03**	**08-Jan-03**	**14-Jan-03**
Event					
	Seen by JS (Asst Psychologist) and TM.	CC (JF) saw DB when he came to collect a week's supply of medication.	CC (JF) saw DB when he came to collect a week's supply of medication - however there was no one able to dispense them.	CC (JF) delivers DB's medication to his flat.	DB DNA Tamworth Rd to collect medication.
Additional Information					
	DB apologised for missing previous appointments with the psychologist and T M last week. He was advised that were he to miss any further appointments he would be offered no further ones. He was annoyed with himself for this especially as he had requested them in the first instance. Thinking of doing a law degree. Spending lots of time with girlfriend. JF became DBs care coordinator at this time.				DB claimed he had found a prescription at home and therefore did not need to come in.
Good Practice					
Data Source					
	TM Witness statement	JF Witness statement & electronic record	JF Witness statement & electronic record	JF Witness statement & electronic record	JF Witness statement

Event Date / Time				
	21-Jan-03	**28-Jan-03**	**29-Jan-03**	**05-Feb-03**
Event				
	DB went to the community base to collect his medication.	Dr FC and CPN (JF) undertook a domiciliary visit.	DNA meeting with CC (JF) to provide a urine sample as previously agreed.	DB attended meeting with CC (JF).
Additional Information				
	DB explained he had split up with his girlfriend on 17th Jan and had returned home. Felt physically unwell, but was reluctant to see GP as suggested by JF as GP had signed a medical recommendation for DB to be detained under the MHA 1983. Had been smoking Cannabis (£10 week) over last 3 - 4 months.	Relationship with a professional woman, appealed against decision denying access to his children (hearing in March), denies using crack cocaine, uses cannabis regularly, alcohol 3 pints every 2 days, advised to attend Oaks (did not meet threshold), advised to attend Cranstoun project (reluctant), compliant with medication and aftercare, euthymic, no psychotic symptoms, self reported abstinence from crack, using cannabis and alcohol, risk of harm to self and others low.	It had been agreed the previous day that DB would attend Tamworth Rd to provide a urine sample.	Collected a week's supply of medication, felt better. Had not provided a urine sample as was suffering from a urine infection. Still smoking cannabis. Things going OK with his partner, but did not have much to do when she was at work.
Good Practice				
Data Source				
	Board report & electronic record	Dr FC (locum staff grade psychiatrist) letter & electronic record	JF Witness statements & electronic record	JF Witness statement & electronic record

Event Date / Time					
	12-Feb-03	**13-Feb-03**	**26-Feb-03**	**05-Mar-03**	**12-Mar-03**
Event					
	DB DNA outpatient appointment with Dr FC at Tamworth Road Resource Centre.	DB came to Tamworth Rd to pick-up weekly medication.	DB attended outpatient appointment at Tamworth Road Resource Centre.	DB came to Tamworth Rd and met with CC (JF).	DB DNA meeting with CC (JF).
Additional Information					
	Further appt organised for 26th Feb.	Saw CC (JF) apologised for missing yesterday's appointment - had been staying with partner and had not received the appt in time.	Euthymic with no psychotic symptoms, self reported compliance with medication, self reported abstinence from substance misuse, does not want to attend Cranstoun project, refusing urine drug screening, split up with girlfriend and was feeling abit down, physically run down. Given a phlebotomy form for Mayday hospital. Provided with one weeks supply of medication.	JF and DB went out for coffee, chatted about childhood and family. DB agreed to give a urine sample, but this was not possible as there were no sample bottles in the clinical room. Agreed to meet next week.	
Good Practice					
Data Source					
	Board Report & electronic record	JF Witness statement & electronic record	Dr FC (locum staff grade psychiatrist) letter & electronic record	JF Witness statement & electronic record	JF Witness statement & electronic record

Event Date / Time					
	14-Mar-03	**17-Mar-03**	**19-Mar-03**	**27-Mar-03**	**03-Apr-03**
Event					
	CC (JF) tel called DB.	DB attended Tamworth Rd and picked up a week's supply of medication.	Outpatient appt at Tamworth Road Resource Centre.	Outpatient appt at Tamworth Road Resource Centre, DB seen by Dr FM.	DB attended team base to collect a week's supply of medication.
Additional Information					
	DB had the flu.		Abdominal discomfort and weight loss encouraged to see GP, calmer than last interview, dislikes the forensic tag which labels him, agreed to give blood specimen for serum lithium levels and a sample of urine, but clinic room is not resourced to provide these services, euthymic with no psychotic symptoms, self reported compliance with medication, self reported abstinence from substance misuse. Seen in conjunction with JF. Risks considered unchanged. Agreed a CPA meeting would be held at the end of April 2003, where discussion about moving DB onto standard community mental health team.	Self reported compliance with medication, weight loss, denies illicit drug use, reported that mental state was stable, but appeared argumentative and irritable, worried that as long as he continues with the forensic team will affect job prospects, keen to be discharged to the local CMHT. To decrease Clonazepam from 1mg to 0.5mg. To be seen again on 15/5/03.	DB in arrears with rent.
Good Practice					
Data Source					
	JF Witness statement & electronic record	JF Witness statement & electronic record	Dr FC (locum staff grade psychiatrist) letter& electronic record	Seen by Dr Fazia Mufti (Consultant Psychiatrist) letter & electronic record	JF Witness statement & electronic record

Event Date / Time					
	09-Apr-03	**17-Apr-03**	**20-Apr-03 - 9:55**	**20-Apr-03 - 14:32**	**20-Apr-03**
Event					
	DNA outpatient appointment at Tamworth Road Resource Centre.	Outpatient appt at Tamworth Road Resource Centre, DB seen by Dr FC. ASW (VE) was also in attendance at this meeting.	DB attended ELMHS at Mayday Hospital requesting detox.	Attended Mayday Hospital complaining of a headache.	DB and "Nick" murdered PG.
Additional Information					
	Arrived early for appt and declined to wait.	Euthymic with no psychotic symptoms, refusing venepuncture and urine drug screen, self reported compliance with medication and abstenence from substance misuse, self reported attendance to GP for investigations of physical problems, does not want to attend specialist drug services. Made derogatory comments to Dr. Following the meeting, contact was made with the biochemistry depts and it was discovered that DB had last had a blood test 12th Nov 2002.	Violent and aggressive.	Analgesia administered.	
Good Practice					
Data Source					
	To be seen by Dr FC letter from administrator on 14th April suggested DNA & electronic record	Dr FC (locum staff grade psychiatrist) letter & electronic record	A&E Triage Notes, DB's witness statement	A&E Triage Notes	Trust investigation report, press releases

Event Date / Time					
	21-Apr-03	**21-Apr-03**	**22-Apr-03**	**22-Apr-03**	**22-Apr-03**
Event					
	DB attended Mayday hospital complaining of an assault and head laceration, left before being seen.	DB attended Croydon Police station and confessed to killing PG.	Letter from Dr FC (Locum Staff Grade Psychiatrist) to GP (Dr Cutting) concerning meeting with DB on 17th April.	Dr Nicholson (FME at Croydon Police Station) is not S 12 approved, therefore requires a second opinion from the team on DB suitability to be interviewed and an appropriate adult to sit in on the interview.	Croydon Social Services Emergency Duty Team Report - request for an appropriate adult for DB at police station.
Additional Information					
				Dr Nicholson felt DB was fit to be interviewed.	
Good Practice					
Data Source					
	Local Management Report for SUI	Local Management Report for SUI	Dr FC (locum staff grade psychiatrist) letter	Electronic records	Electronic records

Event Date / Time					
	22-Apr-03	**22-Apr-03**	**28-Apr-08**	**15-May-03**	**28-May-03**
Event					
	Assessed by Dr MH in the presence of his solicitor to determine fitness to be interviewed.	Appropriate Adult Report completed by Teresa Mullaney (Team Manager).	JF calls Highdown prison to inquire after DB who is on the hospital wing.	Serious Incident Evaluation Meeting Re DB.	CPA Meeting for DB at HMP Belmarsh.
Additional Information					
				Attendees Dr MH (Forensic Team for DB), Dr Hicks (Central East Team for PG), L Joseph (ELMHS), Dr Mufti (Mid Central Team for DB), T Mullaney (Forensic Team).	Attendees Gary Sillifant (Principle Officer), Dr Faisal (Psychiatrist HMP Belmarsh), James Forrester, Community Mental Health Practitioner and Julia Telfer (Forensic Mental Health Liaison Nurse). Apologies Dr Harty (Cons Forensic Psychiatrist), Dr Mufti (Cons Psychiatrist) and Jackie Ashby (Probation HMP Belmarsh)*.
Good Practice					
Data Source					
	Local Management Report for SUI & electronic record		Electronic records		

Appendix C – AA amended tabular timeline

Back ground	Risk History	CPA
Mother died in 1995 from non-Hodgkin's lymphoma, Father died in 1997/1998(?) from myocardial infarction. Physical and emotional abuse from father, he was an alcoholic. In other reports physical abuse denied. Mother suffered from depression and also took many ODs left school in 1977, worked until 1983 when she left to have a baby. Has not worked since.	Dec. 1997: Served 7 days in prison after assaulting a police officer while intoxicated. 1998: Serious assault on a man in a soup kitchen (AA and several others involved) which resulted in him being repeatedly stabbed and beaten and falling into a coma with resultant brain injuries. AA received 3 1/2 year prison sentence for GBH/affray. AA was intoxicated at time of incident. Released on license in February 2002. License revoked on 26/09/2002 and returned to prison to finish her sentence. Presented at A&E on 29.09.02 with PV bleed. Letter in 2002 by Amanda Owen referring to Community Team makes reference to possibility of Forensic Team being involved but leaving decision up to Community Team once assessed.	Last reviewed 25 November 2003 by care co-ordinator.
Long history of borderline personality disorder. Depression E&OH dependence Previous admission in 1998 to KCH with withdrawal fits. Was referred to Norwood team by the Liaison psychiatric services at KCH. Has history of impulsive acts of self harm and violence whilst intoxicated was in Holloway Prison for GBH after stabbing someone, repeated history of overdoses and cutting. Known to Croydon mental health services since 1997 (initially Mayday/Liaison/Crisis Team), although not living in sector under Lambeth team during this period. While on license in 2002 lots of contacts with A&E Dept, feeling depressed and suicidal.	AA is potentially a risk to herself and others when intoxicated. AA is a risk of harm to herself due to impulsive acts, such as running in front of traffic.	Early warning signs - Alcohol misuse. Deliberate self-harm (primarily cutting, but also overdose). Social isolation/withdrawal and self-neglect. Presentations to A&E departments reporting overdose/requesting admission to hospital.
AA has a diagnosis of borderline personality disorder with major depression complicated by alcohol dependency. She has experienced chronic and extreme levels of distress and anxiety. She has a history of deliberate self-harm by cutting, overdose and as a result of impulsive risk-taking behaviour, particularly when intoxicated. She received outpatient treatment for bulimia nervosa between 1994 - 1996. AA was abstinent from alcohol between 1995-1997. Returned to drinking in Jan 1997.	Risk assessment highlighted that lack of contact with daughter increases her distress.	
AA has a 14-year old daughter with whom she is trying to strengthen her relationship. She is estranged from her ex-partner and one of her sisters. One other sister she does keep in contact with at present. Was married between 1987-1994. New partner 1992-1998 left unannounced also had drinking problems.	Probation Officer telephone call to ward 25.02.03 in nursing notes.	
Known since 1989 to Social Services (1989, 1991-1992, 1997, 1999, 2002-).	Thorough risk assessment completed on 26.03.03 while an inpatient.	
	Liaison notes	

Date/Time	01-Feb-02	07-Feb-02	28-Jan-03	04-Feb-03	05-Feb-03
Details of Event	Letter from Dr Tony Davies (AA's Community Psychiatrist) and Richard Sparkes (Lambeth Social Services, Substance Misuse Team) to discuss AA's aftercare when she leaves prison.	Letter from Richard Sparkes to Dr Tony Davies agreeing to her MH support.	Released from prison.	1:1 session with substance misuse worker.	Referral to the Oaks by Substance Misuse worker.
Supplementary Information		Struggling to find her accommodation on her release.		AA would still like to go to Rehab, still has contact with her daughter. AA is staying in B&B.	Dry at present.
Supplementary Information				Substance misuse worker made referral to rehab - AA DNA'd on 10 Feb also DNA'd the Oaks on 11 Feb 03.	
Supplementary Information					
Supplementary Information					
Data Source	Letter from Dr Davies		Medical notes	Substance misuse notes	Oaks notes

Date/Time	11-Feb-03	18-Feb-03	23-Feb-03	23-Feb-03	04-Mar-03
Details of Event	Substance misuse worker telephoned AA.	Taken to A&E by ambulance from B&B, very disturbed, asking those around her to kill her, claimed she attempted to set fire to own hair (no evidence to support this).	Presented to A&E (Mayday) complaining of having taken an overdose of paracetemol.	AA was brought in by the police 30 mins after discharge from A&E as she was found jumping in front of cars and was admitted to hospital informally.	Substance misuse worker telephoned B&B, hospitals (Mayday, Bromley, Guys, Kings College).
Supplementary Information	AA reported that she had not been well. Rehab assessment rearranged.		Later denied OD saying she just wanted admission and was discharged by liaison psychiatrist.		Called MH services who advised that AA had been admitted to Bethlem Hospital.
Supplementary Information					
Supplementary Information					
Supplementary Information					
Data Source	Substance misuse notes	Liaison notes	Liaison notes	Medical notes. Liaison notes	Substance misuse notes

Date/Time	06-Mar-03	21-Mar-03	22-Mar-03	24-Mar-03	25-Mar-03
Details of Event	Substance misuse worker visited AA in hospital.	Discharged from hospital to B&B.	Taken to A&E by the police (not s136).	Took her own discharge from Bethlem.	Taken to A&E by Pastor of Christ Church after she had presented at Church claiming she was suicidal.
Supplementary Information	AA feeling scared and wants to end it. Spending all her time in her room. Prescribed anti depressants.	AA had returned to the ward twice intoxicated.	Suicidal, agitated, self harm. Agreed to readmit to Bethlem over the weekend.		Went missing from A&E. Police informed.
Supplementary Information	Discussed with ward staff AA is cutting herself and breaking plates.				
Supplementary Information					
Supplementary Information					
Data Source	Substance misuse notes	Medical notes. Substance misuse notes	Medical notes	Medical notes	Laision notes

Date/Time	25-Mar-03	26-Mar-03	07-Apr-03	13-Apr-03	16-Apr-03
Details of Event	Admitted to hospital on s136.	Transferred to AHGF informally.	Telephone call from AHGF to Substance Misuse worker to inform of AA's readmission.	Presentation at A&E. Self harm, feeling suicidal.	Substance misuse worker attended ward round.
Supplementary Information	Police report AA called police saying she wanted to kill herself, slashed her wrists, violent to police and members of the public. Intoxicated.	Went AWOL from ward and was returned via A&E or LAS on a number of occasions, said she tried to hang herself in the bathroom, superficial cuts on wrists. Had left ward on occasions and returned intoxicated.		Self discharged on Friday. Readmitted to AHGF.	To complete alcohol detox. By Wednesday. AA has been advised if she does leave the ward she will be discharged.
Supplementary Information					
Supplementary Information					
Supplementary Information					
Data Source	Medical notes	Medical notes	Substance misuse notes	Liaison notes	Medical notes

Date/Time	23-Apr-03	22-May-03	28-May-03	05-Jun-03	27-Jun-03
Details of Event	Ward round.	Assessed and accepted by Mount Carmel Rehab Unit. On waiting list for bed.	Self referred to the Oaks.	Discharged to Mount Carmel (Streatham).	SHO review.
Supplementary Information	Requested transfer of consultant. Told not possible as an inpatient.		AA requested doctor chase up referral to Eating Disorders outpatients.	Much more stable and positive over the previous weeks leading up to discharge. Not drinking.	Presented as OK, no suicidal or homicidal thoughts. Plan to review in 1 month.
Supplementary Information	Section 2 completed. Plan for substance misuse worker to look for rehab placement. Expressed during this admission her fears of living alone. Gradually behaviour on ward improved and appeared more settled.				
Supplementary Information					
Supplementary Information					
Data Source	Medical notes	Medical notes	Medical notes	Medical notes	Medical notes

Date/Time	01-Jul-03	24-Jul-03	11-Aug-03	13-Aug-03	18-Aug-03
Details of Event	AA was referred to the Cawley Centre at the Maudsley by Matt.	Outpatient appt - SHO clinic.	Substance misuse worker liaison with housing department. Case has been closed, will need to re-refer. Supportive letter written. Advised that AA would need to refer herself to HPU on discharge from Rehab.	Discharged from Mount Carmel.	Substance misuse worker telephoned AA. Staying in B&B, not used alcohol since attending Alcoholics Anonymous meeting on Wed. Appt arranged for 21.08.03.
Supplementary Information		Remains abstinent from alcohol, in Rehab placement. Next appt Oct 03.		AA used alcohol while with a new resident, also getting up late, not taking her medication.	
Supplementary Information					
Supplementary Information					
Supplementary Information					
Data Source	Substance misuse file	Medical notes	Substance misuse notes	Substance misuse notes	Substance misuse notes

Date/Time	21-Aug-03	10-Sep-03	11-Sep-03	15-Sep-03	22-Sep-03
Details of Event	Self referred to the Oaks by telephone.	Telephone call from substance misuse worker to AA.	1:1 session between AA and substance misuse worker.	Substance Misuse worker chased up referral to Cawley Centre (application not returned from mental health service). Also chased up Oaks referral who agreed to send assessment appt asap.	Substance misuse worker organised freedom pass for AA.
Supplementary Information	Abstinent from alcohol. Wants day programme. Assessment offered for 09/09/03.	AA missed her appt at the Oaks. Substance misuse worker attempted to rearrange.	AA seems to be doing well not drinking alcohol, staying at B&B. AA to look at college courses.		
Supplementary Information					
Supplementary Information					
Supplementary Information					
Data Source	Oaks notes	substance misuse file	Substance misuse notes	Substance misuse file	Substance misuse file

Date/Time	23-Sep-03	29-Sep-03	16-Oct-03	21-Oct-03	23-Oct-03
Details of Event	Substance misuse worker telephoned duty worker at Westways. Discussed referral to Cawley Centre.	Telephone call from Westways to Substance Misuse team.	Letter to Substance Misuse service informing them that the Oaks had discharged AA for failing to attend 2 pre-arranged appointments.	Substance Misuse worker in telephone contact with AA.	Outpatient appt - SHO clinic.
Supplementary Information		AA has an appt in Nov 03 with SHO. Cannot find referral to Cawley Centre but funding has been agreed.		Informed that her housing application has been approved.	Remains abstinent from alcohol. Tablets ran out 5 days previously and felt depressed and anxious. Doing voluntary work in St Norwood. To be reviewed in 3 months time.
Supplementary Information					
Supplementary Information					
Supplementary Information					
Data Source	Substance misuse file	Substance misuse file	Substance misuse file. Oaks notes	Substance Misuse file	Medical notes

Date/Time	24-Oct-03	03-Nov-03	03-Nov-03	05-Nov-03	12-Nov-03
Details of Event	Substance misuse worker liaison with Housing Dept.	Telephone call between Secretary (NW team) and Substance Misuse Team.	Referral made by Substance Misuse worker to Mental Health Resettlement Team. Appt arranged for 4.11.03. AA informed.	AA met with MH Resettlement Team. MIND furniture arranged. Tenancy agreement, and amenities sorted out previous day.	Care Co-ordinator allocated. Informed Substance Misuse worker.
Supplementary Information	AA was offered a bedsit that she turned down. Substance Misuse worker requesting another offer to be made.	Advised that AA should be housed soon and her case would be closed to the Substance Misuse team. Secretary informed her that a key worker was not allocated to her.			
Supplementary Information					
Supplementary Information					
Supplementary Information					
Data Source	Substance misuse notes	Substance misuse notes	Substance misuse notes	Substance misuse file	Substance Misuse file

Date/Time	21-Nov-03	26-Nov-03	28-Nov-03
Details of Event	Seen at WW to assess, agreed to see and support. AA is remaining abstinent from alcohol and coping well, awaiting results of an appeal for DLA. AA said that she was having difficulties making her money stretch, in touch with her daughter, whom she says is very attentive to her, wanting to stay well in order to offer her daughter some stability, agreed to see next week.	CPA review.	Seen at WW, remains well and coping, going to see about her appeal for DLA, agreed to see next week.
Supplementary Information	AA had taken up tenency on 10.11.03.		
Supplementary Information			
Supplementary Information			
Supplementary Information			
Data Source	CCS - Care Co-ordinator	CCS - Care Co-ordinator	CCS - Care Co-ordinator

Date/Time	05-Jan-04	26-Jan-04	28-Jan-04
Details of Event	Visited her home as she had an appointment with CPN who is sick today. AA told me how ever she was going to cancel her appointment because she been also suffering with flu. Her mood was pleasant and she was pleased to see me. I have told her that CPN will contact her on her returned to work.	DNA phoned AA to ask how she was, not feeling well physically agreed to see 2/2/04.	Substance misuse worker telephoned AA. AA reported feeling depressed. Advised to contact Westways.
Supplementary Information			Substance misuse worker also informed Westways re: AA feeling depressed and concerns regarding her medication.
Supplementary Information			
Supplementary Information			
Supplementary Information			
Data Source	AT, Duty Worker at CMHT	CCS - Care Co-ordinator	Substance misuse file

Date/Time	02-Feb-04	12-Feb-04	19-Feb-04	06-Apr-04
Details of Event	Seen at WW complained of being bored and consequently eating too much, AA has put on a lot of weight. Encouraged her to look at her diet and what foods she was eating gave her some information on the resources that were available, encouraged her to pop into the Fairfield Club and pick up a referral form, also given details on the new womens group. AA said that she would do this and seemed pleased with the opportunities.	DNA phoned not well physically agreed she would phone next week to make a further appointment.	Substance misuse worker telephoned AA. AA is feeling better. GP has informed her that she has cracked ribs. Seemed more cheerful.	Attended OPA.
Supplementary Information				Seen by SHO - Not too bad recently, currently abstenant from alcohol. Daughter has been living with her since March 04 and she has found this helpful. Due to attend a care course at college at the end of the month.
Supplementary Information	Agreed to see in two weeks.			Next appt 3/12.
Supplementary Information				
Supplementary Information				
Data Source	CCS - Care Co-ordinator	CCS - Care Co-ordinator	Substance misuse file	Medical notes

Date/Time	08-Apr-04	20-May-04	01-Jul-04	27-Aug-04
Details of Event	Substance misuse worker attempted to call AA and CC at Westways.	Phone call between AA and Substance Misuse Worker.	Outpatient appointment at Westways CMHT with SHO.	Case closed to Substance Misuse as AA being supported by CMHT (Westways).
Supplementary Information	Left messages for both.	Doing well, not using alcohol, daughter living with her. Had been in contact with housing re 2 bed flat. Reported to be in contact with Westways.		Called AA the day before to confirm still doing well and completed case closure summary.
Supplementary Information				
Supplementary Information				
Supplementary Information				
Data Source	Substance misuse file	Substance Misuse File	Medical notes	Substance Misuse File

Date/Time	14/21 Sep-04	21-Sep-04 (9.50pm)	22-Sep-07 (approx 7.30am)
Details of Event	Phone call to Substance misuse. AA was at police station reporting ex-partner missing.	Seen at Mayday A&E Dept claiming that she was suicidal and had considered jumping from a ground floor window. Smells of alcohol.	Police attended A&E and removed AA from the premises it was understood that she had been taken to South Norwood Police Station.
Supplementary Information	Ex-partner had allegedly taken money out of AA's bank account. AA was reported to have been drinking again.	AA was seen by medical and psych services as she was confused and incoherent. Presentation appears to have been precipitated by binge drinking following which her daughter had left home to stay with her father and this had upset AA. AA mentioned on many occasions that she did not think she had the capacity to control herself. AA was aware that she had a significant history of violence when under the influence of alcohol. AA admitted to regular use of cannabis (up to 15 joints per day).	A Plan was formulated to Contact Community Mental Health Team and inform them of AA's presentation at A&E for the CMHT team to contact Police at South Norwood with regard to follow up.
Supplementary Information	Advised the patient is being seen at Westways CMHT	Reviewed by SHO and discussed with SpR. Referred to medics to exclude organic causes for symptoms but no physical problems were found.	
Supplementary Information		AA became increasingly aggressive and confrontational. She refused to leave the department when he behaviour became threatening.	
Supplementary Information			
Data Source	Substance Misuse File	CCS - Liaison Nurse	CCS - Care Co-ordinator

Date/Time	22-Sep-04	22-Sep-04	23-Sep-04	23-Sep-04
Details of Event	Spoke to Manager of HTT/ELMS re AA's behaviour at A&E and the police having to be called. Sandy spoke to the police and they have given her a public order ticket. (offence), they have released her and the G.P.has given here some Diazapam. I Intended to make a home visit for this afternoon in Pauline's absence.	Brought to hospital on s136.	Assessment by doctor in s136 suite.	Admitted informally to Alex Ground floor following ASW assessment. S136 ended.
Supplementary Information		s136 forms states that the police were called by LAS to a female running in the road, threatening suicide. Needed restraining for assessment. Smelling of alcohol, very abusive, assessment had to be terminated.	Said she was going to jump through her ground floor window as she wanted to get the paramedics and the police to tell her where her daughter was. She had been missing since Sunday. Says she wants her daughter back living with her. Says she sees CC from Westways and that this is ongoing.	Agreed detox regime.
Supplementary Information			Says she lost custody of her daughter when aged 3, says it took her 12 years to get her back. Stayed off alcohol for 2 years and then got her daughter back Feb 04.	
Supplementary Information			Telephone call from Dr Persaud. Offer admission, observe for withdrawal symptoms, Dr Persaud to be called before benzodiazepines prescribed.	
Supplementary Information				
Data Source	CCS - Care Co-ordinator	Medical notes	Medical notes	

Date/Time	24-Sep-04	25-Sep-04	26-Sep-04	26-Sep-04
Details of Event	While on ward tested positive for morphine.	AWOL from ward. Police informed	Phone call received from PICU enquiring about contact that HTT had with AA last night. I advised them of her attendance at A&E, and her subsequent removal by Police.	Request by A&E staff for HTT to assess Ms Hibbs who has arrived @ A&E. AA has advised staff that she is distressed about access arrangements with daughter.
Supplementary Information			PICU advised that AA has been admitted to their Sec 136 suite.	
Supplementary Information				We were aware that Ms AA was assessed at 136 suite PICU on 22/09/04. PLN telephoned PICU, they advised that she was admitted informally to Alex Ground Floor ward.
Supplementary Information				
Supplementary Information				Contacted Alex GF. They confirmed that she is currently an in-patient. Carl liaised with A&E, they will arrange for her transfer back to BRH.
Data Source			CCS - Care Co-ordinator	Substance Misuse File

Date/Time	29-Sep-04	30-Sep-04	30-Sep-04	02-Oct-04
Details of Event	Ward round. Plan to discharge home as drinking and taking illicit drugs.	Presented to A+E at 05.20hrs requesting to see member of mental health team. Contact made with AGF as AA recently in pt. Informed by staff that she was discharged yesterday. Represented at 11.55pm. Smelled strongly of alcohol. Refusing to leave the dept until her daughter's whereabouts are known. Security in attendance.	AA self referred to the Oaks.	Seen at A&E department by RC (bank nurse) and RW (SW) following presentation last night. She was unable to return home because she had lost her keys and unable to get into her flat.
Supplementary Information	Became abusive when informed of discharge. Taxi arranged to take her home	Mayday made contact with Substance Misuse Team. Lost keys, daughter missing, started using alcohol again. Advised that AA has a worker at Westways.	Drinking daily.	Plan Lorazepam 1mg tds given for 2 days. Discharge home. AA to contact Oaks Resource Centre on Monday for alcohol problems.
Supplementary Information		Daughter missing for 3/7.		
Supplementary Information				
Supplementary Information				
Data Source		CCS - Care Co-ordinator. Substance Misuse file. Liaison notes.	Substance Misuse File. Oaks notes	Substance Misuse File

Date/Time	05-Oct-04	07-Oct-04	08-Oct-04	09-Oct-04
Details of Event	DNA OPD with SHO (7 day follow up).	AA attended A+E initially stating to staff that she felt suicidal. She also said that she had taken 8 x venlaflaxine and some painkillers, ? type ? amount. She later denied that she had taken OD to A+E staff. Bloods taken as procedure, returned clear, no abnormalities found. Liasion team contacted at 6.30 am to review.	Brought to A&E Mayday Hosp by ambulance which she had ordered. Stating that she was suicidal and requesting hospital admission under section of the mental health act.	Admitted to G2 for detox.
Supplementary Information	Further appnt sent for 14.10.04.	During interview with Liaison Nurse AA became very abusive and it was impossible to continue the conversation. She was directed to services that could support but the verbal abuse continued in the waiting area, security staff escorted her off of the premises. However she remained in the porch area of A+E with male friend. They both appeared to be drinking from a can of beer.	She remained in hospital overnight in CDU where she slept peacefully under the influence of alcohol.	AA had experienced chronic and extreme levels of distress and anxiety. Also complaining of auditory and visual hallucinations.
Supplementary Information		Contact Care Co-ordinator at Westways re: AAs continued presentations and Oaks re: AAs current level of engagement with their service.	Medical notes (not dated/signed) state that daughter left AA after calling police and was taken to dad's. Fell and broke wrist/arm last time at dad's. Child in need referral done.	
Supplementary Information				
Supplementary Information				
Data Source	Case Notes	CCS - Care Co-ordinator	Substance Misuse File	

Date/Time	09-Oct-04 assessed at 10 am	11-Oct-04	13-Oct-04
Details of Event	Assessment - In the past six days AA has presented more than ten times to the A&E department and has been verbally aggressive towards staff. All presentations were under influence of alcohol. Presentations becoming more frequent and more demanding of police and A&E personnel.	DNA'd appt at the Oaks.	Gresham 2 Ward Round.
Supplementary Information	Increasingly unkempt, and chaotic, with her reporting more 'risky' and increasingly promiscuous behaviour. Precipitants listed as problems with daughter at the moment, says she 'hates her mum and is disgusted by her'. Voices telling her to kill herself.		AA was very unhappy, confrontational and verbally aggressive. The ward had, had real problems managing her behaviour. Plan to transfer to Alex Ground Floor. Management plan was discussed with Dr P, if AA wished to leave, she should be allowed to and was not sectionable. Also, if she returned intoxicated, she would be discharged.
Supplementary Information	CCS records identify that Miss AA is on enhanced CPA, and that she has been identified as being of high risk to self and to others. Her Crisis Plan identifies the current presentation patterns as indicators of relapse, and that the appropriate response should be contact with her care team. As it is a weekend there are no team members available, and in the absence of crisis services, the decision made to arrange admission to the BRH Gresham 1 ward.		
Supplementary Information	Discussed with Dr P who is agreement with the admission.		
Supplementary Information	Discussed with Ms AA the need for her to cooperate with services and agree to remain on the ward if services are to be of any meaningful help. She has agreed and says that she understands that if she does not remain on the ward, and/or if she consumes alcohol whilst an inpatient she is likely to be discharged.		
Data Source	CCS - Care Co-ordinator	Liaison notes	CCS - Care Co-ordinator

Date/Time	19-Oct-04	20-Oct-04	21-Oct-04
Details of Event	Discharged from AHGF as she returned under the influence of alcohol and very abusive and threatening to staff. AA was not happy to leave.	Self presented to A&E at St Thomas' at 1630hrs, stating that she was suicidal. Seen at 1900hrs.	Presented to Westways accompanied by her sister. Seen by duty worker AT and JN.
Supplementary Information	D/W - HTT not a candidate, Cons - happy to discharge on olanzapine.	Described vague suicidal ideas and threats of harm to others No plans to act on these at present. History of DSH by cutting and overdose. Longstanding alcohol problems increase impulsive harm to self/others.	She was stating that she was unable to go back to her flat as it had been trashed. She expressed the need for a safe place to stay. She presented in a very agitated state, was verbally abusive, misinterpreting intentions to help her as a way of trying to avoid any responsibility to support her.
Supplementary Information	Case conference with social services re: daughter reported that staff should not assist AA to make contact with her daughter as she could face an injunction. She had also been threatening towards ex-partner (father of daughter) and his mother making threats to kill.	15 yr old daughter under the care of her father, AA has no contact with her at the moment and cites this as one of the main reasons for her current crisis. Plan (As agreed with Dr P) AA to contact his secretary in the morning for an appt. tomorrow afternoon. he advised that should she require admission she could be reassessed at Mayday Hospital. AA stated intent to go to Mayday PLN'S at Mayday informed.	AA's flat was visited and found to be untidy but not uninhabitable.
Supplementary Information			The ward was contacted and informed care co-ordinator that it had been decided that because of AA's behaviour, due to her personality issues and alcohol abuse, and no evidence of mental illness whilst on the ward she should be discharged. [19.10.04]
Supplementary Information			She was seen by Dr P and he explained that countless attempts to help AA had all failed. AA needs to take some responsibility for her own life. This was agreed and the family have also had great problems with her behaviour. Dr P agreed to support a referral to the HTT and this was done.
Data Source	Case Notes	Substance Misuse File /CCS entry	Substance Misuse File

Date/Time	21-Oct-04	21-Oct-04	22-Oct-04
Details of Event	Referral to HTT by Team Leader, NW CMHT	Informed by A+E staff that during the early hours of Wednesday morning [20/10/04] AA had attended A+E seen by casualty SHO, was verbally abusive and threatened to kick him, he asked for security to remove her. She later returned to A+E, staff unsure how she entered dept, she was found in the relative's room having sexual intercourse with a man she had met in the dept, A+E staff have written an incident report.	Presented to A+E 00.30hrs, called by SR A+E to inform AA had presented and was being verbally abusive to the receptionist. On contact with AA and triage nurse, her request tonight was to have help with an alcohol detox. Informed AA of her appointment with the Oaks RC at 9am 22/10, she was aware of this plan. She fluctuated from being somewhat calm and engaging to verbally abusive to everyone, punched window in reception. Taken outside with security.
Supplementary Information	AA was assessed at home by HTT. Several implements and sharp objects around the house (knife, pair of scissors, a dart) which she said were for self defence. Wanting admission for detox.		AA said she was unable to get into her flat as she didn't have key's. Wanted help to get into flat. This situation went on for two hours. AA refused to leave dept, saying call the police, they'll get me in. Police officer's arrived at A+E for a separate incident but took AA back to her home address.
Supplementary Information			
Supplementary Information			
Supplementary Information			
Data Source	Oaks notes. HTT letter.	CCS - Care Co-ordinator	CCS - Care Co-ordinator. Liaison notes

Date/Time	25-Oct-04	09-Nov-04	11-Oct-04	15-Nov-04
Details of Event	Telephone call from The Oaks to say that AA has been offered an appointment at 10 am on Thursday 28 October. This is for the information of HTT/A&E.	Self referred to the Oaks by telephone.	Failed second appt at Oaks and discharged to GP.	Self presented to Specialist care management substance misuse team.
Supplementary Information		Drinking large bottles of vodka daily.	Letter cc.'d to Mayday Liaison service.	Agitated, claimed bus pass being used by another and she needed money to get to BRH. Stated that flat had been smashed up and she was going to be evicted. Claimed that she had relapsed after her relationship broke down. Also said that she was being physically abused by her ex-partner and that 'people were after her, out to kill her'
Supplementary Information				Advised that case closed and if she wished to re-refer to go to ICS -(Initial Contact Service).
Supplementary Information				
Supplementary Information				
Data Source	CCS - Care Co-ordinator	Oaks notes		Substance Misuse File

Date/Time	17-Nov-04	22-Nov-04	25-Nov-04	02-Dec-04
Details of Event	AA has been sitting outside Tamworth Rd since 9am with male pt . Drinking cans of beer and abusive to staff and anyone else who approached them demanding cigarettes and coffee. Spoke to NE team Leader. AA was discharged from AHGF aprox 3weeks ago with no follow up other than to attend Oaks resource centre for assistance with alcohol abstinence.	AA self referred to Substance Misuse. Requesting rehab detox, in danger of losing flat, violence from ex-partner and that she was being threatened.	Seen by Consultant.	DNA OPD.
Supplementary Information	Spoke to AA and advised that unless she left the premises police would be called as she is causing a disturbance. After some discussion she left with another patient. Stated she was going to PO to collect £120.00 owed to her.	Noted to have relapse after breakdown of relationship.	Depressed still with alcohol problem not suicidal, continue on medication.	Entry in notes states seen by Dr P 1/7 ago.
Supplementary Information				
Supplementary Information				
Supplementary Information				
Data Source	CCS - HTT Manager	Substance Misuse File	Case Notes	Case Notes

Date/Time	12-Dec-04	16-Dec-04	17-Dec-04	20-Dec-04
Details of Event	Attended A&E for the second time in 12hrs, claims that the psychiatric nurse told her to sober up and come back and he would help her.	Seen by SHO. Given Rx for venefaxine and lactalose.	AA attended Westways resource centre with her friend ED both were intoxicated and drinking vodka and smoking cigarettes in the reception area. She was racially abusive to a client sitting in the waiting area. AA and her friend were asked to leave the building and they refused, AA was verbally abusive with foul language and threatening. The police were called AA and friend left just before they arrived. It was not clear what AA wanted but did appear unhappy with a prescription she was given.	Assessment at Oaks.
Supplementary Information	Accompanied by a male friend ED. Demanding admission for Detox, explained that we were unable to access detox beds and that she should attend the Oaks, became abusive, refused to leave, Male friend also became abusive. AA and ED left requesting that Oaks were informed that she planned to present in the morning.			Self referred, drinking daily, type and amount varies. Suicidal. Paranoia leads to aggression.
Supplementary Information				
Supplementary Information				
Supplementary Information				
Data Source	Substance Misuse File. CCS - Liaison	Case Notes	CCS - NW Team Member	Oaks notes

Date/Time	22-Dec-04	04-Jan-05	05-Jan-05	11-Jan-05
Details of Event	Appointment offered by Oaks for 4 Jan 05(letter cc'd to consultant.	AA attended Oaks 2 1/2 hours late.	Pt brought to A&E yesterday by LAS following an OD of Venlafaxine ?quantity and had been drinking++ prior to/during OD. She stayed in CIDU overnight for observation.	Allocated case worker by Substance Misuse.
Supplementary Information		Seen by Addictions Consultant. Discussed request for Detox, to be assigned a key worker and inpatient detox to be arranged and AA advised to contact Social Services re follow-up.	She was seen this am on her own although her partner ED was with her in CIDU, c/o nausea, drinking++, depressed with suicidal thoughts. She also stated that her daughter had a miscarriage recently.	
Supplementary Information			Reports went to Oaks yesterday, given appointment February 2005. On assessment she claimed to have suicidal thoughts but denied any current plans to kill herself or to DSH. She appeared dishevelled but was calm and pleasant during the interview. Speech normal in rate and tone. Denied any abnormal thoughts. Plan Inform westways and Oaks of pt's presentation (fax sent).Referred to medics as pt's c/o nausea. Psychiatrically fit for discharge.	
Supplementary Information			Brief risk screen completed.	
Supplementary Information				
Data Source	Medical Records	Oaks Notes	Substance Misuse File/Liaison notes. CCS entry	Substance Misuse File

Date/Time	13-Jan-05	14-Jan-05	17-Jan-05
Details of Event	DNA SHO clinic at Westways. (Locum SHO).	AA presented at Taberner Hse (Substance Misuse).	Phone call to Substance Misuse Team for CC.
Supplementary Information	Plan - offer another appt on 01.02.05.	Not seen by a worker but spoken to over the phone. She was aggressive in tone. Needed help with detox but had to wait 4 weeks and so she wanted to be placed in a psychiatric unit.	CC stated that although she has had contact with AA in the past when she was more stable, she has not got an active role with her presently. CC stated that AA does not fall in WW catchment area and should be referred to Tamworth Rd CMHT but there had been no formal handover to them. CC could not say whether AA was under a consultant. CC stated that AA was on standard CPA.
Supplementary Information		AA said that she needed support with her mental health and an admission. CC had informed AA that she no longer came under WW and told her to go to Tamworth Road CMHT.	Agreed to inform of Cons, any OP appt and any meds.CC stated that if AA needed help with Freedom Pass she should consult the CMHT duty worker as CC had been told not to see AA as she had been threatening at their last meeting.
Supplementary Information		AA said she cannot go back to her flat and is staying with a male friend at Violet Rd (ED?) and this is making her situation event more difficult.	
Supplementary Information		Substance Misuse worker arranged an appointment to see AA on 17.01, left messages for CC and at Oaks seeking clarification.	
Data Source		Substance Misuse File	Substance Misuse File

Date/Time	19-Jan-05	19-Jan-05	20-Jan-05	
Details of Event	Oaks contacted substance misuse to inform them that AA is on waiting list for Detox.	Taken to St Georges A&E from police cells following arrest for alleged offence. Told police of OD on arrival at police station.	Seen by duty psych SHO.	It is understood that AA was arrested with 2 other people by police following an the fatal stabbing of ED on 19 January 2005 at the residence of Mr ED.
Supplementary Information		O/D of 60 venefaxine (at 15:30) and blow to head after being pushed and hitting head on concrete (18.1 - pm). Stated that partner (ED) was stabbed today. Suicidal ideation, due for detox in 1-2/52.	Admits alcohol, 'friend died yesterday of alcoholism, heart attack' denies it as a trigger. Denies stabbing ED and claims SO stabbed him in the head and she was trying to stop him.(Reports that she harmed SO in 1999 and went to prison for it 3yrs 9months for GBH).	
Supplementary Information			Started drinking again October because not coping with daughter, daughter reported to have had a miscarriage on 26.12.04 - 1 month earlier.	AA was charged with the murder of ED on 22 January and was held at Bronzefield Prison, Middlesex. She appeared briefly at the Old Bailey on Monday 31 January to be remanded to the same prison pending trial. Her next appearance in court will be for Plea and Directions on 14 March 2005.
Supplementary Information		Stated that she is living Violet Lane (ED's address).	Discharged to the care of the police.	
Supplementary Information				
Data Source	Substance Misuse File	A&E Card - St Georges	A&E Card - St Georges	CCS - Care Co-ordinator

Appendix D

Witnesses interviewed

Witness	Interviewers	Case	Date of witness hearing
James Forrester Care coordinator 2003	Dr Sally Adams and Malcolm Barnard	DB	Thursday 7 December 2006
AA Patient/perpetrator	Dr Sally Adams and Malcolm Barnard	AA	Thursday 7 December 2006
Cliff Bean Assistant director clinical governance and trust risk manager	Dr Sally Adams and Malcolm Barnard	Both	Monday 18 December 2006
Sue Lewis Trust assistant director of nursing and trust child protection lead	Dr Sally Adams and Malcolm Barnard	Both	Monday 18 December 2006
Rosie Peregrine-Jones Clinical governance manager	Dr Sally Adams and Malcolm Barnard	Both	Monday 18 December 2006
Andy Maris-Shaw Home treatment team manager	Dr Sally Adams and Malcolm Barnard	Both	Tuesday 19 December 2006
Professor Hilary McCallion Trust board member responsible for child protection in 2003 and director of nursing	Dr Sally Adams and Malcolm Barnard	Both	Tuesday 19 December 2006
EB DB's sister	Dr Sally Adams and Malcolm Barnard	DB	Wednesday 4 April 2007
CB DB's mother	Dr Sally Adams and Malcolm Barnard	DB	Wednesday 4 April 2007
Dr Rodrigues GP	Dr Sally Adams and Malcolm Barnard	AA	Wednesday 4 April 2006
Mary Bragg Charge nurse	Dr Sally Adams and Malcolm Barnard	AA	Thursday 26 April 2007
Dr Raj Persaud Consultant psychiatrist	Dr Sally Adams, Malcolm Barnard and Simon Wood	AA	Thursday 26 April 2007
Dr Mari Harty Consultant psychiatrist	Dr Sally Adams and Malcolm Barnard and Simon Wood	DB	Friday 4 May 2007
Pauline LaForge Care coordinator	Dr Sally Adams and Malcolm Barnard	AA	Friday 4 May 2007
DB Patient/perpetrator	Dr Sally Adams and Malcolm Barnard	DB	Thursday 10 May 2007

Mike Ogakwu Dr Persaud's SHO	Dr Sally Adams and Malcolm Barnard	AA	Tuesday 29 May 2007
Dr Faiza Mufti Consultant psychiatrist	Dr Sally Adams and Simon Wood	DB	Wednesday 20 June 2007
Teresa Mullaney Croydon community forensic team leader	Dr Sally Adams and Malcolm Barnard	DB	Monday 25 June 2007
Fran Bristow Croydon borough wide services manager	Dr Sally Adams and Malcolm Barnard	DB	Tuesday 7 August 2007
Martin King Community psychiatric nurse	Martin King has left the trust and neither SLaM or Verita could locate this nurse to invite him to come for interview	DB	-
Dr Jonathan Vince Consultant psychiatrist	Unable to interview due to being on Special Leave and not responding to our requests to interview	DB	-

Appendix E

NPSA contributory factor classification framework[1]

Sub-components underpinning the framework of factors influencing clinical practice

1. Institutional context
    - Economic and regulatory context
    - National health service executive
    - Clinical negligence scheme for trusts
    - Links with external organisations

2. Organisational and management factors components

CONTRIBUTORY FACTOR	COMPONENTS
Organisational structure	• hierarchical arrangement of staff within the organisational context • span of control • levels of decision-making
Policy, standards and goals	• mission statement and objectives • management arrangements (function) • contract services • human resources • financial resources/constraints • information services • maintenance management • task design • education and training policy • policies and procedures • facilities and equipment

[1] Based on the "A protocol for the Investigation and Analysis of Clinical Incidents" Vincent C, Adams S, Chapman J, Hewett D, Prior S, Strange P and Tizzard A (1998)

	• risk management (e.g. incident reporting, adverse incident investigation and analysis) • health and safety management (e.g. fire safety, waste management, infection control and occupational health) • quality improvement
Risks imported/exported	
Safety culture	Is invoked via the other organisational processes and management factors • attitude to work, safety and others in the workplace • provision of support mechanisms by management for all staff
Financial resources and constraints	

All of the components in the table above involve some or all of the following processes:

- goal setting
- communicating
- organising
- managing
- designing
- operating
- building
- maintaining

3. Work environment components

CONTRIBUTORY FACTOR	COMPONENTS
Administration	• ease of running and review of general administration systems • notes handling
Building and design	• maintenance management • functionality (ergonomic assessment e.g. lighting, space etc)
Environment	• housekeeping • control of the physical environment (e.g. temp, light etc) • movement of patients between wards/sites
Equipment/supplies	• malfunction/failure/reliability • unavailability • maintenance management • functionality (e.g. ergonomic design, fail-safe, standardisation)
Staffing	• (un)availability
Education and training	• induction • management's influence on training • process • refresher training • provision of training (in general)
Workload/hours of work	• regular rest breaks • optimal work load (neither too high or too low) • involved in non-job related duties
Time factors	• delays

4. Team components

CONTRIBUTORY FACTOR	COMPONENTS
Verbal communication	• communication between junior and senior staff • communication between professions • communication outside the ward/department • adequate hand-over • communication between staff and patient • communication between specialities and departments • communication between staff of the same grade • voicing disagreements and concerns • communication between staff and relatives/carers
Written communication	• incomplete/absent information (e.g. test results) • discrepancies in the notes • inadequately flagged notes • legibility and signatures of records • adequate management plan • availability of records • quality of information in the notes
Supervision and seeking help	• availability of senior staff • responsiveness of senior staff • willingness of junior staff to seek help • responsiveness of junior staff • availability of junior staff

Congruence/consistency	• similar definition of tasks between professions • similar definition of task between different grades of staff • similar definition of task between same grade of staff
Leadership and responsibility	• effective leadership • clear definitions of responsibility
Staff colleagues response to incidents	• support by peers after an incident • support by staff of comparable grades across professions e.g. senior nurse and junior doctor

5. Individual (staff) components

FACTOR	TAXONOMIC COMPONENTS
Competence	• verification of qualifications • verification of skills and knowledge
Skills and knowledge	• these are possibly the same as for competence
Physical and mental stressors	• motivation • mental stressors (e.g. the effects of workload/sickness on the individuals mental state • physical stressors (e.g. the effects of workload on the individuals physical health

6. Task components

FACTOR	TAXONOMIC COMPONENTS
Availability and use of protocols	• procedures for reviewing and updating protocols • availability of protocols to staff • use of protocols • availability of specific types of protocol e.g. PPH and H&S • quality of information included in the protocol • accident and incident investigation procedures
Availability and accuracy of test results	• tests not done • disagreements regarding the interpretation of the test results • need to chase up test results
Decision-making aids	• the availability, use and reliability of specific types of equipment e.g. CTG • the availability, use and reliability of specific types of tests e.g. blood testing • the availability and use of a senior clinician
Task design	• can a specific task be completed by a trained member of staff in adequate time and correctly

7. Patient components

FACTOR	TAXONOMIC COMPONENTS
Condition	• complexity • seriousness
Personal	• personality • language • external support • social and family circumstances
Treatment	• known risks associated with treatment
History	• medically • personally • emotionally
Staff/patient relationship	• good working relationship

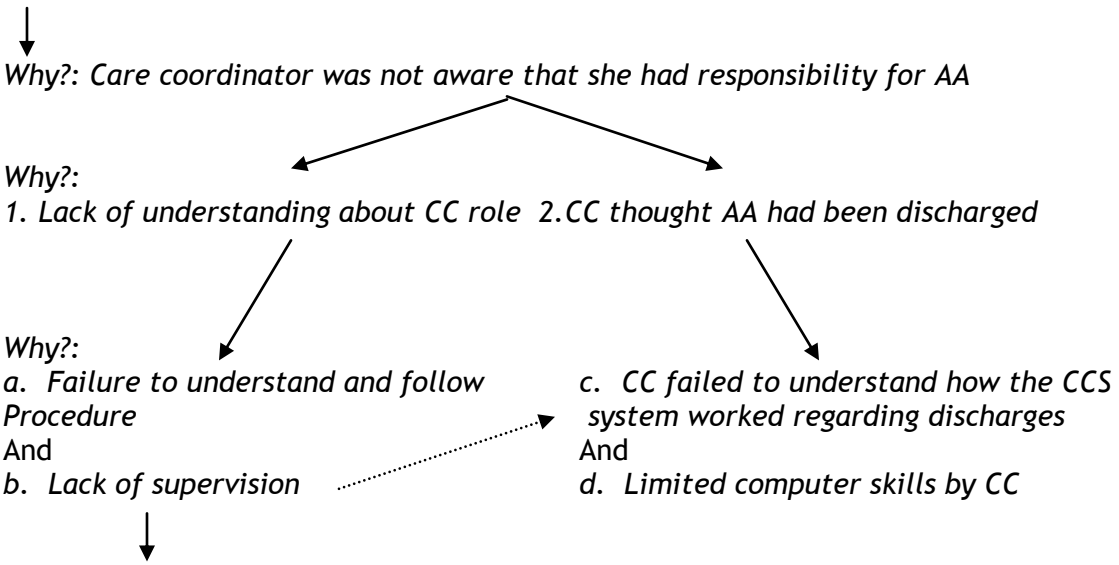
Appendix F

Relevant five why diagram

Contributory factor analysis for new C/SDP in the AA case

Lack of multi-disciplinary input into the care and treatment of AA

Why?: failure of the care co-ordinator to involve the wider MDT in AA's care



ROOT CAUSE = Two of the original root causes found by the SLaMs investigation are relevant as the root causes associated with this analysis. This analysis therefore gives further support that the trust's root causes are correct.