Strictly Confidential

Independent investigation into the care and treatment provided to Mr X by the South London and Maudsley NHS Foundation Trust

Commissioned by NHS London Strategic Health Authority

February 2010

NHS London

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr X was commissioned by NHS London Strategic Health Authority pursuant to *HSG (94)27*[1]. This investigation was asked to examine a set of circumstances associated with the death of Mrs Carmelita Tulloch on the 5 September 2006[2]. Mr X was subsequently arrested and convicted as the perpetrator of this offence.

Mr X received care and treatment for his mental health condition from the South London and Maudsley NHS Foundation Trust (the Trust). It is the care and treatment that Mr X received from this organisation that is the subject of this Investigation.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in an exceptionally professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

We would also like to thank the families of both Mrs Tulloch and of Mr X who offered their full support to this process and who worked with the Investigation Team. We acknowledge their distress and we are grateful for the openness and honesty with which they engaged with the Investigation.

This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

2. Condolences to the Victim's Family

The Independent Investigation Team would like to give their condolences to the family and friends of Mrs Carmelita Tulloch. Mrs Tulloch's parents worked with the Independent Investigation Team throughout and we have appreciated their dignified and diligent inputs into this Investigation during what has been for them a very difficult time.

It is the sincere hope of the Independent Investigation Team that this inquiry has addressed all of the issues that Mrs Tulloch's family have sought to have had examined.

It is the wish of Mrs Tulloch's parents that her name is not annonymised in this report

3. Executive Summary

3.1. Incident Description and Consequences

At around nine o'clock in the morning on Tuesday the 5 September 2006 Mrs Carmelita Tulloch was following her normal route to work close to where she lived. That morning Mr X was also walking the same streets carrying a kitchen knife from his home. The Court heard when sentencing Mr X that he had armed himself with the intention to find, and stab, a woman.

Mr X found Mrs Tulloch and attacked her suddenly and without warning. Mr X stabbed Mrs Tulloch seven times and she bled to death at the side of the road before anyone could do anything to save her. At the time of the attack Mr X was 17 years of age.

The Consultant Psychiatrist Instructed by The Crown in this case, stated that Mr X was suffering from paranoid schizophrenia at the time of the killing and that this abnormality of mind was of such a severity that it substantially impaired his responsibility for the killing.

His Honour Judge McKinnon stated that, 'the sentence of the Court is that a hospital order be made under Section 37 of the Act; the mental illness is schizophrenia...and I make a restriction order under Section 41 of the Act...due to the nature and gravity of the offence, the antecedents and the risk of further offending in order to protect the public.'

At the time of writing this report Mr X was being detained in a Secure Hospital environment.

3.2. Background to the Independent Investigation

The Health and Social Care Advisory Service was commissioned by NHS London (the London Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimize the

possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

3.3. Terms of Reference

The Independent Investigation Team should undertake all the tasks listed below in order to produce a detailed report on the care and treatment Mr X received and make recommendations to help to ensure that any mistakes made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Independent Investigation Team will:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan
- review the progress that the Trust has made in implementing the action plan
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration

Stage 2

a) To examine the mental health care received by Mr X in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr X's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;

- the extent to which Mr X's prescribed care plans were effectively drawn up, delivered and complied with by Mr X;

- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:

- medication;
- staff responses to service user and carer concerns;
- involvement of Mr X and his family in the drawing up and appropriateness of his care plan;
- the range of treatments and interventions considered;
- social care interventions;
- the reliability of case notes and other documentation.

- his assessed risk of potential harm to himself and others by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:
  - the risk of Mr X harming himself or others;
  - the training of clinical staff in risk assessment;
  - the systems and procedures in place during the period of Mr X's contact with services.

b) Consider the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular reference to the sharing of information for the purpose of risk assessment.

c) Involve the perpetrator and his family as fully as is considered appropriate.

d) Involve the victim's family as fully as is considered appropriate.

e) Review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriateness of use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation.

f) Consider any other matters arising during the course of the Independent Investigation which are relevant to the occurrence of the incident, or might prevent a re-occurrence.

g) Use root cause analysis as appropriate for the purpose of enabling lessons to be learned.

h) Ensure that any action plan and recommendations take full account of the progress that health and social care services have made since the completion of the Internal Investigation report.

i) Consider such other matters as the public interest may require.

j) Prepare an Independent Investigation Report for the Primary Care Trust.

k) Work with the Primary Care Trust in the period between the delivery of the Investigation Report and its formal publication.

3.4. The Investigation Team

Investigation Team Leader and Chair

Dr Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service

Investigation Team Members

Dr Stephen Wright	Consultant in Community Psychiatry & Early Intervention, Leeds Partnerships NHS Foundation Trust, Honorary Senior Lecturer, University of Leeds School of Medicine
Mrs Helen Waldock	Director of Nursing, Health and Social care Advisory Service
Mr Charles Holloway	Health and Social Care Advisory Service Associate. Lay Member
Mrs Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member

Support to the Investigation Team

Mr Christopher Welton	Investigation Manager, Health and Social

	Care Advisory Service

Independent Advice to Panel

Mr Ashley Irons	Solicitor, Capsticks
Mr Paul Grey	Independent Management Consultant, service user and advisor on cultural diversity issues

3.5. Findings and Conclusions

Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

1. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the homicide that occurred on 5 September 2006. In the realm of mental health service provision it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

2. **Contributory Factor.** The term is used in this report to denote a process or a system that failed to operate successfully, thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr X's mental health and/or the failure to manage it effectively.

3. **Service Issue.** The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 5 September 2006, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

Key Causal Factors

The Independent Investigation Team found one key causal factor with regard to the events of the 5 September 2006.

- ***Key Casual Factor Number One. The failure to institute an appropriate CPA, assessment and treatment programme for Mr X ensured that his mental illness was partially treated. His Honour Judge McKinnon found Mr X's mental illness was a direct causal factor in the death of Mrs Tulloch.***

Contributory Factors

The Independent Investigation Team found ten factors that contributed to the less than effective care and treatment package that Mr X received.

- ***Key Contributory Factor Number One. The failure to manage the ongoing assessment, care, risk and treatment needs of Mr X whilst receiving care from the Youth Offending Team Child and Adolescent Mental Health Services (YOT CAMHS) meant that his mental illness was untreated. This extended period of time where his condition remained untreated ensured that his mental illness continued to worsen. Mr X's mental state was considered by the Court when sentencing him to have played a major factor in the events of 5 September 2006.***

- ***Key Contributory Factor Number Two. Mr X's condition was not adequately assessed, managed and monitored during the period that he received his care and treatment from the Lambeth Early Onset Crisis Assessment Team (LEO CAT). This ensured that his condition remained partially treated.***

- ***Key Contributory Factor Number Three. Failure to provide an early diagnosis and treatment package led to Mr X's condition worsening over a period of time. This delay prevented a coherent package of care and treatment being delivered in a timely manner.***

- ***Key Contributory Factor Number Four. The failure to adequately monitor Mr X's adherence to his treatment plan contributed to the escalation of his condition in the days preceding the events of the 5 September 2006.***

- ***Key Contributory Factor Number Five. The lack of a detailed risk assessment conducted in the full light of Mr X's psychiatric and forensic history prevented a coherent plan of care and treatment from being developed. This ensured that Mr X remained an unknown quantity and that his condition was only partially treated.***

- ***Contributory Factor Number Six. The LEO CAT did not effectively engage with the family of Mr X. This meant that the family remained unclear about his mental illness, his medication and his future clinical plan of care. This lack of clarity and engagement left both Mr X and his family in a vulnerable situation. The absence of a carer assessment exacerbated this situation.***

- ***Key Contributory Factor Number Seven. The failure to communicate between agencies and services ensured that essential information regarding Mr X's history and risk were not known. This had a direct influence on how he was perceived by the LEO CAT service and how his care pathway was managed.***

- ***Key Contributory Factor Number Eight. The absence of clinical supervision and clinical leadership in the YOT CAMHS ensured that Mr AQ, the CPN, did not have the support and professional guidance that he required. This had an impact on the quality of the care and treatment that Mr X subsequently received.***

- ***Key Contributory Factor Number Nine. YOT CAMHS, CAMHS and LEO services all worked more or less in isolation from each other. Clinical leadership was sporadic and services lacked cohesion, vision and a culture of collaborative working. This left individual clinicians vulnerable and isolated and this had a negative effect on the quality of care that service users received.***

- ***Key Contributory Factor Number Ten. Clinical practice within the Trust did not conform to internal policies and procedures.***

Service Issues

The Independent Investigation Team found three service issues whilst examining the care and treatment that Mr X received.

- ***Service Issue Number One. The Trust appointed an individual who held a clinical caseload and conducted clinical duties whilst not holding a qualification recognised in the United Kingdom.***

- ***Service Issue Number Two. No 'safeguarding children' assessments were undertaken for either Mr X or his sister even thought there were significant indicators evident to suggest that the wellbeing of both children could be compromised.***

- ***Service Issue Number Three. Some of Mr X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry in this case has potentially left both the health care professionals and the Trust vulnerable.***

Conclusions

The Trust clinical witnesses expressed their belief that the death of Mrs Tulloch on the 5 September 2006 could not have been predicted and that nothing in Mr X's history, either known or not known at the time, could have made any difference to his assessed level of risk and any resulting plan of care, and that as such the case was handled appropriately and that nothing could have been done differently. The Independent Investigation Team would like to make the following clear:

- the Independent Investigation Team agree that Mrs Tulloch's death could not have been predicted;

- we would like to acknowledge the fact that it is very difficult to treat patients who do not wish to be treated and who may not cooperate and that even with perfect systems it is not always possible to prevent an individual's mental health deteriorating;

- the Independent Investigation Team do believe that Mr X's case should have been managed in a more coherent and timely manner during the 12 months that he received his care and treatment from the Trust. He attended a total of 25 appointments over a thirteen month period and this should have yielded a comprehensive care package for this young man. It did not. During the vast majority of this period Mr X's condition was entirely untreated and grew worse. His condition was only treated during the last nine weeks of his contact with the Trust and it is known that he was not compliant with his medication for the last two weeks of this period. Mr X did not receive a comprehensive or coherent plan of care and treatment and his condition was therefore partially treated. Whilst it is recognised that severe mental illness cannot always be fully treated, it is the view of the Independent Investigation Team that Mr X's case could have been managed differently.

3.6. Recommendations

The recommendations of the Independent Investigation Team are as follows:

Recommendation Number One. A number of the findings relate to core practice that would be expected and required of community staff, for example, managing and undertaking thorough risk assessments, completing clinical documentation and completing forensic risk histories. The Trust should develop core competencies for community staff, including medical staff, which will include the requirements for staff to work to established policy and procedure and to specify what actions need to be undertaken. The core competencies should be completed with care coordinators as part of the appraisal process. Team managers should also work towards core competencies which ensure that they know what is expected of them as part of their management role.

Recommendation Number Two. The potential of the Trust Integrated Record System should be maximised to ensure that it delivers a focussed breakdown by team and by care coordinator to be available on the:

- completion of Care Programme Approach reviews;
- completion of risk assessments;
- completion of child in need risk screens;

- frequency that carer assessments are offered.

Recommendation Number Three. A policy review took place during 2008. The policy review included a review of the brief risk screen. The revised Policy on the Framework for Clinical Risk Assessment and the Management of Harm was ratified in September 2008. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

Recommendation Number Four. The Trust's Care Programme Approach Policy was reviewed during 2008 in light of new Department of Health Guidance. A revised Trust Care Programme Approach Policy was published in September 2008. The policy contains details of the Trust's response to the needs of carers. The revised policy was publicised to staff through line management channels, and Directorate Clinical Governance Committees. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

Recommendation Number Five. The Lambeth Carer Strategy is a new approach which was introduced into the Trust in 2008. This strategy was developed by local Voluntary Groups, the Local Authority and NHS agencies. The strategy is easy to understand and based on thorough research and understanding of the Borough of Lambeth. This strategy has made a robust attempt to engage with ethnic minority groups within the Borough to ensure its relevance and success. The Trust should conduct an audit against the effectiveness of this strategy on the publication of this report and make any necessary revisions. The audit should as a basic minimum:

- determine how many carer assessments have been offered;
- determine how many carer assessments have been accepted;
- determine the ratio of carer assessments taken up by BME carers;
- determine the quality and effectiveness of the resulting care plans.

Recommendation Number Six. Existing policies and procedures regarding the liaison with the YOT/probation should be reviewed in the light of the lessons learned from the Mr X case and revised accordingly.

Recommendation Number Seven. A new system for referral has been developed by one of the CAMHS Consultant Psychiatrists which has been approved by the Trust and has been in place since 12 November 2008. The Trust reports that this new system is working effectively. At the time of writing this report the Trust planned to send out GP and Partner Agency Information Packs. It is unclear what audit processes have been deployed to assess how well this new process is working. It is recommended that this process is reviewed specifically in the light of communications with GPs and audited to this effect within six months of the publication of this report.

Recommendation Number Eight. The existing clinical supervision policy should be reviewed and an audit conducted to ascertain its effectiveness. Any necessary revisions should then be made.

Recommendation Number Nine. All Team Leaders/Managers should have key responsibilities regarding clinical and caseload supervision in their job descriptions and should be appraised to ascertain their performance in this area.

Recommendation Number Ten. Trust clinical supervision processes should be directly linked to extant Trust professional regulation processes to ensure that any notifications of poor practice are acted upon with immediate effect.

Recommendation Number Eleven. The Trust's Human Resources department should have in place a system of identifying transferable qualifications of overseas trained psychologists and ensure that qualifications, skills and experience are commensurate with current United Kingdom requirements.

Recommendation Number Twelve. The Trust should conduct an audit within the Lambeth-based CAMHS to assure the Trust Board that clinical records are being contemporaneously made.

Recommendation Number Thirteen. The Trust Information Technology Team must ensure that clinical records cannot be amended by any member of a clinical team following a serious untoward incident.

Recommendation Number Fourteen. That the Service Level Agreement ratified on the 10 June 2007 between the CAMHS and the Lambeth YOT is audited to ensure it is working properly and is fit for purpose.

Recommendation Number Fifteen. That the system introduced in November 2008 for referral to the Lambeth CAMHS is fully audited to confirm that it is working well and is fit for purpose.

Recommendation Number Sixteen. The Trust acknowledges the far reaching nature of the independent investigation and the opportunity that this provides for organisation-wide learning. The Trust should arrange learning feedback sessions to enable the findings of this investigation to be raised with a wide audience and to help ensure that lessons are learnt.

Recommendation Number Seventeen. The Trust should develop strategies to ensure that condolence; support and advice are offered to the families / loved ones of the victims of homicide without this endangering the police investigation and judicial processes, and that the Being Open Policy (2008) is reviewed as necessary and fully implemented.

Recommendation Number Eighteen. Structured Investigations and Board Level Inquiry reports should be thoroughly examined to ensure that the recommendations are SMART. Examination should take place prior to the report's submission to the Serious Untoward Incident (SUI) Panel, at the SUI Panel and at any Board Level Inquiry. The Board Level Inquiry should have an examination of the recommendations as a routine part of the inquiry terms of reference.

Recommendation Number Nineteen. The findings of the independent investigations should be raised and discussed at:

- forthcoming Child Safeguarding conferences;
- in Trust newsletters and Patient Safety Bulletins;

- Police Liaison Committees.

Recommendation Number Twenty. Where there are actions arising from investigations into inpatient suicides and homicides the action plans should automatically be made a standing agenda item at the relevant Borough-based Clinical Governance Committee(s).

Clinical Governance Committees should, as part of their terms of reference, include an examination and review of any newly ratified Trust policies and procedures. An audit process should be in place to ensure that the policies and procedures are subsequently audited with involvement from clinical staff that work at the point of patient care.

Recommendation Number Twenty-one. The current nursing practice assessment visits should continue on an annual basis. The terms of reference for the visits should be reviewed and amended in the light of the findings of the independent investigations.

Recommendation Number Twenty-two. The terms of reference for structured investigations and Board Level Inquiries should include an examination and assessment of compliance with Trust Policy and Procedure which includes:

- Care Programme Approach;
- Risk assessment and management of harm framework;
- Clinical records standards.

It was apparent during the course of this investigation that the Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006, was not clearly understood by either the Trust or the Police Service. A high-level discussion needs to take place to avoid further confusion in the future and to ensure that victims' families are communicated with in a timely and helpful manner.

Recommendation Number Twenty-three. NHS London, the London Strategic Health Authority, should engage in discussions with the Metropolitan and City Police Forces to ensure that the Memorandum can be implemented effectively.

4. Incident Description and Consequences

The following information has been taken from the Court Sentencing Hearing transcription which was made on the 2 April 2007.

At around nine o'clock in the morning on Tuesday the 5 September 2006 Mrs Carmelita Tulloch was following her normal route to work close to where she lived. That morning Mr X was also walking the same streets carrying a kitchen knife from his home. The Court heard that Mr X had armed himself with the intention to find, and stab, a woman.

Mr X found Mrs Tulloch and attacked her suddenly and without warning. Mr X stabbed Mrs Tulloch seven times and she bled to death at the side of the road before anyone could do anything to save her. At the time of the attack Mr X was 17 years of age.

The Consultant Psychiatrist Instructed by The Crown in this case stated that Mr X was suffering from paranoid schizophrenia at the time of the killing and that this abnormality of mind was of such a severity that it substantially impaired his responsibility for the killing.

His Honour Judge McKinnon stated that, 'the sentence of the Court is a hospital order made under Section 37 of the Act; the mental illness is schizophrenia...and I make a restriction order under Section 41 of the Act...due to the nature and gravity of the offence, the antecedents and the risk of further offending in order to protect the public.'[3]

At the time of writing this report Mr X was being detained in a Secure Hospital environment.

5. Background and Context to the Investigation (Purpose of Report)

The Health and Social Care Advisory Service was commissioned by NHS London (the London Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

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

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

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

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimize the possibility of a reoccurrence of similar events, and to make recommendations for the delivery

of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what would have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been fully investigated by an impartial and independent Investigation Team.

6. Terms of Reference

The terms of reference for the Independent Investigation into the care and treatment of Mr X were developed by NHS London and Lambeth Primary Care Trust. They are set out in full below.

The Independent Investigation Team should undertake all the tasks listed below in order to produce a detailed report on the care and treatment Mr X received and make recommendations to help ensure that any mistakes made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Panel will:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan
- review the progress that the Trust has made in implementing the action plan
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration

Stage 2

a) To examine the mental health care received by Mr X in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr X's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;

- the extent to which Mr X's prescribed care plans were effectively drawn up, delivered and complied with by Mr X;

- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:

- medication;
- staff responses to service user and carer concerns;
- involvement of Mr X and his family in the drawing up and appropriateness of his care plan;
- the range of treatments and interventions considered;
- social care interventions;
- the reliability of case notes and other documentation.

- his assessed risk of potential harm to himself and others, by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:

  - the risk of Mr X harming himself or others;
  - the training of clinical staff in risk assessment;
  - the systems and procedures in place during the period of Mr X's contact with services.

b) Consider the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular reference to the sharing of information for the purpose of risk assessment.

c) Involve the perpetrator and his family as fully as is considered appropriate.

d) Involve the victim's family as fully as is considered appropriate.

e) Review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriateness of use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation.

f) Consider any other matters arising during the course of the External Investigation which are relevant to the occurrence of the incident or might prevent a re-occurrence.

g) Use root cause analysis as appropriate for the purpose of enabling lessons to be learned.

h) Ensure that any action plan and recommendations take full account of the progress that health and social care services have made since the completion of the internal Investigation report.

i) Consider such other matters as the public interest may require.

j) Prepare an External Investigation Report for the Primary Care Trust.

k) Work with the Primary Care Trust in the period between the delivery of the Investigation Report and its formal publication.

7. The Independent Investigation Team

This Investigation was undertaken by the following panel of healthcare professionals who are independent of the healthcare services provided by the South London and Maudsley NHS Foundation Trust.

Investigation Team Leader and Chair

Dr Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service

Investigation Team Members

Dr Stephen Wright	Consultant in Community Psychiatry & Early Intervention, Leeds Partnerships NHS Foundation Trust, Honorary Senior Lecturer, University of Leeds School of Medicine
Mrs Helen Waldock	Director of Nursing, Health and Social care Advisory Service
Mr Charles Holloway	Health and Social Care Advisory Service Associate. Lay Member
Mrs Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member

Support to the Investigation Team

Mr Christopher Welton	Investigation Manager, Health and Social Care Advisory Service

Independent Advice to Panel

Mr Ashley Irons	Solicitor, Capsticks
Mr Paul Grey	Independent Management Consultant, service user and advisor on cultural diversity issues

8. Investigation Methodology

In May 2008 NHS London commissioned the Health and Social Care Advisory Service to conduct this Independent Investigation under the Terms of Reference set out in section seven of this report. The Investigation Methodology is set out below.

Consent and Communication with Mr X

At the inception of this Investigation Mr X was written to by NHS London in order to obtain his consent for the Independent Investigation Team to access his clinical records. A letter was sent out to him on the 10 July 2008. An additional letter was sent to Mr X's solicitor by the Strategic Health Authority on the 22 August 2008 which further outlined the function of the Independent Investigation as a statutory inquiry.

Regular communications ensued between the Health and Social Care Advisory Service and Scott-Moncrieff, Harbour and Sinclair Solicitors who acted on Mr X's behalf. On the 24 September 2009 Mr X signed a consent form giving the Independent Investigation Team full permission to access his clinical records. On the 2 October 2008 two members of the Independent Investigation Team went to the Trust to access and photocopy all extant clinical records.

The Independent Investigation Team had hoped to meet with Mr X in order to explain the Investigation process to him in person and to understand from him directly any views that he might hold regarding the care and treatment that he had received from the Trust. Unfortunately due to Mr X's continued ill health this has not been possible. At the time of writing this report the Investigation Team had not been able to meet with Mr X.

Communication with the Victim's Family

On the 19 February 2008 a meeting was held between the parents of Mrs Tulloch and the Head of Clinical Governance from NHS London. During this meeting it was explained that NHS London would be commissioning a full Independent Investigation under the auspices of HSG (94) 27 regarding the care and treatment that Mr X received from the South London and Maudsley NHS Trust.

On the 29 July 2008 the Independent Investigation Team Leader wrote to the parents of Mrs Tulloch. This letter explained the purpose of the Independent Investigation and proposed that an introductory meeting should take place so that the family of Mrs Tulloch could be communicated with directly and consulted, where appropriate, regarding the Terms of Reference.

On the 20 August 2008 the Independent Investigation Team Leader and the Nurse Member of the Investigation Team met with the parents of Mrs Tulloch in their home. The Terms of reference were discussed and they were given an opportunity to contribute to them. An invitation was extended to them to be called as formal witnesses to the Investigation.

On the 24 November 2008 the parents of Mrs Tulloch met formally with the Independent Investigation Team. During this meeting they had the opportunity to raise their concerns regarding the care and treatment that Mr X received, and to express their grief about the death of their daughter and the impact that this has had on both them and the rest of Mrs Tulloch's family. On this same date the parents of Mrs Tulloch also met with the Trust Chief Executive and members of the Trust Executive Team who expressed their sincere regret regarding the death of Mrs Tulloch.

Regular communication has been maintained between the parents of Mrs Tulloch and the Investigation Team throughout the course of this process.

Communication with the Perpetrator's Family

The family of Mr X provided invaluable support to the Independent Investigation Team. The Investigation Team Leader and Investigation Nurse Team Member met informally with the mother and sister of Mr X who were accompanied by their solicitor on the 28 October 2008. During this meeting the purpose of the Independent Investigation was explained in full to them, they were given an opportunity to contribute to the Terms of Reference and an invitation was extended to them to be called as formal witnesses to the Investigation.

On the 8 December 2008 Mr X's mother and sister met formally with the Independent Investigation Team. The Independent Investigation Team has remained in contact with the family of Mr X with the support of their solicitor.

Initial Communication with the South London and Maudsley NHS Foundation Trust

On the 25 June 2008 a letter was sent from the Investigation Team Leader to the Trust Chief Executive. The purpose of this correspondence was to commence introductions and to arrange for an initial meeting to take place. The Trust promptly responded by identifying a liaison person.

On the 22 September 2008 a meeting was arranged with the Senior Management Team of the Trust's Lambeth Directorate. The purpose of the meeting was to clarify the Investigation process and to address any concerns or questions that the Management Team may have had.
A workshop was also held on this day to which all potential witnesses for the Investigation were invited. The Investigation Team Leader was present and accompanied by a Solicitor from Capsticks. The purpose of the workshop was to ensure that the Investigation process was as fair and transparent as possible. All potential witnesses were given a verbal briefing, briefing packs and a question and answer session was also held.

On the 2 October 2008 two members of the Investigation Team visited the Trust Headquarters and photocopied all extant copies of Mr X's clinical records. On this occasion a meeting was held between the Investigation Team Leader and the Trust CEO.

Communication with the Trust was maintained throughout via the designated Trust Investigation Liaison Leads.

Witnesses Called by the Independent Investigation Team

The Independent Investigation Team was not able to interview all of the individuals involved in the care and treatment of Mr X. Due to the passage of time some of the witnesses that the Team wanted to call were either living abroad or were no longer contactable. Every effort was made to contact everyone who comprised Mr X's clinical care team between 5 August 2005 and the date of the events of 5 September 2006. A total of twenty-five witnesses were interviewed by the Independent Investigation Team.

Table One

Witnesses Interviewed by the Investigation Team

Date	Witness	Interviewers
24 November 2008	• Trust CEO, • Trust Director of Nursing • Trust Deputy Director Patient Safety and Assurance • Dr MB • Ms F-J • Ms SS • Trust Borough Director • Trust Borough Clinical Director • The parents of Mrs Tulloch • Dr GM Trust CAMHS Clinical Director • Dr EI	Investigation Team Leader Investigation Team Doctor Investigation Team Nurse Investigation Lay member
26 November 2008	• Ms JB, Director of CAMHS • Ms SL, Assistant Director Child Protection • Ms JP, Child Protection Lead Nurse • Ms LH, General Manager • Dr PH (YOT)	Investigation Team Leader Investigation Team Doctor Investigation Team Nurse Investigation Lay member Investigation Service User Member
27 November 2008	• Ms JN, Care Coordinator • Mr BW Service Manager • Dr KM (YOT)	Investigation Team Leader Investigation Team Doctor Investigation Team Nurse Investigation Lay member Investigation Service User Member
8 December 2008	• Dr CP • The mother and sister of Mr X	Investigation Team Leader Investigation Team Doctor Investigation Team Nurse Investigation Lay member Investigation Service User Member
18 February 2009	• Dr M, GP	Investigation Team Leader Investigation Team Nurse
2 July 2009	• Lambeth PCT Lead Mental Health Commissioner	Investigation Team Leader

Independent Investigation Team Meetings:

The Independent Investigation Team met on a total of seven occasions.

18 September 2008. First Team day: this day consisted of a full briefing regarding the case and the Investigation process.

31 October 2008. Second Team day: this day consisted of an analysis of the draft Timeline and emerging issues.

24 November 2008. Corporate Witness interviews were held

26 November 2008. Witness interviews were held

27 November 2008. Witness interviews were held

8 December 2008. Third Team day: this day was a root cause analysis day whereupon the data was considered in a systematic fashion as explained directly in the section below.

23 February 2009. Fourth Team day: this day ensured that all findings and conclusions were set out in full accordance with the Investigation Team's wishes.

Additional meetings were held with the Trust on the following dates:

10 December 2008: the Independent Investigation Team Leader met with the Trust Director of Nursing.

13 March 2009: The Independent Investigation Team Leader together with the medical and nurse members of the panel held a meeting with the Trust Clinical Governance Team to discuss findings and recommendations.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned

culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilized the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

Salmon Compliant Procedures

The Investigation Team adopted Salmon compliant procedures during the course of their work. This is set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign

(h) that they will be given the opportunity to review clinical records prior to and during the interview

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

9. Information and Evidence Gathered (Documents)

During the course of this investigation some 6,000 pages of documentary evidence were gathered and considered. The following documents were actively used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. South London and Maudsley NHS Foundation Trust clinical records for Mr X
2. General Practice records for Mr X 1999
3. The Trust Internal Investigation report and archive
4. The Trust Board Level Inquiry report and archive
5. Youth Offending Team Internal Investigation Report
6. Trust Electronic clinical record log books
7. Media transcripts and newspaper articles
8. South London and the Maudsley clinical risk policy, both risk to self and risk to others (undated)
9. Lambeth Integrated Mental Health Services: A Ten Year Review. September 2003
10. Protocol for bed management when demand exceeds capacity in local adult services. April 2005
11. Safeguarding Children policy and procedures. June 2003, 2005 and 2008
12. Care Programme Approach Policy 2000
13. Incident Policy 2006
14. Lambeth Mental Health services organisational Chart
15. Framework for Clinical Risk Assessment and Management of Harm. Version Three. 2005
16. All other current clinical policies, procedures and strategies that were/are currently operational within the Lambeth Clinical Directorate relating to young people who are service users.
17. Independent Healthcare Commission reports
18. Independent Mental Health Act Commission reports
19. Clinical Witness interview transcriptions
20. Trust Mr X action planning and implementation reports (arising from the Trust Internal Investigation Processes)
21. Trust Board minutes and documentation

22. Memorandum of Understanding between the association of Chief Police Officers (ACPO) and the NHS Security Management Service

23. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006

24. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

10. Profile of the Trust Mental Health Services (Past, Present and Transition)

A description of the Trust's services in Lambeth between 1999 and 2009

Lambeth Adult Mental Health Services

Introduction

The South London and Maudsley NHS Trust was formed in 1999. In 2006 the South London and Maudsley NHS Foundation Trust (the Trust) was founded under the Health and Social Care Community Health and Standards Act) 2003.

The Trust provides the most extensive portfolio of mental health services in the United Kingdom, supported by internationally recognised training and research. The Trust provides a full range of mental health services for people of all ages, from 100 community-based sites across South London as well as units based on three acute sites and three psychiatric hospitals:

- Bethlem Royal Hospital
- Lambeth Hospital
- Maudsley Hospital

The Trust provides mental health and substance misuse services for people living in the London Boroughs of Croydon, Lambeth, Southwark and Lewisham (an approximate population of 1.1 million) and substance misuse services in Bexley, Greenwich and Bromley.

The local community served by the Trust has very high levels of mental health need, in parts amongst the highest in the country. There are also high levels of social deprivation and substance misuse, and a very mobile population including large numbers of refugees.

Other things to note include:

- specialist services are provided to people from across the United Kingdom;
- adult mental health and social care services are fully integrated;
- around 5,000 service users receive inpatient hospital treatment each year;

- around 32,000 service users receive community-based care and treatment from the Trust each year;
- the Trust employs around 4,800 staff;
- the Trust and the Institute of Psychiatry manage the only mental health Biomedical Research Centre in the United Kingdom;
- the Trust's annual turnover is around £358 million.

Services in the London Borough of Lambeth

The London Borough of Lambeth is one of the most densely populated inner London boroughs with a population of around 270,000. Based on the 2001 census, 38% of Lambeth's population are comprised of ethnic minorities, the seventh highest figure for a London borough. Approximately 150 languages are spoken in the Borough. After English, the main languages spoken are Portuguese, Yoruba, French, Spanish and Twi.

The 2007 Index of Multiple Deprivation (IMD) places Lambeth as the fifth most deprived borough in London and the 19th most deprived in England. 11.4% of the population are aged over 60, whilst 19.9% are aged under 18 (2006 Mid-Year Estimate).

Outline of the Lambeth Directorate

The Adult Mental Health Directorate shares the same boundaries as the local authority and provides joint health and social care services. Other services, including those for older adults, children, adolescents, substance misuse specialist needs and learning disabilities are shared across the Trust with some bases in the Borough.

In January 2006 Lambeth Adult Mental Healthcare was reorganised so that services are aligned to GP practices. There are now three locality community mental health teams; North, South West and South East each providing an Assessment and Treatment Service and a Recovery and Support Service. Added to this is a borough-wide Assertive Outreach Service centrally based in Brixton.

Alongside the generic team are specialist rehabilitation, forensic and early onset teams, which also have ward and community-based teams. These also provide additional services, for

instance, supported housing, vocational services and day services, which are run either by the Trust or in conjunction with the voluntary sector.

Services in the London Borough of Lambeth between 1999 and 2003

Following the creation of the South London and Maudsley NHS Trust in 1999, the two East sectors in Lambeth (Brixton and Norwood) and three West sectors (Streatham, Clapham and Kennington) combined to form a single Lambeth Borough based mental health service. Each of the five sector services at that time had the following three functional teams:

- Assessment and Treatment Teams, which provided the gateway to services. They accepted referrals from GPs to assess people and either provide brief treatment or referral on to more appropriate care.
- Rapid Assessment Teams, which provided an urgent referral service to GPs for people who were in crisis.
- Case Management Teams, which provided intensive community treatment to people with severe and enduring mental ill health. Case management teams operated a zoning system, which gave service users with the greatest levels of need the highest levels of care.

In addition there were community-based Borough; forensic services (which took referrals from courts, prison), and rehabilitation services which provided a range of inpatient, supported housing and day care facilities.

In 2003 the first Home Treatment Team was set up in Lambeth. The Home Treatment Team provides intensive support to patients in their home, immediately after discharge from hospital or in order to prevent their admission to hospital.

The 10-Year Review

In September 2003 the Lambeth Adult Mental Health Directorate launched a review of services in Lambeth. This was the most comprehensive review of Lambeth Mental Health Services in a decade. There had been many developments over ten years and it was time to take stock and agree a new strategy and direction for the service and the changes required to improve services.

This review involved a wide ranging consultation of stakeholders and service users and looked at both hospital and community services. This programme included:

Inpatient Services:

- The conversion of Nelson Ward at Lambeth Hospital from an acute inpatient unit into a Challenging Behaviour Unit (CBU).
- A reduction of bed numbers by 16 following expansion of the Home Treatment Team, and the introduction of Dove House, a Women's Crisis House.
- The creation of single sex hospital wards in order to promote privacy and dignity for patients who are admitted.
- The development of the role of Lloyd Still Ward at St. Thomas' Hospital to deliver care for people with both physical and mental health problems.

Community Services:

- The alignment of the Community Mental Health Teams [CMHTs] to GP practices so that existing Primary Care Trust (PCT) structures and boundaries are mirrored.
- Expansion of the Lambeth Early Onset Service - LEO.
- Development of an Assertive Outreach team for the whole Borough, for those patients with severe and enduring mental illness who present with an ongoing significant risk to themselves or others and whom other community services have found difficulty in engaging.
- Development of Recovery and Support teams in each locality. The existing Case Management Teams changed into a Recovery and Support Service. They provide specialist community based treatment and care to those people who have severe mental health problems and who have some willingness to engage with services.
- Changes to the utility of out-patient services, to improve waiting times and efficiency.
- Work to improve attitudes and respect. For service users from ethnic minorities whose experiences have historically been poor in this area, Spektra, (the Trust's cultural consultancy service) works in areas of cultural consultancy and mediation, to improve the experience of individual service users and the relationships they have with staff.

Service changes

Between 2006 and 2008 a number of services were closed. These included the Hopton Road long stay rehabilitation beds, the Dove House Women's Unit, and the Emergency Clinic at the Maudsley Hospital.

Going forward - Joint Commissioning Strategy 2007-2012

Following the disinvestment, Lambeth PCT has made mental health a key priority in its five year commissioning strategy to 2012 and has agreed to increase investment in mental health services. The Local Authority has also committed to a radical programme of enhancing commissioning capabilities and personalising care services. There are three priority areas for Adult Mental Health services set out in the Joint Commissioning Strategy for Adult Mental Health 2008-11:

- Primary Care. This focuses on the management of common mental illness in primary care settings. The strategic challenge is to increase investment in evidence-based interventions, such as talking therapies.
- Severe Mental Illness. The strategic challenge is to embrace systematically a recovery model of support and intervention.
- Social Inclusion and Well-being. A more strategic focus is needed on improving health and well being, integrating plans for adults with mental health problems to other work across age groups.

In order to support the three commissioning priority areas, a number of improvements to the way services are commissioned are being developed. These include a comprehensive needs assessment framework, service redesign to fit defined care pathways, development of user, carer and community engagement, and development of personalised care and carer support strategy. This work has been brought together under the remit of the Lambeth Mental Health Improvement Programme.

In the last year, there has been a total investment of £8.45m to improve community (£3.45m) and inpatient mental health services (£5m) in Lambeth.

Achievements to date - Community Services

- Improved access to talking therapies and psychology services, through an expanded service with local GP practices, and recruitment of Primary Care Mental Health Graduate Workers. - *£1m*

- Improved access to Primary Care and Secondary Care Services, through the recruitment of three Gateway Workers. - *£150K*

- Improved access to services for people from Black and Ethnic minority communities through the recruitment of three Community Development Workers. - *£175k*

- Community Support packages for people with severe mental illness, including those with complex needs, for an additional 50 people, through Umbrella Services. This service delivers personalised care/support packages designed to help people with Serious Mental Illness to live comfortable and meaningful lives in their own homes. - *£300k*

- Extra posts created within the Home Treatment Team. - *£430k*

- Investment in Vocational Matters, a user-led service which provides people with advice on accessing employment and benefit entitlement. - *£40k*

- Investment in Occupational Therapists within the Community Mental Health Teams. The OT's in three sector community teams are the first port of call for people who want support to access vocational choices in the community. The OT's will work closely with the existing vocational provider's network. - *£150k*

Achievements to date - Inpatient Services

- In January 2009 inpatient services previously based at St Thomas' Hospital were relocated to a new £4.2m ward at Lambeth Hospital.

Lambeth Forensic In-patient services

- In August 2006 Bridge House opened at a cost of £10m. This is a Medium Secure Unit of 24 beds on the Lambeth Hospital site. This development, returned patients to their local area from out of area placements.

- In 2008, River House was opened on the Bethlem Royal Hospital site in Beckenham. River House is an 89 bed, £33m new build scheme which provides medium secure beds for patients from Lambeth, Southwark and Croydon. It includes a women's unit, an acute ICU, a dangerous and severe personality disorder unit and a rehabilitation unit.

- In August 2008 a new 12-bed Forensic Rehabilitation Service, with facilities to accommodate four female and eight male residents, was opened at Hopton Road in Streatham. One of the aims of this service is to enable the Trust to discharge patients from Bridge House who no longer need to receive MSU care.

Prison services

- In 2008 The Trust [as part of a consortia] won a contract to provide mental health services in Brixton prison including an in-reach team, management of the health care wing and the drug treatment service.

Changes planned for 2009/10

Community Services

- Lambeth PCT have commissioned an 'Improving Access to Psychological Therapies' (IAPT) Service.

- Lambeth Adult Mental Services are participating in a national pilot to develop Integrated Care Pathways based on an Integrated Assessment Tool. This work will be part of the pilot for payment by results [PBR] feeding into a London wide programme.

Inpatient Services

- Proposed changes to inpatient services at the Maudsley Hospital are taking place as part of the strategy to provide adult acute mental health services for Lambeth residents at Lambeth Hospital. The changes will also enable the Trust to relocate inpatient services currently provided at Guy's Hospital to the Maudsley.

- Inpatient adult services for female Lambeth residents will in future be provided at Lambeth Hospital rather than the Maudsley Hospital.

- Overall, there will be a total of 267 adult inpatient beds for Lambeth residents, compared to 274 at the moment [out of a total of 1,100 beds provided by the Trust]. The reduction in the number of inpatient beds is offset by the increase in the provision of community services.

Lambeth Early Onset Services – LEO

Lambeth LEO services were the first early onset services in the country, and provided the benchmark for this type of service nationally. Lambeth LEO services consist of the LEO Community Team, LEO Inpatient Unit, and LEO Crisis Assessment Team (LEO CAT Teams).

LEO Community Team

The Team provides individually tailored treatment packages which include a range of practical, supportive and psychopharmacological interventions. The aims of the service are to improve clinical and social outcomes through early identification, assessment, treatment and support of people with psychosis using a multi-disciplinary framework. The service aims to engage clients at the earliest possible opportunity following their first or second presentation to mental health services. The LEO Team work assertively to strengthen and extend these links and re-establish those which have broken down. The service is for patients between 16-35 years of age who reside in the Borough of Lambeth.

LEO Inpatient Unit

The LEO ward is an 18 bed inpatient acute unit based on the Lambeth Hospital site. The unit opened in March 2001. It caters primarily for younger people experiencing psychosis for the first time who need hospital admission. The unit comprises ten male and eight female beds which are all in single rooms.

The aim is to improve clinical and social outcomes through early symptom management, psychological adjustment, social recovery, vocational support, family support, safe space, periods of medication and assessment, low dose medication, cognitive and psychosocial interventions.

Lambeth Early Onset Crisis Assessment Team (LEO CAT)

The Team offers a community-based service and works intensively with prospective service users and families aiming to provide early assessment and treatment for service users experiencing their first episode of psychosis. The service is for residents of Lambeth, aged 16-35 years presenting for the first time with a psychotic episode.

The Lambeth Youth Offending Service

The Lambeth Youth Offending Service (YOS) is a multi-agency service consisting of staff from the NHS, Police, Probation, and Social Services. In 2006 there was a single professional Trust CAMHS worker in the YOS. This post was not integrated into the Child and Adolescent Mental Health Services (CAMHS) management structure.

By the end of 2006 YOS had a Multi-disciplinary CAMHS Team with robust links to the Trust's CAMHS management structure. This Team now includes a band 7 Team Leader, a Consultant Psychiatrist, and a band 6 Practitioner. The YOT Team links into the Adolescent Mental Health Team at their weekly meeting to discuss cases and to receive clinical supervision.

Outline of the CAMHS Directorate

CAMHS in the Trust are managed within a single Directorate structure and include four CAMHS Borough services and the National and Specialist Services. The CAMHS Service Director and CAMHS Clinical Director lead and manage the directorate and each borough

service and the National and Specialist outpatient and inpatient services have a lead Clinician and a Service manager.

The CAMHS Directorate consists of five clinical units – National and Specialist Services and four CAMHS Services in the boroughs of Lambeth, Southwark, Lewisham and Croydon. The national outpatient service specialist/research teams are based at the Michael Rutter Centre, Maudsley Hospital; there are five paediatric liaison services at Guy's, King's, Lewisham, Mayday and St Thomas' Hospitals; four inpatient units, three based at Bethlam Royal Hospital and one at Guy's Hospital; seven child and adolescent community multidisciplinary team bases, two in Croydon (Lennard Lodge and 78 London Road); two in Lambeth (Brixton Water Lane and Black Prince Road), two in Southwark (Camberwell and the Bloomfield) and one in Lewisham Park. There are Tier 2 Services in all boroughs primary care and joint working with Child Health and Social Services.

As well as providing a range of services to local children, specialist tertiary services are provided to children and adolescents throughout the country. Adolescent Units at Guy's Hospital and at the Bethlam Royal Hospital and the Children's Unit at the Bethlam Royal Hospital provide supra-regional tertiary inpatient treatment and assessment. An Adolescent Medium Secure Unit, funded by NCG, was opened in October 2005. Professional staff also work closely with local authority social services, education, community health services, acute paediatrics, primary care, the voluntary sector and the criminal justice system.

All Borough Services have learning disability services, Looked After Children Services and links with Youth Offending Teams though configured differently in each area.

The Directorate has a total budget of approximately £25 million and CAMHS is jointly commissioned by the respective local authorities (Education and Social Services) and PCTs. There are approximately 450 staff employed by the CAMHS Directorate.

The National and Specialist CAMHS have a sound academic and clinical reputation nationally and internally.

Lambeth CAMHS

The objective of the Lambeth Child and Adolescent Mental Health Services (CAMHS) is to provide a multidisciplinary diagnostic, assessment, treatment, advisory and consultative service for children and adolescents with emotional and behavioural disorders in particular those at high risk or those with more severe psychiatric disorder. The service comprises both Tier 2 and Tier 3 elements, and the service is being structured so that the Tier 2 and Tier 3 activities form part of an integrated CAMHS.

The services are based on five sites: the Adolescent Service, at Black Prince Road; and Children's Service at 19 Brixton Water Lane; Children's Psychological medicine (Paediatric Liaison) at St Thomas' Hospital; the Children Looked After Mental Health Service based at International House; and the neurodevelopmental Team at Mary Sheridan house. The teams are multidisciplinary including psychiatry, clinical child psychology, child psychotherapy, psychiatric nursing with recruitment in train for family therapy and occupational therapy. The Children's Service will see appropriately referred children under 12 and the adolescent Service accepts all appropriate referrals of 12 years and above, up to the 18th birthday. There is flexibility of staff involvement in services depending on clinical issues and skills, some of whom work across these services. The clinical psychologists work closely with Child Health in relation to special needs work.

In addition there is a Drug and Alcohol team based at Black Prince Road and a CAMHS Youth offending Service (YOS) based at the YOS in Brixton. The redesign process had led to a strengthened Early Intervention Service a newly configured Neurodevelopmental team based at the Mary Sheridan House in primary care services.

11. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted on the life of Mr X and on his care and treatment from mental health services. We are grateful to the family of Mr X for their assistance in compiling the following information.

Background Information

Mr X was born in South London on the 9 October 1988. Mr X is one of four children, he has two elder sisters and one other sister two years younger than himself. The mother of Mr X told mental health services that he developed normally as a young child and whilst not scholastic managed an average performance at school. According to his mother when Mr X was nine years old he started to behave strangely when his father, to whom he was very close, collapsed whilst walking down the street and went into a coma. Mr X's father is now wheelchair-bound as a result of this incident[4].

At the age of eight years Mr X was arrested for writing graffiti and was cautioned at the age of ten years for separate offences of burglary and theft[5]. At the age of eleven his school reported that he was violent towards his peers. At secondary school his behaviour continued to deteriorate[6]. According to histories taken by his clinical team from both Mr X and his family it appears that he began to smoke cannabis from the age of 14 and started using skunk from the age of 15.

February 2003. At the age of 14 Mr X was excluded from school after being found in possession of illicit substances[7].

18 August 2003. Aged fourteen years and three months Mr X was arrested for possession of cannabis, he was given a police reprimand[8].

July 2003. Mr X was excluded from school for 20 days for being abusive and threatening to staff[9].

4 February 2004. On this date Mr X was arrested for possession of cannabis and was given a final warning by the police[10].

23 April 2004. Mr X received his first conviction at the age of 15 for possession of class c drugs. He was given a three-month Referral Order[11].

24 April 2004. Mr X was assigned to the Lambeth Youth Offending Team (YOT).

16 July 2004. The Referral Order was extended to 12 months for the offence of robbery. It is the first evidence of Mr X's violent behaviour. The pre-sentence report described the offence details as 'Mr X struck the Sainsbury Security Guard over his shoulder with a barbell pole in an attempt to assist his friend.'[12]

July 2005. His school described him at this stage as being generally abusive and challenging. Mr X left school.

16 July 2005. Mr X was convicted of robbery and given a referral order and had to pay a fine of £20.00[13].

10 August 2005. Mr X was convicted of common assault following hitting a supermarket officer with a metal pole that he was attempting to take home in a supermarket trolley (see the events of 16 July 2004 above). He was given an eighty hour Community Punishment and Rehabilitation Order and made to pay £50.00 compensation[14].

Between the 12 August and the 8 September Mr X failed to keep his appointments with the YOT.

8 September 2005. A formal referral was made to the Substance Misuse worker within the Youth Offending Team by Ms WP who was his Youth Offending Team Officer[15].

20 September 2005. Mr X's mother contacted Ms WP to voice her concerns about her son's behaviour and withdrawal. Mr X's mother described a recent event where Mr X had punched a wall and became so violent and threatening that she had to call the police[16].

28 September 2005. Following a telephone call to Mr X's mother a meeting was arranged for 11.30am on this date for Mr AQ, a Trust Community Psychiatric Nurse embedded within the Youth Offending Team, to meet with Mr X. Mr AQ recorded that Mr X was unkempt and guarded. Mr AQ recorded that there was evidence of thought blocking and that a mental health assessment 'will be desirable. An appointment has been arranged for 29 September 2005 at 12.30.' **There is no record that this appointment took place**.[17]

29 September 2005. Dr JM, Mr X's GP, wrote a referral letter to the Consultant Psychiatrist of the Lambeth Rapid Response Team. Mr X's mother had called the surgery in an anxious state as Mr X appeared to be ill and was using cannabis. This letter detailed episodes of violence and aggression[18].

The GP also wrote to Mr X encouraging him to come to the surgery for a talk.

It would appear from the YOT notes that the mother of Mr X had been encouraged to contact his GP by Ms WP, his YOT Officer, as it appeared that Mr X was finding it difficult to meet the conditions of his Community Punishment and Rehabilitation Order[19]. The GP was not made aware of Mr X's Youth Offending history at this time.

30 September 2005. A referral form from Ms WP was received by the Lambeth Child and Adolescent Mental Health Services to ensure the continued input from Mr AQ the embedded Trust CAMHS CPN. This referral form stated that Mr X's mother had concerns about her safety and that of her family with regard to Mr X's behaviour[20].

On this same day the Trust Rapid Response Team re-directed the GP referral to the Child and Adolescent Mental Health Service[21].

3 October 2005. A person from the Child and Adolescent Mental Health Team telephoned the mother of Mr X and decided that he did not need to be seen by their service as he was already being seen by Mr AQ within the YOT[22].

6 October 2005. Ms WP sent an email to Mr AQ explaining that she had contacted Mr X's mother suggesting that she provided a medical letter stating that she had referred Mr X to 'the doctors' as this information would make a difference to the outcome of the pending breach

process (this process was due to the fact that Mr X had been too unwell to engage with the YOT and comply with the requirements of his Combined Rehabilitation Order) [23].

13 October 2005. Mr X attended a meeting with Mr AQ. Mr X denied any mental health issues such as hearing voices etc. His access to job seekers allowance was discussed[24].

19 October 2005. Mr X was convicted of a breach of the Combined Rehabilitation Order and was made subject to a Community Rehabilitation Order for one year[25].

20 October 2005. On this date Mr AQ wrote a Mental Health Assessment Report, following a meeting with both Mr X and his mother. This reports details a meeting that was held between him, Mr X and his mother. The report stated that Mr X appeared unkempt and guarded, that his speech was barely audible and slow in delivery. However although he was somewhat distant and detached he was orientated in time, place and person. Mr AQ decided that Mr X would benefit from structured motivational counselling for 'about 6-12 sessions' for at least the duration of his order. The report mentioned that a letter had been written by Mr AQ, it does not mention to whom the letter was written or why[26].

3 November 2005. Mr X met with Mr AQ. At this meeting Mr X was noted as appearing noticeably relaxed and less suspicious, he denied any sleep disturbance or intrusive thoughts[27].

15 December 2005. Mr X met with Mr AQ where he appeared to be unusually positive and affirmative regarding his proposed course in auto mechanics[28].

22 December 2005. Mr X met with Mr AQ. Mr AQ noted that there was a marked and noticeable progress in his presentation and demeanour. Mr X had good eye contact and his 'conversation was affirmative and directional[29].

29 December 2005. Mr X's YOT records noted that he attended a meeting with Mr AQ on this day[30].

20 January 2006. Mr X met with Mr AQ. Apparently he had missed a previous appointment with Mr AQ as his college course had clashed with it[31].

10 February 2006. Mr X kept his appointment with Mr AQ[32].

24 February 2006. Mr X did not keep his appointment with Mr AQ on this day, no reason for this was recorded[33].

2 March 2006. Mr X did not keep his appointment with Mr AQ on this day, no reason for this was recorded[34].

10 March 2006. Mr AQ reminded Mr X to attend his sessions which Mr X had apparently missed as he could not remember the new arrangements that had been put into place to prevent further clashes with his college course[35].

22 March 2006. Mr X made an unscheduled visit to the YOT. Mr AQ described Mr X as being 'rather vague and mildly confused regarding his scheduled appointment (which had been set for the 24 March 2006). His speech was patchy and unrelated.' Mr AQ also recorded that Mr X was not entirely insightful into the events that had lead to him being expelled from his college course. He denied hitting a teacher and denied any threats that he had made towards the staff and students at the college[36].

24 March 2006. Mr X kept his appointment with Mr AQ. Mr AQ described Mr X as appearing unkempt and lacking in concentration, 'his whole demeanour indicates regression in his health'. Mr X was vague about his cannabis use and reluctantly admitted to spending £50 per week on it. Mr AQ wrote that he was going to arrange for the Consultant Psychiatrist to provide 'evaluation and input'[37].

31 March 2006. Mr X attended his appointment with Mr AQ. However due to a fire alarm incident the meeting had to be cancelled. There is no mention of Mr X's mental state or any progress regarding a Consultant Psychiatrist assessment[38].

5 April 2006. Mr X presented at the YOT for an unscheduled appointment. Mr AQ reported him as being somewhat muddled. He said that could not sleep as he had a lot on his mind. He appeared gaunt and emaciated and admitted that he had lost weight. His concentration span

appeared to be shorter than usual, however Mr X denied any visual or auditory abnormalities. He denied any substance misuse. Mr AQ recorded the following plan:

- *'Mr X will try to go to bed before 12 midnight*
- *If necessary Mr X will have a hot chocolate or milky drink*
- *Mr X will try to spend more time outdoors than staying in his room hours on end by himself*
- *Mr X will try to do some exercise like walking now that the weather is getting better*
- *Mr X is encouraged to eat habitually and regularly in order to offset his weight loss*
- *Mr X to engage with a vocational course in order to encourage and stimulate and broaden his interests*
- *This CPN will liaise with Mr X's mother to monitor his current mental state'*

The next appointment was set for the 7 April 2006[39].

7 April 2006. Mr X's mother contacted the YOT expressing her concerns regarding her son's well being. She was told that Mr AQ would be contacting her in order to discuss how best to proceed. Mr X's mother left her telephone number so that Mr AQ could contact her directly.

On this date Mr X attended his session with Mr AQ accompanied by his mother and his case worker Ms WP due to their concerns about his deteriorating mental health. His mother told Mr AQ that Mr X was only sleeping about 3 hours each night and that he preferred his own company and listened to rap music. His mother also reported that Mr X had admitted to recently trying cocaine.

It was agreed that Mr AQ would monitor Mr X for another week before referring him to the Consultant Psychiatrist. Mr X's mother said that she would report any further deterioration to the YOT Team, and Mr, AQ agreed to meet with Mr X twice a week[40].

21 April 2006. Mr AQ met Mr X for his prearranged session, no other sessions had occurred since the 7 April as had been arranged. Mr X appeared to be distant and his conversation was patchy. His concentration was poor and he appeared to be disorientated especially regarding time. He could not recall the events of the past two weeks. Mr AQ records his intention to undertake a 'mini mental state assessment next week.'[41]

28 April 2006. Mr X kept his appointment with Mr AQ. He is recorded as being unkempt and dishevelled. His eye contact was poor and his train of thought was 'patchy and incoherent at times'. Mr AQ recorded that there appeared to have been gradual erosion into Mr X's mental state. Mr AQ wrote that a formal mental health assessment was to be arranged[42].

5 May 2006. Mr X turned up on the wrong day to see Mr AQ who gave him his fare home[43].

12 May 2006. Mr X arrived on time to see Mr AQ and was informed that Mr AQ was not in the building but that Mr X could see the duty Community Psychiatric Nurse. M X declined[44].

2 June 2006. Mr AQ recorded that Mr X did not attend the prearranged session for this day. Mr AQ informed Mr X's case worker[45].

9 June 2006. Mr X met with Mr AQ. It is not recorded what Mr X's mental state was on this day[46].

12 June 2006. Mr X and his mother went to his GP to ask for help. They reported that Mr X was smoking skunk on a daily basis and had been doing so for several years. Mr X was reported as hearing sounds, not voices, and also having visual hallucinations. Mr X was referred to the Lambeth Early Onset (LEO) Team by his GP[47].

21 June 2006. The GP letter was date stamped as having been received by the Trust.

22 June 2006. The LEO Team called Mr X's GP. They could not get through and they could not leave a message[48].

23 June 2006. The LEO Team called Mr X's GP. They could not get through and they could not leave a message[49].

26 June 2006. A LEO Crisis Assessment Team (LEO CAT) meeting was held where Mr X's case was discussed. It was thought that he may be displaying early signs of psychosis, perhaps as a result of smoking cannabis. Dr EI and Ms JN were present at this meeting, they became Mr X's Consultant Psychiatrist and Care Coordinator respectively[50].

27 June 2006. A LEO CAT worker telephoned Mr X's mother. She told the worker that she had been worried for about a year which was when Mr X had first started to hear voices. At this time Mr X's mother said she was not afraid of him becoming violent. A meeting was arranged for the 29 June 2006[51].

29 June 2006. Mr X was assessed by the LEO CAT by Ms JN, his assigned Care Coordinator and Mr BG, a Community Psychiatric Nurse. The clinical records document the impression that Mr X had been suffering from prodromal (early stage) symptoms for one year and that he had a four month history of positive psychotic symptoms. At this meeting Ms JN was told by Mr X's mother about his involvement with the Youth Offending Team[52].

30 June 2006. Mr X attended his meeting with Mr AQ at the YOT. Mr AQ reported that Mr X had poor eye contact and showed some psycho motor retardation. Mr AQ noted that Mr X could not explain why he had missed his last two sessions. Mr AQ wrote that he thought Mr X had some symptoms of a shizoform disorder 'for which I am arranging for Consultant Psychiatrist Dr CP to see.' It would appear that the YOT CAMHS worker was not aware of the LEO CAT referral and assessment at this stage. [53]

3 July 2006. At the LEO CAT weekly meeting at which both DR EI and Ms JN were present it was documented that Mr X had been hearing his friend's voices from a radio. It was felt that he 'may have been stoned' at his last appointment[54].

5 July 2006. (This note was added from memory on the 7 September 2006) Dr EI recorded that he met with Mr X and his mother to discuss the need for anti-psychotic medication and the various options that were available. It was decided that medication would be an appropriate thing at that stage and a prescription of Aripiprazole 5mg was prescribed for seven days, to be reviewed frequently and increased gradually and according to the clinical picture to 10 mg to avoid side effects.

Mr X did not say very much during this interview, but his mother was very active showing her concern and wanting her son to be started on his new treatment as soon as possible[55].

7 July 2006. Ms JN contacted Mr X's mother to see how he was tolerating his medication. His mother reported that he accepted the medication and that he was sleeping a little more

than he had been used to. Ms JN reminded Mr X's mother that his next appointment would take place on the 10 July 2006. There is no record of this meeting having taken place[56].

12 July 2006. Fasting bloods were taken to screen for organic illness and to establish metabolic baseline parameters[57].

18 July 2006. Ms JN telephoned Mr X's mother to find out how he was tolerating his medication. Another appointment was set for the following day at 12 noon. Mr X appeared to be doing well on his medication[58].

19 July 2006. Mr X and his mother attended the meeting with Ms JN. Mr X did not appear happy to be present. Mr X appeared to be responding to auditory hallucinations and his mother answered most of the questions. Mr X was taking his medication every day and he appeared to be more relaxed. Ms JN asked Mr X if it would be possible to go through the relapse prevention card sort exercise. Mr X said that he did not want to. Mr X said that he thought he was at the meeting to discuss his headaches. Eventually Mr X was encouraged to take part in the card sort exercise but he had to be prompted a great deal by Ms JN and his mother. Ms

JN decided to end the session. Another appointment was arranged for the 25 July 2006[59].

25 July 2006. (This note was entered from memory on the 12 September 2006) Dr RK, a SHO, and Ms JN met with Mr X and his mother. Dr RK recorded that his general impression was that Mr X was improving. Mr X's mother felt that the medication had led to a rapid improvement and that Mr X had also reduced his skunk intake. It was recorded that Mr X did not express any delusions, although he was not sure whether or not he could read minds. He said that he had not heard any more voices from the radio. It was agreed that the Aripiprazole would be raised to 10mg OD, both Mr X and his mother appeared to be happy with the plan to gradually increase this to 15 mg over the coming weeks. Mr X agreed to go through the CORE-OM during this session and agreed to do the PSYRATS at the next session. The next session was arranged for the 1 August 2006[60].

27 July 2006. A contingency plan was drawn up so that the LEO Team could visit Mr X at home if needed or if Mr X was to disengage from the service[61].

1 August 2006. Mr X did not keep his appointment. Ms JN wrote that she would call Mr X's mother to arrange another meeting[62].

7 August 2006. The LEO CAT administrator recorded the following from the weekly clinical review:

'mother supposed to phone
Reducing his cannabis
Getting better
Plan
Phone mother'

Ms JN telephoned Mr X's mother to make another appointment for the 8 August at 4pm[63].

9 August 2006. (This note was entered from entries in a notebook on the 15 September 2006) Ms JN recorded that Mr X attended this appointment on his own. He did not appear to be responding to any auditory hallucinations. Mr X reported that he had not been doing anything much since their last appointment but that he was due to commence an e-learning course. Ms JN asked him the 'magical question' (i.e. three wishes) in an attempt to see whether she could get any more information out of him. He said that he did not like being asked so many questions and said that he would rather not come again. Ms JN explained that he would have to keep his appointment and explained why. Another appointment was made for the 17 August 2006[64].

10 August 2006. Mr X was invited to a healthy living group[65].

16 August 2006. Mr AQ, the YOT Community Psychiatric Nurse, discussed Mr X's case with Dr CP, the Consultant Psychiatrist. Mr X had missed several sessions with the YOT Team in August. Dr CP said that further work was needed to formulate the case. No further plans were indicated in the notes[66].

17 August 2006. Mr X's appointment was cancelled with Ms JN as she was off sick. Another appointment was set for the 21 August 2006[67].

21 August 2006. Mr X did not attend this meeting with Ms JN. The plan was to contact him by telephone the next day[68].

22 August 2006. Ms JN tried to telephone Mr X's mother but her telephone was switched off. The plan was for Ms JN to telephone again the next day[69].

24 August 2006. Ms JN recorded in the electronic record that she tried to telephone Mr X's mother 'numerous times during the day, no response. Message left to contact LEO CAT.' Ms JN left a message in the diary for the Team to telephone Mr X's mother the following day as Ms JN was not due into the office[70].

It is about this time that the Court heard that Mr X ceased taking his medication.

31 August 2006. Mr X attended his appointment to see Ms JN. His mother could not park and waited for Mr X in her car. Ms JN was able to speak briefly to her and Mr X's mother reported that he had been well. Mr X appeared to be well when in the therapy room. He made eye contact and responded to questions even though he did not volunteer information. He was reported as fatuously smiling once, but when questioned about it shook his head. Ms JN wanted to draft a timeline with Mr X that day to chart the onset of his illness, Mr X said that he did not want to do this. Ms JN asked Mr X if he was taking his medication. He said that he had forgotten to take it once and that his mother had to remind him to take it. Ms JN decided to make an appointment for Mr X to see Dr EI regarding his medication on the 6 September 2006[71].

5 September 2006. Mr X stabbed Mrs Tulloch to death.

6 September 2006. Mr X went to Kennington Police Station with his father and his uncle to hand himself in for the murder of Mrs Tulloch.

Ms JN records that she was called to Kennington Police Station where Mr X was being kept in a cell in order to act as an appropriate adult for Mr X[72].

2 April 2007. His Honour Judge McKinnon stated that, 'the sentence of the Court is a hospital order made under Section 37 of the Act; the mental illness is schizophrenia...and I make a restriction order under Section 41 of the Act...due to the nature and gravity of the offence, the antecedents and the risk of further offending in order to protect the public.' Mr X

was detained within a Secure Hospital setting where he remained at the time of writing this report.

12. Timeline and Identification of the Critical Issues

RCA Second Stage

Timeline

The Investigation Team formulated a Timeline in table format and also a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other, please see Appendix One. This represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

Critical Issues Arising from the Timeline

On examining the timeline the Independent Investigation Team initially identified four critical junctures that rose directly from the care and treatment that Mr X received from the South London and Maudsley NHS Foundation Trust. These critical junctures are set out below.

1. During the time that Mr X received his care and treatment from the YOT there is evidence to show that assessment, care planning and treatment did not occur in a timely manner. During Mr X's first episode of mental ill health there was plenty of evidence to suggest the early stages of a psychotic disorder. Whilst this was appropriately noted by the CPN no appropriate actions were taken in line with the plan that he had himself devised.

2. On the 29 September 2005 Mr X was referred to the Rapid Response Team by his GP following a consultation with Mr X and his mother. This referral was passed appropriately on to the Child and Adolescent Mental Health Team. However the decision was made not to accept the referral as Mr X was being seen by the CPN at the YOT. This meant that no further assessment was undertaken despite growing concerns from Mr X's family and GP. This in effect delayed his assessment, diagnosis and treatment for a period of ten months.

3. On the 29 June 2006 Mr X was assessed by the LEO CAT. During this meeting Mr X's mother told his Care Coordinator about his previous and recent involvement with the YOT. At no time was this important aspect of Mr X's history investigated further by his new care team. No aspect of his potential risk, either to himself or to others, was assessed or taken into account at this stage.

4. Despite being aware of his previous involvement with the YOT it appeared that no communication took place between the two services regarding Mr X's care and treatment, to the extent that the YOT did not appear to know what had happened to Mr X or why he was no longer attending his meetings with their CPN.

The four critical junctures listed above are incorporated under the relevant headings listed directly below. They are examined in detail under these headings in Section 14 of this report.

Critical Issues Arising from the Review of other Data

The Independent Investigation Team found other critical issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below under the key headings of the Independent Investigation Terms of Reference.

1. **Management of Clinical Care and Treatment.** The Independent Investigation Team could not identify a coherent care and treatment plan for Mr X. The YOT CPN failed to respond appropriately to the development of Mr X's symptoms and needs, and the LEO CAT Care Coordinator did not compile a comprehensive plan of care that was responsive to the needs of Mr X and his family.

2. **Clinical Risk Assessment and Forensic Risk History.** This aspect of Mr X's care was not taken into consideration during his assessment in the summer and autumn of 2006. There was no understanding or exploration of his past criminal history or how this history could have impacted on either his family or the wider public.

3. **Care Programme Approach.** The Independent Investigation Team could find no evidence to support the notion that the Care Programme Approach was being implemented in a thoughtful manner in keeping with both national and local policy. This is evidenced by the fact that Mr X and his family had no documented Care Plan,

no attempt was made to engage with Mr X's GP regarding his CPA, no attempt at a holistic assessment was made and no CPA meetings were held.

4. **Carer Assessments and Carer involvement in Care Planning.** Throughout the examination that the Independent Investigation Team gave to the review of the care and treatment of Mr X, no evidence could be found to suggest that Mr X's mother had been offered a formal carer assessment. Mr X's father was confined to a wheelchair and his mother had a difficult time in managing both her husband's and son's care needs.

5. **Service User Involvement in Care Planning.** There was no evidence to suggest that any attempt had been made to get to know Mr X and to devise a short term treatment plan to alleviate his mental health problems apart from giving him medication. No assessments took place in Mr X's home ensuring that he was seen outside of his familial and social context.

6. **Safeguarding Children/Vulnerable Adult assessment.** Mr X should have been subject to a safeguarding children assessment. This view is held in the light of his persistent substance misuse problem, his social needs and those of his family with particular regard to his father's difficulties. A safeguarding children assessment should also have been considered as his younger sister was still living at home and should have been assessed in her own right. Mr X's father could definitely have been regarded as a vulnerable adult and should have been assessed in the light of Mr X's violent past behaviour.

7. **Interagency Communication and Working.** There is no evidence that the LEO CAT made any attempt to contact either the YOT or Mr X's GP. We can be fairly certain that the LEO CAT were aware of Mr X's prior involvement with the YOT as this initial contact has been documented on the 29 June 2006. Communication within the Adolescent Team, especially regarding referrals, appears to have been managed poorly. Aside from two missed calls, there is no documentation held by either Mr X's GP Practice, or the Trust electronic record, to evidence that the teams involved made any attempt to communicate with primary care services at all.

8. **Organisational Change Management.** Between 2001 and 2006 the South London and Maudsley NHS Foundation Trust underwent a high degree of organisational change. This change encompassed the merging of corporate services, the development of local Lambeth services and a Trust wide adoption of new electronic clinical records systems. This appears to have placed additional pressures on the LEO CAT and YOT CAMHS.

9. **Adherence to National and Local Policy Guidance.** South London and Maudsley NHS Foundation Trust were found to have sound policies in place at the time of the incident. The Independent Investigation Team did not find evidence to demonstrate that these local policies were adhered to by clinical staff on a day to day basis regarding the care and treatment of Mr X.

10. **Documentation.** The overall quality of Mr X's clinical record was found to be poor by the Independent Investigation Team. Evidence of risk assessment and care planning were virtually nonexistent. The Investigation also noted that seven entries in Mr X's record had not been entered contemporaneously.

11. **Clinical Supervision and Clinical Experience.** The practice and process of both clinical and caseload supervision could not be tracked by the Independent Investigation Team during their review. Concerns were also raised regarding the qualifications of Ms JN who acted as Mr X's Care Coordinator and also regarding the suitability of the assessments that she conducted with Mr X at the time. There are key concerns regarding the qualifications and status of the Care Coordinator:

- Was Mr X's Care Coordinator suitably qualified?
- If not what was her employment status? Was she a care assistant?
- If so should she have been given an enhanced case load?
- If so what supervision did she receive?

The above eleven critical issues were identified by the Independent Investigation Team as requiring an in-depth review. It must be stressed that critical issues in themselves do not necessarily have a direct causal bearing upon an incident.

The Independent Investigation Team also conducted a review into the South London and Maudsley NHS Foundation Trust Internal Investigation process, reporting, and action planning implementation outcomes. This is explored in section 16 below.

13. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

RCA Third Stage

This section of the report will examine all of the evidence collected by the Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue factors.

In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'key causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the homicide that occurred on the 5 September 2006. In the realm of mental health service provision it is never a simple or straight forward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr X's mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Trust that is not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 5 September

2006, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

13.1. Critical Issue Number 1. Management of Clinical Care and Treatment

Management of the Clinical Care that Mr X Received

Section 14.1. examines the context in which the clinical care that Mr X received was given and seeks to give an account of how services were managed during the period that Mr X was receiving his care and treatment, and how by default his particular case was managed.

13.1.1. Youth Offending Team Child and Adolescent Mental Health Services 20 September 2005 - 30 June 2006

13.1.1.2. Background and Description of Events

Mr X was known to the Youth Offending Team (YOT) from the 24 April 2004 following a conviction for the possession of a class C drug. Mr X received a three-month Referral Order on this occasion. His case was allocated to Mr PB on the 16 May 2004. Following this, on the 16 July 2004, Mr X was convicted of robbery. For this offence he received a Referral Order and £20.00 costs. Mr X met frequently with his allocated YOT worker who supported him in engaging with educational activities (school and the National Association for the Care and Resettlement of Offenders) and drugs awareness services until April 2005 when his Referral Order was complete. During this time Mr X had been permanently excluded from the National Association for the Care and Resettlement of Offenders local facility for fighting with another pupil although he continued to attend school two days a week.

On the 10 August 2005 Mr X was convicted of common assault, and received an eight-hour Community Punishment Order and £50.00 fine (Mr X had assaulted a security market guard with a barbell pole) and his case was reactivated with the Youth Offending Team and allocated to Ms WP. The first contact Ms WP had with the case was with Mr X's mother, as Mr X declined to attend. His mother expressed concern about Mr X who had spent the six week summer holiday playing on his computer in his room. Ms WP informed Mr X's mother that she would refer him to a mental health nurse. Mr X was referred to Mr AQ the Trust Community Psychiatric Nurse (CPN) embedded within the Lambeth YOT.

The first face to face contact Ms WP had with Mr X was on the 8 September 2005 when he was noted to be 'vacant with no eye contact'. Mr X was referred to Mr JB the Drugs Worker within the YOT. By this stage it was becoming clear that Mr X was finding it difficult to attend his YOT appointments and it was thought that his mental health could be the cause of this[73].

The YOT CPN, Mr AQ, met with Mr X on the 28 September 2005 for the first time, for 15 minutes. Mr X was reported as being isolative and withdrawn, punching walls and generally behaving in a bizarre manner. A brief mental state assessment was completed where Mr X was noted to be 'thought blocked, lacking in spontaneity in verbal and facial expression, preoccupied and suspicious'. Mr AQ's opinion was that a mental health assessment was desirable and an appointment was booked for the 29 September 2005. It is not recorded who this assessment was to be conducted by[74].

The following day (the 29 September) Mr X was referred to the Lambeth Rapid Response Team by his GP for an opinion and an assessment following a meeting with Mr X's mother. This was redirected to the Lambeth CAMHS Team the following day by fax. The CAMHS manager spoke to Mr X's mother who informed her that he was being seen by the CPN at the YOT. On the 3 October 2005 the CAMHS manager decided that Mr X did not need to be seen by their service at that time as he was already being seen by a Trust mental health worker. The CAMHS service records noted that 'Mr X is already working with the YOT CPN and he does not need to be seen by the adolescent service'[75].

On the 6 October 2005 Ms WP contacted Mr X's mother for a medical letter. It had been decided that Mr X would have to attend Court because he had not been able to honour the requirements of his Community Punishment Order. Ms WP had suggested to Mr X's mother that a doctor's letter could make a difference to the outcome of the Court process. Mr X's mother stated that she had already taken him to the GP who had made a referral to the CAMHs Service[76].

On the 13 October 2005 Mr X attended his second meeting with Mr AQ, the YOT CPN. Although Mr X denied hearing voices or having intrusive thoughts his eye contact was poor and his isolative behaviour was continuing he presented as monosyllabic and guarded in his

speech file. A meeting was arranged with Mr X's mother in order to obtain additional background information[77].

On the 19 October 2005 Mr X was convicted of a breach of his Combined Rehabilitation Order and was made subject to a Community Rehabilitation Order for one year[78].

On the 20 October 2005 Mr AQ met with Mr X's mother who reported that his behaviour had changed following his father's illness and subsequent disability. She reported that Mr X did not go out by himself, and neither did he interact with his family. Mr X's mother reported that she had reduced the amount of money she gave her son in an attempt to reduce his cannabis intake. Mr AQ decided at this stage that Mr X would benefit from structured motivational counselling that would consist of between six and twelve sessions.[79].

On the 28 October 2005 Mr AQ reported to Ms WP that his professional views about Mr X's mental health were inconclusive and that he was seeking further background information from Mr X's mother[80].

On the 31st October 2005 the YOT notes record that the police had been called to the home of Mr X as there was a disturbance, with his mother making the allegation that Mr X had punched a hole in the wall. Mr X was arrested and taken to the police station but no further action was taken as his mother withdrew her statement[81].

A further meeting between Mr X and Mr AQ took place on the 3 November 2005, the incident of the 31 October was not discussed. Mr AQ noted that Mr X looked more relaxed and less suspicious[82].

During the ensuing period Mr X met regularly with his YOT worker, Connections and NARCO to discuss his training and work placement options

On the 15 and 22 December 2005 Mr X met with Mr AQ where he was noted to have improved. He was reported to have had "good eye contact and his conversation was affirmative and directional" [83].

Further meetings with Mr AQ are recorded as having taken place on the 29 December 2005, 20 January 2006, 10 February 2006, and the 24 February 2006, however no reference was made with regard to Mr X's mental state. Mr X missed his appointment with Mr AQ on the 2 March 2006.

By the 22 March 2006 when Mr X next met with Mr AQ he had been expelled from his training project for allegedly hitting a teacher. His speech was reported as being patchy and unrelated. Mr AQ followed this appointment up on the 24 March 2006 when Mr X presented as unkempt, fidgety and lacking in concentration, reluctantly admitted to spending £50.00 a week on cannabis. There was a clear indication that Mr X's mental state had deteriorated and the CPN planned to arrange for a Consultant Psychiatrist evaluation and input[84].

On the 5 April 2006 Mr X self presented to Mr AQ when he was recorded as being muddled with poor sleep. Mr X denied any perceptual disturbances although he did report having a disturbed appetite; he was noted by Mr AQ as being 'puzzled and incoherent'. A practical plan was agreed around sleep hygiene, regular meals and activity[85].

On the 7 April 2006 Ms WP, Mr X's YOT Officer, recorded a contact from Mr X's mother who was concerned because Mr X was getting up in the early hours of the morning and going out for walks and that at times he would burst out laughing in his room. Mr X and his mother were seen later the same day by Mr AQ. Mr X's mother reported that her son had lost weight and largely kept to his own company. The plan was for Mr AQ to monitor Mr X twice a week for the next couple of weeks before referring him to see a consultant psychiatrist[86].

On the 21 and 28 April 2006 Mr X continued to present to Mr AQ as unkempt and dishevelled with poor eye contact, patchy and incoherent speech and poor concentration. Mr AQ concluded that there has been a gradual deterioration in his mental state and that a formal mental health assessment needed to be arranged[87].

Mr X then turned up on the wrong day for his next appointment and also missed his subsequent appointment with Mr AQ. At the next session that was held with Mr AQ on the 9 June 2006 there was no indication of Mr Xs presentation or mental state recorded[88].

On the 21 June 2006 Mr X and his mother met with his GP to ask for help. Mr X was smoking skunk on a daily basis and had been doing so for several years. Mr X was reported as hearing sounds, not voices, and also having visual hallucinations. Mr X was referred to the LEO Team by his GP. During this meeting it would not appear that Mr X's ongoing participation with the YOT was discussed[89].

Mr X's final appointment with Mr AQ was on 30 June 2006 when it was recorded that Mr X presented as 'vague and spaced out with poor eye contact and psychomotor retardation'. Mr AQ concluded that Mr X appeared to have residual symptoms of a schizoform disorder for which he was planning to arrange an appointment with a Consultant Psychiatrist'[90]. Unbeknown to Mr AQ on the day before Mr X had also been seen by the Lambeth Early Onset Team following a referral from his GP.

On the 16 August Mr AQ discussed Mr X's failure to attend appointments with Dr CP, the embedded YOT CAMHS Consultant Psychiatrist. The plan was that further work was required to formulate the case. However no further plans or meetings were recorded within the clinical documentation.

Mr X was not seen again by Mr AQ at the YOT. The YOT Internal Investigation Report into the care that it provided to Mr X stated that according to its records 39 appointments were offered to Mr X by Mr AQ the CAHMS worker. This Independent Investigation has been able to find evidence of 23 appointments only that were offered to Mr X by Mr AQ.

13.1.1.3. Context to Youth Offending Teams 2005-2006 and the Local Situation

In England and Wales a Youth Offending Team (YOT) is a statutory multi-agency team that is coordinated by a local authority and overseen by the Youth Justice Board. It deals with young offenders, sets up community services and reparation plans, and attempts to prevent youth recidivism and incarceration. Youth Offending Teams engage in a wide variety of work with young offenders (those under 18) in order to achieve their aims. YOT's supervise young people who have been ordered by the court to serve sentences in the community or in the secure estate. The Children Act 2004 places a duty on agencies to work in partnership to achieve the best outcomes for children.

In Lambeth the CAMHs service provides a child mental health service for children and young people aged up to 18 years and their families, including the service to the Lambeth YOT through embedded CAMHS workers.

The Independent Investigation Team learnt from clinical witnesses that the YOT CAMHs Service underwent 'radical changes' prior to the incident of 5 September 2006. The CAMHs Service to the YOT had originally been provided by a Senior Clinical Psychologist and a Junior Clinical Psychologist being supported, through regular case reviews, by the Consultant Psychiatrist in his capacity of Clinical Lead to the Tier Three CAMHS Team. Both these key staff members left the service within a period of six months. The Independent Investigation Team learnt, during clinical witness interviews, that there was a disagreement between the new Manager of the CAMHs service and the Consultant Psychiatrist as to the required skill mix for the YOT CAMHs Service and that there were significant delays in appointing to these posts resulting in the CAMHs service only being able to provide emergency assessments. In the interim the service was covered through the provision of agency and locum workers[91].

At the end of 2005 a Consultant Psychiatrist was appointed to the Lambeth CAMH's service. This post was split between the Children's Mental Health Service and the Adolescent Service. As part of the Adolescent Service the Consultant would offer twice weekly sessions to the YOT. At this time there were two locum staff members working without a Team Leader. There were no systems or processes in place for the Consultant to access clients and the service provided was described as '*ad hoc*' (by clinical witnesses to the Independent Investigation) due to pressures from the other areas within the post and the lack of structured arrangements. Eventually the Consultant took on some of the tasks that would more usually fall within the remit of the Team Leader such as supervision of staff and minuting meetings. The Consultant went on leave in June 2006 returning to work in July 2006 by which time one of the locum staff had left the service. On exploring the caseload of the remaining member of staff it became apparent that there were many cases, far too many for one person to work with. Some of these cases had not been seen for a long time, there was no structure to the records and no regular communication evidenced with primary care. The Electronic Patient Journey System (EPJS) was introduced into the YOT Service in the summer of 2006 and this system also highlighted problems as there were cases being flagged up on it that were not currently on the case worker's case load and *vice versa*[92].

The YOT CAMHs workers were regarded as part of the core service of the Trust CAMHS being expected to attend the weekly Multi Disciplinary Team meeting, bring cases for discussion, and attend the referrals meetings. The YOT CAMHS workers were supervised by the CAMHS Service Team Manager. The YOT CAMHS Service was a Tier Two service designed to receive referrals from the YOT for initial assessments. The expectation was that if mild to moderate problems of anxiety or depression were presented then this would be managed by the YOT CAMHS workers. If the presenting issues were more complex, such as psychosis or severe depression with a risk of self harm, then cases would be referred to the Tier Three Services (a simple definition of the Tier system is to be found in the glossary below).

During this period the CAMHS Service comprising the Tier Three Multi Disciplinary Team, the YOT workers and the Drug and Alcohol Team, were all managed by one Service Manager. This Service Manager was responsible for the supervision of the YOT workers and in turn was supervised by the CAHMS Lead Clinician. There were two Consultant Psychiatrists within the CAMHS Team, one of whom held the responsibility for providing two sessions a week to the YOT.

The CAMHS Team involvement with the YOT was described by clinical witnesses to the Independent Investigation Team as being ‘challenging’. This challenge was apparent in terms of managing and supporting a satellite service, and was exacerbated by not having a clear expectation or understanding of the service required by the YOT[93].

13.1.1.4. Findings

There are three headings under which the findings in this section are examined. They are as follows:

- Clinical decisions made by Mr X’s YOT CAMHS worker;
- Skills, competency and supervision of the YOT CAMHS workers;
- Service structure and practice.

Clinical Decisions Made by Mr X's YOT CAMHS Worker

It would appear that Mr X met with Mr AQ a total of 18 occasions. On eight separate occasions Mr AQ recorded symptoms suggesting a deterioration of Mr X's mental state, and on four of these occasions he recorded psychotic symptoms.

On the 28 September 2005, and the 21 April 2006 Mr AQ recorded his intention to undertake an assessment of Mr X's mental state. These assessments were not documented in Mr X's clinical record and the Independent Investigation Team has concluded that they did not in fact take place.

On the 24 March 2006 and the 28 April 2006 Mr AQ recorded his decision to seek a formal assessment from the CAMHS Consultant Psychiatrist. There are no records of any formal assessments being conducted by the CAMHS Consultant Psychiatrist and the Independent Investigation Team has concluded that they did not in fact take place. It would appear that Mr X did not see a Psychiatrist whilst attending the YOT service.

During the period that Mr X attended the YOT Mr AQ gathered a significant amount of data concerning Mr X's family background and mental state. However Mr AQ did not draw this together into a comprehensive assessment, nor did he make use of information available in the YOT records to inform his assessment or interventions. Mr AQ did not formulate a risk assessment or care plan, to have no risk assessment in what is recognised to be a high risk service is remarkable. There is no evidence to suggest that Mr AQ presented this case to the CAMHs Team or that he discussed any of his recorded concerns with his supervisor.

Skills, Competency and Supervision of the YOT CAMHS Workers

During the period that Mr X received input from the YOT CAMHS, the YOT CAMHS workers were locum staff. On examination the Independent Investigation Team has been able to ascertain that a Clinical Supervision arrangement for these individuals was at best sporadic.

The Independent Investigation Team were told by several clinical witnesses that a new Consultant Psychiatrist had been appointed during this period and put in the precarious position of having to work across three teams whilst also providing a service to the YOT. At this time there was no service level agreement between the YOT and CAMHS Services; this

was further compounded by the lack of procedures and policy governing the new Consultant Psychiatrist's appointment and the resulting lack of clarity around roles and responsibilities. The Consultant Psychiatrist informed the Independent Investigation Team that she did not have any confidence in Mr AQ's clinical ability as he was often unable to provide a coherent account of what he was planning to do with the service users on his caseload. The Consultant Psychiatrist was not aware at that time of what she could do regarding her concerns about Mr AQ's performance.

The Independent Investigation Team heard that there appeared to have been a lack of harmony between the senior clinicians and the management of the CAMHs service not only in the appointment of the locum staff but also around the quality and competence of individuals. Concerns about the clinical practice of Mr AQ from both of the Consultant Psychiatrists appear to have been 'dismissed' by the CAMHS Team manager.

Service Structure and Practice within the YOT

On the 29 September 2005 Mr X's GP made a referral to the Rapid Response Team because he had significant concerns amount Mr X's mental state following acts of violence and aggression within his home. The GP letter stated that Mr X had been using cannabis and had been reported by his mother as being both withdrawn and deluded. This referral was appropriately re-routed by the Rapid Response Team to the Lambeth CAMHS Team.

There were clear structures in place to deal with psychosis within the CAMHS Team at the time when Mr X was being seen by Mr AQ. There were, and are, approximately 20 young people with psychosis at any given time within the Tier Three Services and the Team had experience of working with families, were in a position to provide assertive outreach and psychological therapies as well as interventions to work with co morbid substance misuse. It would not have been unreasonable for a referral such as the one made by Mr X's GP to have been accepted by this Team, especially as the GP referral had mentioned acts of violence and aggression in the home.

The referral process into Tier Three CAMHS had changed during the time that Mr X was receiving his care and treatment. Originally the referral process had been a duty-based system where information would be gathered from the referring agent and the family to make a baseline assessment of risk and urgency. Any serious concerns, such as a possible psychosis,

would be discussed with the Consultant Psychiatrist and the appropriate allocation made. At the time of Mr X's referral the CAMHS' Manager was screening all referrals. The CAMHS' Manager did not discuss Mr X's referral with the Consultant Psychiatrist and neither were checks made with the YOT CPN to ascertain information about Mr X's mental state. There is no evidence in Mr X's clinical record to suggest that the GP was informed regarding the rationale behind the decision not to accept Mr X on to the CAMHS caseload. The presentation described within the GP referral letter would merit a Tier Three referral and assessment. The care that he was receiving within the YOT was a Tier Two service which would not have been best equipped to deal with an emerging psychosis.

During this period Mr X was not complying with the terms of his Community Order. The Independent Investigation Team could see on examination of Mr X's YOT records that his YOT Officer, Ms WP, was concerned about his mental state and had suggested that his mother visit his GP in order to get a doctor's letter because Mr X was in danger of being found in breach of his Community Order. This suggestion possibly preempted the GP referral made on the 29 September 2005. What remains unclear is why:

- Ms WP had not asked Mr AQ to formally approach the YOT Consultant Psychiatrist to conduct an assessment and write a letter for the Court regarding Mr X's mental state and subsequent inability to attend his YOT appointments;
- why Mr X's mother had not informed the GP of Mr X's involvement with the YOT.

This lack of joined up working on the part of the YOT clearly did not work in Mr X's best interests as he was found by the Court to be in breach of his Community Order on the 19 October 2005.

Ms WP, Mr X's YOT Officer, initially referred Mr X to the Team's drug worker who conducted an initial assessment referring Mr X onto the ACAPS (Alcohol Counselling and Preventive Service) where he was seen for structured programme of work around his cannabis use. The outcome of the intervention is not known however it would appear that the case was closed to the ACAPS on 6 October 2005.

13.1.1.5. Conclusions

The decision made by the CAMHS Team Manager not to pursue the GP referral was incorrect within the context of Trust local operational policy and procedure. Mr X was probably showing the early signs of psychosis at this stage and the GP referral letter outlined this possibility clearly. The YOT CAMHS Team was not the appropriate place in which to assess and manage the care and treatment of a young person who was developing a psychosis. It was clear that Mr X was severely psychotic. It is the view of the Independent Investigation Team that this possibility was evident between 2005 and 2006. It is possible that the Service Manager did discuss the case with Mr AQ however there is no record on the clinical file to indicate that this was the case. It is also possible that the Service Manager discussed this case with other members of CAMHS Multi Disciplinary Team, however yet again there is no evidence in the clinical file that this was the case.

In view of the findings regarding Mr AQ's clinical practice as it related to Mr X it would appear that he was able to recognize the psychotic symptoms that Mr X was displaying. Mr AQ was appropriately concerned as he recorded that a medical opinion was needed but it is clear that he did not realize the significance or urgency and the potentially detrimental effect these symptoms can have on an individual if left untreated. The Independent Investigation Team concludes that the assessment, care planning and risk assessment, evident in the worked example of the care given to Mr X, fell below that expected of a registered nurse and that Mr AQ's practice in this instance was hindered by inadequate staffing, management and supervision.

Unfortunately Mr AQ was not available to give evidence to either the Trust Internal Investigation or the Independent Investigation as he currently resides in Africa. It has not been possible to establish any rationale or explanation for his lack of timely interventions. The then manager of the service has also left the Trust and remains untraceable.

Whilst there are clear issues about the clinical practice of Mr AQ there are also issues regarding the intra team communications during this period within the YOT, within the CAMHS Team and between both the YOT and the CAMHS Team. This is exemplified by the work conducted by the worker from ACAPS and feedback from the Connections worker about the failed placements. The Independent Investigation Team was not able to detect that processes were in place to facilitate discussion and provide coordinated care to Mr X.

During this period a new Consultant Psychiatrist was appointed to a split role that was recognised to be difficult and demanding. In the first instance little support was offered to this post leaving the Consultant in a vulnerable position. This Consultant used her initiative and attempted to provide some structure to the YOT CAMHs service. This was not sufficient at the time to ensure that cases were managed in a coordinated manner. The difficulties encountered by the new Consultant Psychiatrist were compounded by the new management arrangements and the resulting changes that occurred to referral and supervision processes.

On balance and after reflection the Independent Investigation Team conclude that the period during which Mr X received care from the YOT CAHMS worker constituted a missed opportunity for Mr X to have an early psychiatric opinion. A long duration of untreated psychosis (DUP) has repeatedly been shown to be associated with poorer outcomes in schizophrenia (Norman *et al*, 2005)[94]. This failure to provide a timely intervention ensured that Mr X's condition at this stage remained untreated. The services responsible for providing care and treatment to Mr X at this time had in their possession sufficient information to indicate that his needs were of a complex and serious nature. This was not managed in a coordinated or coherent manner. The Independent Investigation Team could find no evidence to suggest that the YOT CAMHS service was being adequately managed during this period, and this resulted in Mr X's care and treatment not being managed in an appropriate manner.

- ***Key Contributory Factor Number One. The failure to manage the ongoing assessment, care, risk and treatment needs of Mr X whilst receiving care from the YOT CAMHS meant that his mental illness was untreated. This extended period of time where his condition remained untreated ensured that his mental illness continued to worsen. Mr X's mental state was considered by the Court when sentencing him to have played a major factor in the events of 5 September 2006.***

13.1.2.1. Management of the Clinical Care and Treatment provided by the Lambeth Early Onset (LEO) Team 21 June 2006 – 6 September 2006

13.1.2.2. Background and Description of events

Mr X was referred by his GP to the LEO service on 21 June 2006 following an appointment that had been held at the practice surgery at which both Mr X and his mother were present. Mr X and his mother attended the surgery because they needed help. Mr X was apparently

smoking skunk on a daily basis and at this time his mother reported that he was 'hearing sounds' and having visual hallucinations[95]. An appointment was negotiated for the 29 June 2006 with a worker from the LEO CAT. Mr X attended this appointment with his mother[96].

On the 29 June 2006 Mr X and his mother were seen by Mr BG, a Community Psychiatric Nurse, and Ms JN, a psychologist and Mr X's allocated Care Coordinator, for an initial assessment. An assessment was conducted with the help of Mr X's mother who responded to most of the questioning. The impression was: "Mr X is a 17 year old young man with a one year duration of prodromal symptoms and a four month history of positive psychotic symptoms'[97]. Mr X's mother stated that he had cut off his dreadlocks, which he loved, on his previous birthday and that he was behaving bizarrely and complaining of hearing voices. Mr X described hearing voices from his stereo and stated that he thought his father may be inserting unusual thoughts in his head. **On this occasion it was recorded that Ms JN was told by Mr X's mother about his involvement with the Youth Offending Team[98]**.

On the 30 June 2006 Mr X met with Mr AQ at the YOT.

On the 5 July 2006 Mr X, accompanied by his mother, was seen by the LEO CAT Consultant Psychiatrist, Dr EI. This was to discuss his medication and to arrange for blood monitoring tests. Mr X was prescribed Aripiprazole tablets 5mg OD by Dr EI for seven days. The plan was for this medication to be increased to 10 mg if it was tolerated. Mr X's mother expressed great concern for her son's wellbeing during this meeting and wanted his medication to be commenced as soon as possible[99].

On the 7 July 2006 Ms JN contacted Mr X's mother to see how he was tolerating the medication. Mr X's mother said that he appeared to be calmer. Ms JN reminded Mr X's mother to call if she had difficulties and that Mr X's next appointment was on the 10 July 2006 at 12 noon[100].

On the 18 July 2006 Ms JN telephoned Mr X's mother to see how he was doing and to offer another appointment. An appointment was set for the 19 July at noon and duly took place. Mr X and his mother both attended the appointment with Ms JN. Mr X did not appear to want to be present and his mother answered most of the questions. Mr X was distracted and appeared to be having hallucinations. Mr X's mother stated that she had been giving him his

medication every day and that he was taking it. Ms JN attempted to engage in a relapse prevention exercise that was of little interest to Mr X and the session was cut short[101].

Mr X's progress was reviewed by Ms JN, his Care Coordinator and Dr RK, a Senior House Officer on the 25 July 2006. Mr X attended this meeting with his mother. He appeared to be more relaxed than before and said that he had been cutting back on his cannabis intake. His medication was reviewed and increased to Aripiprazole 10 mg. This was dispensed for one week. His next appointment was set for the 1 August 2006. The Care Coordinator completed the CORE-OM assessment with him and made plans for Mr X to complete PSYRATS during his next session[102].

On the 27 July 2006 a contingency plan was drawn up by Ms JN so that the LEO services could do a home visit if needed or if Mr X was to disengage from services[103]. It is not clear from the clinical record how aware Mr X and his family were of this contingency plan.

On the 1 August 2006 Mr X did not attend his booked appointment, however he did attend for an appointment on the 8 August 2006. Ms JN recorded the following day that Mr X had attended this appointment on his own and that he did not appear to be responding to any auditory hallucinations. Mr X reported that he had not been doing anything much since their last appointment, but that he was due to commence an e-learning course. Ms JN asked him the 'magical question' (i.e. three wishes) in an attempt to see whether she could get any more information out of him. He said that he did not like being asked so many questions and said that he would rather not come again. Ms JN explained that he would have to keep future appointments and explained why. Another appointment was made for the 17 August 2006[104].

On the 21 August 2006 Mr X did not attend his appointment with Ms JN. Ms JN planned to contact Mr X the next day, but did not check to see whether his medication had been collected. On the 22 August 2006 Ms JN made a telephone call to Mr X's mother. A voicemail was left stating that she would call again the next day. On the 24 August 2006 it is recorded that Ms JN called Mr X's mother 'numerous times' throughout the day and got no response. A message was left on the answer machine for either Mr X or his mother to contact the LEO Team. There is no recorded decision as to why the Contingency Plan was not put into place in the form of a home visit[105]. It is about this time that the Court heard that Mr X ceased taking his medication.

On the 31 August 2006 Mr X met with Ms JN. He said that he had been attending his course and that he was not as confused as he had previously been. Mr X had the effects of cannabis discussed with him. It appeared that Mr X had been taking his medication, but that he had missed one tablet that week. He continued to show little insight stating that he only took the medication because he had to and that it helped with his headaches. Mr X also admitted to smoking more skunk that week. An appointment was made to have his medication reviewed by the Consultant Psychiatrist on the 6 September 2006. The impression of the clinical team was that things 'were going the right way'[106].

13.1.2.3. Context

All of the information for section 14.2.3. has been taken from the Trust LEO CAT Operational Policy 2002 which was in operation at the time Mr X was receiving his care and treatment. This policy provided guidance to ensure the delivery of a specialized, flexible and easily accessible home-based early detection & crisis assessment mental health team for young people:

- aged 16 – 35 (the average age of clients is 22 years);
- living in the Borough of Lambeth; and
- presenting for the first time with psychosis.

LEO CAT is part of a comprehensive early intervention service system within the Lambeth Mental Health Service provision of South London and Maudsley NHS Foundation Trust. The LEO service systems comprise:

- a Crisis Assessment Team (LEO CAT);
- an assertive follow-up community team (LEO Community Team);
- an 18 bed inpatient unit (LEO Inpatient Unit);
- a service for client's at ultra high risk of psychosis (Outreach and Support in South London – OASIS).

LEO CAT is the point of entry to both the LEO Inpatient Unit and the Assertive Outreach Team. Where the client meets LEO criteria LEO CAT will automatically plan for ongoing care by the assertive outreach service.

At the time of the Teams' inception the complement was:

- 1 x H Grade Team Leader
- 0.5 x Consultant Psychiatrist
- 1 x Staff Grade Psychiatrist
- 1 x Clinical Psychologist
- 1 x Social Worker
- 1 x G Grade Nurse
- 1 x F grade Nurse
- 1 x A&C 4 Team Administrator
- 1 x Research Worker

Referral Receipt, Referral Allocation and brief review*:*

The LEO CAT 2002 Operational Policy, which was current at the time of the incident, stated that there would be a daily meeting at 09:00 – 09:30 hours, to be attended by all team members inclusive of the research worker, to discuss new referrals, assessments and work allocation.

Daily at 14:00 – 14:30 hours, there was an additional meeting held to be attended by all available staff.

In addition to the two above mentioned meetings a weekly clinical review meeting took place which focused on current clients. The Operational Policy stated that:

'*All newly assessed clients will be presented to the team inclusive of:*

- *The presenting problem*
- *Full assessment of risk*
- *Clinical signs and symptoms*
- *Previous psychiatric history*
- *Level of need – required level of input*
- *Unsafe or intolerable behaviours*
- *Interpersonal relationships*
- *Social supports (actual and potential)*

- *Current environment/material supports*
- *Substance misuse*
- *Willingness to engage*
- *Management plans*
- *Transfer plans'*

Service user reviews:

The Operational Policy stated that these 'will be attended by the service user, carers, the Care Coordinator and a medical staff member. These will take place as and when required, in a location agreed with the service user.'

Care Coordinators were allocated after the first face to face contact with a new client in accordance with the CPA framework. The 2002 Operational Policy also stated the following with regard to clients that were to be treated as a high priority:

'Highest priority' - to be discussed daily

- *All new referrals with an unknown level of risk*
- *Incomplete assessment*
- *Completed assessment*
- *Clients whose formal risk assessment indicates a high risk of*
  -Violence or aggression to others
  -Self harm
  -Self neglect
- *Clients who have little or no social support*
- *Clients experiencing acutely distressing symptoms such as command hallucinations.*
- *Clients who refuse to engage or those who have disengaged*
- *Clients using or suspected of using alcohol and or other illicit substances which appear to have a negative effect on their presenting mental state'*

13.1.2.4. Findings

Mr X was in contact with the LEO CAT for a period of 11 weeks between the initial referral from his GP on the 21 June 2006 and the death of Ms Tulloch on the 5 September 2006.

During this period it is clear that Mr X's case was not managed in accordance with the LEO CAT Operational Policy. It is the view of the Independent Investigation Team that certain important actions were not carried through in a timely and appropriate manner.

Previous Psychiatric History and Assessment of Risk

Ms JN took a history from both Mr X and his mother on the 29 June 2006. At first glance it looks to be thorough and informative. However it is clearly stated in this history that Mr X had been, and continued to be, involved with the YOT. The Independent Investigation Team understands that Mr X's mother denied Mr X having had any previous mental health history or treatment during this meeting and that this gave Ms JN incorrect information[107].

Ms JN made no attempt to contact the YOT in order to ascertain the nature of Mr X's previous offending. This lack of interagency communication was unfortunate. If Ms JN had followed this up, which would not have been unreasonable considering that Mr X was on enhanced CPA and a vulnerable young adult, she would have been able to understand three things:

1. that Mr X had a previous psychiatric history;
2. that Mr X had a previous forensic history which involved several acts of violence;
3. that Mr X had a previous history of self neglect.

There is no evidence of a risk assessment within Mr X's LEO CAT clinical records. Whilst the Independent Investigation Team can ascertain that a history was taken at the initial consultation on the 29 June 2006 which was pertinent to informing a future risk assessment no further work was documented. The Operational Policy stated that this should have been a priority for all new referrals presenting with unknown levels of risk and an incomplete prior assessment.

Clinical Assessment and Management Plan for Mr X and his Family

It is clear from the clinical records that Ms JN prepared, that Mr X was experiencing distressing symptoms and was clearly subject to auditory hallucinations. Mr X's considerable substance misuse is also recorded alongside the fact that his father was paralyzed and confined to a wheelchair and that Mr X also had a younger sister living in the family home with him.

The Independent Investigation Team found it remarkable that there were no management plans in place for either Mr X or his family. When clinical witnesses were interviewed by the Independent Investigation Team it was felt that the absence of management plans was due to the fact that Mr X's assessment was still ongoing. However it is a fact that after 11 weeks the following actions regarding Mr X's care and treatment had not been considered:

1. a plan for helping Mr X deal with his substance misuse;
2. a risk assessment;
3. care plans to help Mr X and his family manage his condition;
4. a carer assessment for Mr X's mother;
5. a vulnerable adult assessment for Mr X's father, and/or, a holistic assessment of the family's needs;
6. a safe guarding children assessment for Mr X and his younger sister.

The clinical assessments that Ms JN planned to undertake took the form of the Relapse Prevention Card Sort, the CORE-OM and the PSYRATS scale. Whilst the Independent Investigation Team commends the use of such assessments it is clear that Mr X's mental state between the 21 July and the 5 September 2006 was such that he could not take part in them as he had no concentration, limited insight and was in fact acutely mentally ill. There is ample evidence in the clinical record that he strongly disliked this assessment approach and expressed this clearly to the point that he planned not to return if Ms JN continued in this manner[108].

It is the view of the Independent Investigation Team that the Care Coordinator would have been better advised to focus on a more basic holistic plan of assessment and care at this stage rather than undertaking more sophisticated psychological assessments that would have been best completed once Mr X was no longer in an acute phase of his illness. It is clear from the clinical record that these assessments caused Mr X a degree of distress and irritation.

The NICE Guidance on Schizophrenia states that a service user should receive a comprehensive assessment of their needs culminating in an agreed care plan. The emphasis here should be on the word 'needs'. Whilst needs can only be identified following an in depth assessment, the methods chosen to assess Mr X's psychiatric condition were not appropriate

on this occasion and led to a delay in the formulation of a care plan suitable for the safe immediate care and treatment of a vulnerable young adult[109].

Contingency Planning

The Independent Investigation Team confirmed that a contingency plan was prepared for Mr X on the 27 July 2006. It is unclear whether Mr X's mother was aware of it or not. The contingency plan very sensibly stated that the LEO services should conduct a home visit if Mr X's family expressed concerns about his condition deteriorating. The plan also stated that a home visit would be arranged if Mr X ceased to be compliant and failed to keep his appointments. The plan also discussed arrangements for care and treatment to be accessed if Mr X's mental health broke down out of hours[110].

The contingency plan, whilst stating what interventions would be considered if Mr X's mental health began to break down, did not specifically state when these interventions would be initiated, what symptoms/presentation would constitute deterioration or what timeframe was to be deployed. The contingency plan stated that 'we will discuss the best way to re-engage Mr X with the team'. It would appear from the clinical record that Mr X was not seen for a period of three weeks between the 9 August and the 31 August 2006. There appears to have been no assertive attempts to engage Mr X during this period apart from leaving messages on his mother's answer machine. With the benefit of hindsight we know from the Court Transcriptions that it was during this period that Mr X stopped taking his medication. The contingency plan was not put into operation during this period.

13.1.2.5. Conclusions

During the period that Mr X received his care and treatment from the LEO CAT he was seen on seven occasions and it is recorded that Mr X's mother was successfully contacted by telephone on four occasions. Ms JN also made several other attempts to contact Mr X's mother by telephone. The number of contacts is well within those to be expected of the LEO CAT service. The first issue here is that Mr X was presenting as acutely unwell, distressed and not able to function and there was little recognition and response to this in a practical manner, for example, exploration of the voices and experiences he was having, recognition of what he thought was happening to him, or working with his feelings, for example, patient centered care. The approach offered seemed to be prescriptive regardless of the presentation.

The second issue here is case management and the length of time it took for an adequate assessment of Mr X's needs and risks to be developed together with a subsequent plan of care. By the 5 September 2006 the only intervention that had directly impacted on Mr X's psychiatric condition was the prescription of his medication, and it is known that he was not compliant with this for at least two weeks prior to the death of Mrs Tulloch on the 5 September 2006. During the 11 weeks that the LEO CAT service was involved with Mr X and his family no adequate psychiatric history had been compiled and no active management or care plan had been devised. Mr X was a vulnerable young adult who required a more active and dynamic approach regarding both his health and social care needs.

It is clear from Mr X's clinical record that during this period he was hallucinating, easily distracted, unable to concentrate and easily irritated. Mr X failed to attend several appointments and at one stage went three weeks without any contact being made, this at a time when he was taking newly prescribed medication. The Trust clinical team could have known, and should have known, more about Mr X and his psychiatric and forensic history. This information may have ensured that his case was managed differently. The Independent Investigation Team cannot state that there was a direct causal link between the way that Mr X's case was managed and the events of the 5 September 2006, however it is clear that Mr X and his condition were not fully understood and that as a result his condition was partially treated.

- ***Key Contributory Factor Number Two. Mr X's condition was not adequately assessed, managed and monitored during the period that he received his care and treatment from the LEO CAT. This ensured that his condition remained partially treated.***

13.1.3. Summary Conclusions

This section has focused on how the Lambeth-based YOT CAMHS and LEO CAT services responded to the care and treatment needs of Mr X within the framework of a narrative chronology. It can be seen from this examination that Mr X's experience did not follow the care pathway as defined by extant Trust policy and procedure. This section has presented the broad context within which Mr X's care and treatment was provided. The following sections will detail the specific care and treatment issues as set out in Section 13 above.

13.2. Critical Issue Number 2. Diagnosis and Medication and Treatment

13.2.1. Diagnosis

13.2.1.1. Context

The National Institute for Clinical Excellence guidelines for core interventions in schizophrenia (2003) recommend that 'service-users and their relatives seeking help should be assessed and receive treatment at the earliest possible opportunity'[111].

A long duration of untreated psychosis (DUP) has repeatedly been shown to be associated with poorer outcomes in schizophrenia (Norman *et al*, 2005)[112]. Although direct causation has not been robustly demonstrated, this particular measure has become an important target as it is considered to be both modifiable, and is intuitively linked to elements of good practice such as rapid access to evidence-based interventions and strategies to prevent functional decline. Reducing DUP is one of the three targets for preventive interventions outlined in the International Clinical Practice Guidelines for Early Psychosis and it is measured routinely in many of the Early Intervention in Psychosis Teams that have been established in recent years around the United Kingdom. Duration of Untreated Psychosis can be broken down into three phases in order to identify where delays may be occurring[113]. The pre-referral phase marks the time from the emergence of significant psychotic symptoms to a referral being made to an appropriate (usually secondary) mental health service. There may be a number of help-seeking contacts during this period and one of the aims of early detection programmes is to increase awareness about psychosis within the community, leading to quicker recognition and referral of first episode psychosis.

The post-referral phase applies to the interval from a referral being made, up to the first contact with an appropriate service. Effective triage is clearly important here in ensuring that cases with serious mental illness do not have excessive waiting times.

The third phase is the in-service delay, and this is potentially the most worrying phase. It is the interval between the first contact (or assessment) with a service and the initiation of evidence-based treatment.

13.2.1.2. Findings

In the case of Mr X, the Independent Investigation Team found that there were significant delays in both recognition (diagnosis) and consequently the delivery of appropriate interventions. Although the GP made two referrals (one to CAMHS and one to LEO-CAT), Mr X was already within the service having been previously referred to CAMHS-YOT by YOT workers. Whilst it is not possible to identify a precise point at which a diagnosis of a psychotic disorder might reasonably have been reached, the entry at the time of his first contact with the CAMHS YOT CPN suggests that there was some suspicion of a serious mental illness even at this stage. The CPN considered obtaining a psychiatric assessment for Mr X but failed to follow this up. Furthermore there is documentary evidence that Mr X was exhibiting psychotic symptoms and deteriorating functioning during the period February to March 2006, several months before he received a formal diagnosis.

Mr X was engaged in one part of the service, undiagnosed and untreated and his presence there seems to have prevented him from accessing further assessment and appropriate treatment. This was most clearly evident following the first referral by the GP to the adolescent team. The concerns raised were considered not to require further scrutiny, as he was already seeing a member of the wider CAMHS Team. This was a missed opportunity, and the decision and the underlying reasons for the decision were not fed back to the referrer, the family or to members of the multidisciplinary team. Mr X eventually received a diagnosis and treatment following an independent referral to LEO CAT. The LEO CAT were able to see him and initiate treatment promptly at this point but they were unaware that he was being seen in another part of the service and that the entire period of untreated psychosis was, therefore, an excessive ‘in-service delay’.

13.2.1.3. Conclusion

It is unfortunate that Mr X did not receive an earlier diagnosis and treatment package. It cannot be known what impact this delay had on the development of his mental illness and the subsequent events of 5 September 2006. The Independent Investigation Team does believe that detection and treatment at an earlier stage would have increased the likelihood of a better clinical outcome for Mr X’s psychiatric condition, and whilst this delay cannot be judged as being a direct key causal factor regarding the events of the 5 September 2006 it can be regarded as a key contributory factor.

- ***Key Contributory Factor Number Three. Failure to provide an early diagnosis and treatment package led to Mr X's condition worsening over a period of time. This delay prevented a coherent package of care and treatment being delivered in a timely manner.***

13.2.2. Medication and Treatment

13.2.2.1. Context

The management of the acute episode in psychosis requires a holistic approach to treatment. This incorporates evidence-based interventions that are delivered, where possible, in partnership with the service-user and carers. The aim is to develop a comprehensive care plan for a multi-disciplinary approach, and engagement and assessment are crucial to the process. Informed consent should be sought before treatment starts and there is a need for clear language and the consideration of cultural factors. Other measures may be necessary to ensure that there is adequate capacity to give consent.

Early Intervention Teams were developed to provide 'the correct mix of specialist pharmacological, psychological, social, occupational and educational interventions at the earliest opportunity'.

Medication is considered to be necessary during an acute episode and an antipsychotic drug should be started as soon as possible after diagnosis. In a first episode, the guidelines suggest that a second generation or "atypical" antipsychotic is offered following appropriate informed discussion with the service user (and carer where appropriate). This treatment should form part of a comprehensive package of care but should be given at an adequate dose for a minimum of 6 weeks with close monitoring of both effectiveness and side effects.
Family interventions and cognitive-behavioural therapy should be available as a treatment option but their roles may be limited in the acute stages.

The service-user and their family should be supported in an appropriate and least-restrictive setting. The option of treatment within the community may not be feasible in more severe episodes or where attendant risks highlight a need for more intensive support in a hospital or similar. Compulsory detention under the Mental Health Act may also need to be considered in some instances.

Where there are concerns regarding treatment concordance (i.e. that a service-user s may not be taking prescribed medication), the reasons should be explored and, where possible, concerns should be addressed. Consideration may need to be given to the use of compliance aids, long-acting injections, or ultimately compulsory treatment under the Mental Health Act. The National Guidance for the above section is to be found in:

- NICE Guidelines for Schizophrenia (2003, updated 2009)
- NICE Guidelines for Antipsychotic Medication (2002)
- International Clinical Practice Guidelines for Early Psychosis. *British Journal of Psychiatry,* **187 (suppl. 48).** s120-s124

13.2.2.2. Findings

The Independent Investigation Team found that the medication prescribed for Mr X was appropriate and in accordance with the relevant guidelines (see above). Appropriate baseline investigations were carried out and the process of seeking informed consent was followed and balanced with the need to avoid further unnecessary delay in initiating treatment. Aripiprazole is a relatively new drug that was not fully incorporated into specific NICE guidelines on schizophrenia (NICE 2003) or the Trust local LEO operational policy (both of which were under review). However, it is accepted practice to use this medication in such a context in view of its evidence base and low propensity for side effects, particularly when carefully titrated (as in this case). It appears that the prescription was collected from the pharmacy on a weekly basis. Unfortunately the GP was not informed of the treatment plan following the initiation of treatment or the subsequent medical review at which the dose of aripiprazole was increased.

It seems that there was no identified urgency that would have prompted a more rapid dose escalation. However, there was also a low index of suspicion that the patient was not adhering to the treatment plan, thereby preventing the implementation of actions to address this (see context). Mr X subsequently reported that he had discontinued his medication and the reports in the notes suggested that he was unsure why he was supposed to be taking it. It is not clear exactly what level of capacity Mr X had with regard to understanding the

diagnosis, its implications and the need for a sustained intervention that included regular medication.

Mr X's mother too, had little understanding of the importance of regular medication and the need to ensure treatment adherence. Whilst efforts were made to engage her and impart relevant information to her, there may have been too great a reliance on the family to support his treatment during this early, critical phase.

It is unfortunate that on the 31 August 2006 Mr X was seen alone by Ms JN as his mother could not park her car and therefore could not attend the meeting. It was clear on this occasion that Mr X had missed at least one dose of his medication and he stated that his mother had to remind him to take it. Mr X's mother may have been able to have commented further on how well he was adhering to his treatment plan at this stage. Ms JN decided on this occasion to make an appointment for Mr X to see Dr EI on the 6 September 2006 to review his medication. In effect this meant that Mr X was seen twice between the 25 July (when his medication was increased) and the 5 September 2006. With the benefit of hindsight this was insufficient for the adequate monitoring of either his medication or wellbeing. The NICE Guidelines recommend close monitoring, for a child in Mr X's situation it would not have been unreasonable for this to have been twice weekly.

13.2.2.3. Conclusions

The Independent Investigation Team felt that there were missed opportunities in terms of supporting Mr X and his family in sustaining an effective treatment plan. At Mr X's Sentencing Hearing this failure to take his medication was judged to be a reason for the 'dramatic escalation in his condition' in the days leading up to Mrs Tulloch's death.

- ***Key Contributory Factor Number Four. The failure to adequately monitor Mr X's adherence to his treatment plan contributed to the escalation of his condition in the days preceding the events of the 5 September 2006.***

13.3. Critical Issue Number 3. Risk Assessment and Forensic Risk History

13.3.1. Context

Safety is at the heart of all good health care. There has been an implied requirement under the Health and Safety at Work Act for risk assessments to be carried out since 1974[114]. No mental health organisation can afford not to have a programme that actively seeks to reduce and eliminate risk, not only because of financial consequences, but more importantly, solid risk management programmes can significantly improve patient care.

The South London and Maudsley NHS Foundation Trust has comprehensive risk management policies available[115]: Risk Management and Assurance Policy (July 2006) and their local strategy for clinical risk management[116]: 'Framework for Clinical Risk Assessment and Management of Harm' which was ratified in 2001, reviewed in 2003 and further reviewed in 2005. These policies reflect national guidance. The clinical risk assessment and management policy outlines the clinical risk management process, risk assessment, risk management in care planning, within teams and services, procedures and monitoring arrangements. The local Care Programme Approach policy[117] "Towards Integrated CPA and Care Management" also gives comprehensive guidance on the assessment of risk.

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and / or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that service users' risk is assessed and managed to safeguard their health,

well being and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service users past and current clinical presentation to allow an informed professional opinion about assisting the service users recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed themselves. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when these are difficult to reach.

At the time Mr X received his care and treatment from the Trust it operated the system of 'Zoning' which is a method of identifying risk and prioritising service users who require high levels of clinical input.

13.3.2. Findings

At the time of his referral to the LEO CAT Mr X was placed in the 'red zone'. The Trust uses the red zone concept to identify and prioritise those service users that may be a high risk to themselves or to others. At the point of referral and acceptance for assessment by the LEO Team all service users are placed within the red zone and they stay there until there is a good understanding and control of their acute symptoms. Service users also have to demonstrate good levels of engagement with the Team. The Independent Investigation Team were told by clinical witnesses that at the time of the events of 5 September 2006 Mr X continued to be in the 'red zone' indicating that he was still an unknown quantity. To summarise, when Mr X

became a service user with the LEO CAT he was placed on enhanced CPA and was also placed in the red zone.

Despite being on enhanced CPA and being placed in the red zone there was no risk assessment conducted for Mr X, and therefore no subsequent care and treatment plans developed to address his needs in this area. The LEO CAT Operational Policy 2002 stated that all new referrals should receive a full risk assessment as quickly as possible. The same Operational Policy identified high priority Service Users as being those who on referral:

- had an unknown level of risk;
- experienced distressing symptoms such as command hallucinations;
- had a known substance misuse problem.

Forensic History

Mr X had a forensic history which should have been taken into account. His forensic history included the following:

- **18 August 2003.** Mr X was arrested for the possession of cannabis and received a police reprimand;
- **4 February 2004.** Mr X was arrested for possession of cannabis and received a final warning from the police;
- **23 April 2004.** Mr X received his first conviction for possession of Class C drugs and received a three-month Referral Order;
- **16. July 2004.** Mr X's Referral Order was extended to 12 months for the offence of robbery. He was also subsequently convicted of violent behaviour as when confronted with the robbery he struck a security guard with a barbell pole;
- **20 September 2005.** Mr X's mother called the police after he punched a wall at his family home and became violent. He was arrested and taken to the police station. His mother refused to press charges and he was subsequently released.

The YOT CAMHS were also aware of the following incidents:

- **July 2003.** Mr X was excluded from school for 20 days for being abusive and threatening to staff;
- **July 2005.** At this stage staff at Mr X's school described him as being generally abusive and challenging;
- **22 March 2006.** It was reported to the YOT that Mr X had been expelled from his college course because he had hit a teacher and had threatened college staff and students.

The above listed events were not known to the LEO CAT workers. The knowledge of these events would have been known had Ms JN made contact with the YOT services directly upon taking Mr X's history on the 29 June 2006. It is possible that had Ms JN and Dr EI been possession of this information a different clinical management plan for Mr X would have been constructed.

Assessment of Risk to Mr X and his Family

One of the key indicators listed within the LEO CAT Operational Policy for identifying high priority Service Users is that of self neglect. During the period that Ms JN saw Mr X his physical presentation is not noted. However it is clear from the records kept by Mr AQ, the YOT CPN, that Mr X was often unkempt and was rapidly losing weight. When Mr X was referred to the LEO CAT the clinical team would have assessed Mr X as he presented for the first time on the 29 June 2006, at this juncture they had no other baseline to work from. Had Ms JN contacted the YOT then she would have had a baseline upon which to contextualise Mr X's presentation and would have been able to see deterioration in both his mental and physical condition. It would not have been unreasonable for this to have informed a risk assessment and for a care plan to have been swiftly developed in order to ameliorate his problems in this area. It is noted that Mr X was invited to attend a healthy living group on the 10 August 2006, however there is no record that he ever attended this group and it was likely that he was too unwell and lacking in insight for this to have been of benefit to him at this stage.

Mr X's mother had reported to Mr AQ that her son was in the habit of going for long walks in the middle of the night. It is also known that Mr X had a significant and long-standing substance misuse problem that it would be reasonable to believe, was exacerbating his mental

ill health. Both of these behaviours constitute high risk behaviours in a vulnerable and severely ill 17 year old. It is unclear whether Ms JN was aware of Mr X's nocturnal wanderings, or whether indeed, he had continued with them. Although his substance misuse was well known. It was not risk assessed and no treatment plan was put into place.

The potential risks that Mr X posed to his family regarding his violent outbursts were not fully understood by his Care Coordinator due to the lack of communication between the LEO CAT and the YOT. However the Care Coordinator should have considered assessing any potential risks to the family from Mr X in the light of the Trust Vulnerable Adults Policy and the Trust Safe Guarding Children Policy. This was not done.

13.3.3. Conclusions

The Independent Investigation Team formed the impression that Ms JN would have compiled a comprehensive risk assessment in the fullness of time. However Mr X had been known to the LEO CAT service for a period of 11 weeks, and no such assessment had been commenced. The main issue here is the timeliness of the risk assessment intervention. Had Ms JN contacted the YOT she would have been able to understand the potential risks that Mr X posed to both himself and others more clearly, and in line with her Team's Operational Policy, would have been prompted to conduct a risk assessment more swiftly.

The Independent Investigation Team does not believe that any risk assessment conducted at this stage would have predicted Mr X's potential to commit a murder. However a risk assessment at this stage (one that took into account Mr X's full psychiatric and forensic history) may well have prompted a differently constructed care pathway for Mr X. No direct causal link can be made between the absence of a risk assessment and the events of 5 September 2006. This is because the known risk behaviour of Mr X would not have suggested that he was capable of an act of random and unprovoked manslaughter. However the absence of a risk assessment taken in the context of a full psychiatric history meant that Mr X remained an unknown quantity and that aspects of his condition remained unknown. There was too much emphasis placed on the assessment of his psychological profile and not enough emphasis placed on his presenting symptomology.

- ***Key Contributory Factor Number 5. The lack of a detailed risk assessment conducted in the full light of Mr X's psychiatric and forensic history prevented a***

coherent plan of care and treatment from being developed. This ensured that Mr X remained an unknown quantity and that his condition was only partially treated.

13.4. Critical Issue Number 4. The Care Programme Approach, Assessment and Care Panning within the LEO CAT

13.4. 1. Context

The Lambeth Early Onset Crisis Assessment Team (LEO CAT) was set up to provide a specialised, flexible accessible, home-based early detection and crisis assessment team for young people aged between 16 and 35 years. At its inception it was the intention for the team to be able to provide a '*quick and comprehensive assessment*' for clients preferably in their own homes[118].

The LEO CAT is part of a comprehensive early intervention service system within the Lambeth Mental Health Service provision of South London and Maudsley NHS Foundation Trust. The LEO service system comprises:

- A Crisis Assessment Team (LEO CAT)
- an assertive follow-up community team (LEO Community Team)
- an 18 bed Inpatient unit (LEO Inpatient Unit)
- a service for client's at ultra high risk of psychosis (Outreach and Support in South London – OASIS

The LEO CAT is a small and focused service. Following its assessment of new referrals the LEO CAT will either refer clients on to other services within the LEO system as appropriate or back to the care of their GP.

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[119]. Since its introduction it has been reviewed twice by the Department of Health[120]: in 1999 (Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach) to incorporate lessons learned about its use since its introduction and again in 2008[120] (Refocusing the Care Programme Approach).

'The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services' (Building Bridges; DoH 1995)[122]. This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework which can help achieve those positive outcomes for service users by enabling effective co-ordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a key worker whose job is:
    - to keep in close contact with the patient
    - to monitor that the agreed programme of care remains relevant and
    - to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear.

Local Care Programme Approach Policy

The South London and Maudsley NHS Foundation Trust and its partner agencies had a comprehensive policy for the delivery of the Care Programme Approach (Care Programme Approach Policy – Towards Integrated CPA and Care Management; April 2000) which reflected national policy guidelines during the time that Mr X received his care and treatment[123]. It described two levels of CPA: Standard and Enhanced. Every person offered interventions by the mental health services (health and social services) must be "subject" to one of these two tiers of CPA. The policy described the levels of CPA as follows:

Standard CPA: Those people covered by Standard CPA (DoH) will be likely to:

- require the support or intervention of one agency or discipline or;
- require low key support from more than one agency or mental health worker;
- be more able to self manage their mental health problems;
- have an informal support network;
- pose little danger to themselves or others;
- be more likely to maintain contact with services.

Enhanced CPA: Those people covered by enhanced CPA will be likely to:

- fulfil the criteria for Section 117 aftercare and will be automatically included on enhanced CPA (i.e. service users who have been detained in hospital under Section 3, 37, 37/41, 47/49, 48/49 of the Mental Health Act 1983).

For those not subject to Section 117 aftercare the following are the criteria for enhanced CPA:

- a diagnosis of severe and persistent mental illness;
- a requirement for multi-agency involvement and co-ordination.

Plus any of the following:

- individuals with a history of repeated relapse of their illness due to a breakdown in their medical and / or social care in the community;
- individuals with severe social dysfunction or major housing difficulties as a consequence of their illness;
- a history of suicide risk, self harm, severe self neglect, violence or dangerousness to others consequent on their illness, which the responsible clinicians judge to be relevant in view of the service user's current or likely future mental health, taking into account their past history.

This Trust policy also clearly outlined the care co-ordination process including referral, assessment, assessment of risk, contingency and crisis plans, support for service users and their wider families, the care co-ordinator role, moving people between types of CPA (standard and enhanced), transfer of responsibility of care, loss of contact and refusal to maintain contact.

The successful implementation of the Care Programme Approach is fundamental to the delivery of effective mental health care in the community.

During the time that Mr X received his care and treatment from the LEO CAT the Operational Policy (2002) stated that all patients who had received a face to face assessment, and met the LEO criteria would be registered at that point under the CPA on the CCS (current clinical summary) system as receiving enhanced care from the LEO CAT[124].

13.4.2. Findings

Mr X was subject to enhanced CPA. According to both national and local Trust policy Mr X should have received a timely, comprehensive assessment and both a short and long term plan of care. The Independent Investigation Team learned that LEO CAT services users however were not 'formally' subject to full CPA processes until they had been assessed and transferred to the LEO Community Team even though they were enrolled under an enhanced CPA level and allocated a Care Coordinator.

Clinical witnesses told the Independent Investigation that CPA usually occurred at the point of transfer between the LEO CAT and the LEO Community Team. A CPA had not been considered for Mr X whilst he was with the LEO CAT although a contingency plan had been constructed on 27th July to address disengagement from the service and non compliance with medication.

In 2006 the allocation of new cases was confirmed within the weekly clinical review meeting. Generally it was the practice that the Care Coordinator who took the referral was allocated the case. The case would then have been discussed in detail at the weekly multidisciplinary clinical review. If there were any identified risks or issues that could have impacted upon the Care Coordinator working successfully with the client these would be explored further. Any discussions within this meeting would be recorded on the Electronic Patient Journey System (EPJS). Mr X's referral was initially taken on by Ms JN who then became his Care Coordinator. The LEO CAT Care Coordinator role was outlined in the Operational Policy as being primarily concerned with the assessment of new clients. The allocation of a formal care Coordinator would only occur once the service user was referred to the LEO Community Team. The expectation was that the LEO CAT would commence initial treatment together with psychosocial interventions. The Operational Policy for the LEO CAT laid out the following assessment format and areas of focus:

- the presenting clinical problem;
- full assessment of clinical and social risk;
- clinical signs and symptoms;
- comprehensive assessment of psychosis; to include
- course, duration and severity;
- triggers, aggravating factors and predisposing factors;
- co-morbid conditions;
- interventions sought and used;
- level of need –required of input;
- unsafe or intolerable behaviours;
- interpersonal relationships;
- social supports (actual and potential);
- current environmental/material supports;

- previous psychiatric history;
- substance misuse;
- willingness to engage[125].

The Operational Policy 2002 stated:

'once the LEO CAT becomes involved in an assessment the team will remain involved and responsible for the immediate care needs of the client until a clinical decision has been reached regarding the client's future management and care and until a full transfer has been carried out'[126].

The Independent Investigation Team found four specific areas of concern regarding the CPA that Mr X received. They are as follows:

1. timely and comprehensive assessment and care planning;
2. communication with the GP;
3. qualifications and experience of the Care Coordinator;
4. clinical and caseload supervision.

Assessment and Care Planning

Assessment

Mr X was not visited at home during any part of his assessment. This was attributed to the fact that his mother readily brought him to the team base. However the Operational Policy allowed for home visits and it was clear from the clinical witness interviews that home visits were a possibility in terms of both work load and capacity and it was recognised that home visits offered an alternative picture of the client in their social context. Home visits had always been part of normal practice for the LEO CAT. A clinical witness stated that 'it has always been part of the service, we try to do at least one home visit as part of our assessment even in those patients who maybe do not need a home visit'[127]. Visits to clients at home in the community were an integral part of the role of team members working within the LEO CAT during the course of their day to day business[128]. The Independent Investigation Team heard from a clinical witness that 'if we had no contact from the client or the family for about ten days then we would go out and do an unannounced home visit if we had any concerns'. The Independent Investigation Team was also told that missed appointments or missed contacts

with the patient or his family would have routinely triggered a home visit[129]. Mr X did not receive a home visit as part of his routine assessment or when he missed appointments.

The Independent Investigation Team heard from Mr X's mother that she often found it difficult to park her car and this was the reason why she sometimes could not accompany her son during his sessions with his Care Coordinator. It was also clear, as evidenced both in the clinical record and from Mr X's mother's own statement that her son attended his appointments with the LEO CAT reluctantly and would only attend if she brought him herself. Mr X's father was confined to a wheelchair and Mr X's mother was his main carer. At no time was it considered that a home visit would be a practical act of consideration in these circumstances.

The Care Coordinator attempted to engage Mr X in a variety of assessments to develop his understanding of his psychosis and medication requirements. It is clear from the clinical record that Mr X was not able to take part in the assessment processes offered as he was too unwell.

At the first assessment session Mr X and his mother identified the following areas of concern:

- complaining of headaches after smoking skunk;
- hearing voices and sounds;
- behaving bizarrely;
- unable to have a normal conversation;
- distracted and muddled in his thinking;
- changes in his behaviour, for example, cutting off his dreadlocks, isolating himself from his friends;
- smoking marijuana from the age of 14years

At this session Mr X described:

- auditory hallucinations;
- thought insertion;
- somatic symptoms of burning sensations in his limbs and brain.

Identified risks:

- poly substance misuse;
- a criminal history (involved with YOT);
- no insight into his illness.

On observation Mr X presented as:

- having psychomotor retardation;
- disinhibited behaviour (he repeatedly rubbed his crotch);
- responding to visual and auditory hallucinations;
- slowed speech with low tone and volume;
- thought disordered.

Neither Mr X nor his mother disclosed his history of violence at the initial assessment

Mr X presented to LEO CAT as a very unwell young man suffering from psychosis. Clinical witnesses informed the Independent Investigation Team that care planning had not been developed by the time of the incident on the 5 September 2006 as the process of assessment was still being undertaken. Ms JN made several attempts to engage Mr X with a variety of psychological assessments, none of which he had the concentration to complete. It is the view of the Independent Investigation Team that Ms JN had sufficient assessment information by the beginning of July 2006 in order to frame a short term plan of care for Mr X. The outcomes of the assessments she wanted to undertake were not reason enough to postpone the formulation of a care plan. ***Mr X's immediate problems and needs were clearly apparent, significant and viewed by both Mr X's mother and GP as being urgent***.

At no point was Mr X's assessment addressed in a holistic manner. The main assessment focus was that of his mental state. Whilst this is an essential aspect of assessment it has to be noted that no work was undertaken to assess Mr X's wider needs in a social context. Neither was an assessment of his family's needs undertaken.

During the initial assessment meeting between the LEO CAT, Mr X and his mother it was noted that Mr X was involved with the YOT. This significant aspect of his history was not subject to further exploration and as such Mr X's assessment could never have been judged to be complete. Clinical witnesses told the Independent Investigation Team that eventually the

YOT would have been contacted. However waiting for a minimum period of some three months cannot be seen as a sensible course of action.

Care Planning

The LEO CAT Operational Policy 2002 stated that:

'For those clients taken on by the LEO CAT future interventions are planned and negotiated at the earliest possible stage. At all times the client and their carers are involved in the planning of care with their needs constantly seen as a priority'[130].

Clinical witnesses when interviewed stated that care plans were not developed for Mr X because the assessment phase had not yet been completed. A primary function of the LEO CAT, both in 2006 and today, is to provide a comprehensive and quick assessment process. Another key function is planning care. A contingency plan was devised by Ms JN, but despite clear triggers, was not put into action.

There is not a great deal that can be said about the quality of Mr X's care planning because, apart from a contingency plan, none existed. The issues to be addressed are:

- did an eleven-week period provide sufficient opportunity in which to assess Mr X and to plan for his short-term care needs?
- did the LEO CAT processes around CPA prevent 'a safety net of care' from being placed under Mr X?
- should Mr X have been referred more speedily to other services within the LEO system?

The Independent Investigation Team found that Ms JN did draw up an initial assessment that was comprehensive enough to initiate a short-term plan of care. The assessment raised serious and significant factors regarding Mr X's mental health that should have been addressed in accordance with the LEO CAT Operational policy. It would appear however that the Care Coordinator and the clinical team did not feel that Mr X's assessment was complete. It is difficult to understand what further information either Ms JN or the team felt that they were going to ascertain as Mr X was too unwell to be able to engage sufficiently, and Mr X's

family were not being considered as a formal part of the assessment process. The LEO CAT *raison d'être* is to provide 'a quick' assessment to young people in crisis so that they can receive an appropriate care and treatment plan from the most appropriate service as rapidly as possible. It is the view of the Independent Investigation Team, that given the very obvious indicators of Mr X's mental ill health, an eleven-week period was an excessive period of time to elapse without a care plan being initiated. The Operational Policy stated that a client should be held by the LEO CAT for a period of two – four weeks only before being transferred on to the most appropriate service. It would appear that Mr X was held by the LEO CAT for an excessively long period and this contributed to the delay in the development of his CPA.

The LEO CAT stance regarding CPA was, and is, confusing. The terms 'initial' and 'formal' were used when describing Care Coordinators in the LEO CAT Operational Policy. 'Initial' Care Coordinators provided assessment within the LEO CAT (this was the role that Ms JN held). 'Formal' Care Coordinators were allocated once a service user left the LEO CAT and entered the LEO Community Team. It would be reasonable to expect a service user to either be on CPA or not. The Independent Investigation Team learnt that Mr X had been placed on enhanced CPA in June 2006 and yet was not actually due to receive a CPA package for between two and three months, the rationale being that CPA would formally commence once a service user left the LEO CAT and was referred to the LEO Community Team.

The Independent Investigation Team heard from clinical witnesses that CPA could be initiated prior to transfer to the LEO Community Team if a service user's condition merited it. This option had not been considered for Mr X because it was assumed that he was responding well to his medication and that his condition was responding to treatment. The Independent Investigation Team have taken the view that a period of three months between referral and CPA is too long when considering a young person in crisis and presenting with a clear psychosis. Once again had Mr X only been held by the LEO CAT for the advised two – four weeks this delay would not have been such an issue.

The assumption that was made by the clinical team caring for Mr X was that he was improving and responding well to his medication. This assumption appeared to take precedence over everything else. However even though Mr X was thought to have been making progress it was felt that he was too unwell to engage in therapy. This kind of 'limbo

state' is often a difficult, though unavoidable stage when treating a person who is severely unwell. However in the case of Mr X it appeared to have been seen as a key factor in not proceeding with any other kind of intervention. The most notable omission in Mr X's clinical assessment and treatment is that regarding his substance misuse, which is noted in his clinical record as being a steadily increasing problem.

It must be noted here that care and treatment does not solely comprise of medication and that Mr X was a young and vulnerable service user who required a coherent and holistic plan of treatment and care that addressed both his needs and those of his family.

Communication with the GP

The LEO CAT Operational Policy (2002) placed a great deal of emphasis on regular communications between the Care Coordinator/Clinical Team and the GP. When the Independent Investigation Team interviewed the GP it was clear that no communication had ever been received from the LEO CAT regarding the referral that he had sent and Mr X's assessment and progress. The Independent Investigation Team Chair and Nurse Member visited the GP surgery and reviewed Mr X's electronic clinical record. No communication from the LEO CAT was present.

Qualifications and Experience of the Care Coordinator

The Care Coordinator was employed by the Trust from February 2004 having previously obtained a four-year psychology degree from the *University of Newcastle* in Australia. She then completed a two-year programme whilst employed jointly by a child psychiatry service and an adolescent mental health service.

Australian professional qualifications are not automatically recognised in the United Kingdom; certainly the restricted range of experience the Care Coordinator had at the time of her employment with the Trust would not be regarded as conferring the equivalent of Chartered Psychologist status in the United Kingdom, which is the accepted standard for independent professional practice. The fact that she had obtained *The Graduate Basis for Registration* of the *British Psychological Society* (BPS) meant that while she was eligible to apply for training courses to become a professional psychologist she could not be regarded as a professionally qualified psychologist for work in the United Kingdom.

The Trust CPA Policy 2000 in place at the time Mr X received his care and treatment stated that:

'for service users covered by enhanced CPA the role of care Coordinator could be taken on by any statutory organisation member who is part of the Multi-Disciplinary Team e.g. community nurse, social worker, psychologist. occupational therapist and other therapist etc.'

From this it would be reasonable to assume that all Care Coordinators allocated service users subject to enhanced CPA should have been formally registered and qualified health or social care professionals. At the time she was acting as a Care Coordinator for Mr X it would appear that she was not professionally qualified or registered.

It is the responsibility of the Trust, as the employer, to satisfy themselves that any employee is qualified to carry out their duties. It was accordingly *their* responsibility to check the Care Coordinator's qualifications for any clinical post or function she may occupy. If she conducted any assessments that were specifically psychological in nature, it was *her* responsibility to ensure that she was competent to do so, and that she was supervised if appropriate. She would have been acting outside her competence, and outside the professional code of practice of the British Psychological Society, if she did carry out any specific psychological measures. The CORE-OM measure was used by the Care Coordinator, formal qualification as a psychologist is not required for this assessment.

The Independent Investigation Team is not making a causal link between the Care Coordinator's qualifications and the events of the 5 September 2006. There is ample evidence to demonstrate that the Care Coordinator tried to establish a sound rapport with Mr X and that she conscientiously attempted to fulfil her role. Any failings in the management of Mr X's care pathway have to be seen in the context of the LEO CAT service management, caseload supervision and the resulting non-adherence to the care pathway as laid out in the Operational Policy.

Clinical and Caseload Supervision

The Independent Investigation Team heard that clinical supervision was available to all Care Coordinators on a monthly basis within the LEO CAT. The presentation of new cases at the review meetings also acted as a form of caseload supervision.

It would appear from the evidence given by the clinical witnesses to the Independent Investigation that the Care Coordinator worked as part of the Multi-Disciplinary Team and that all decisions made regarding Mr X's care and treatment were discussed fully and agreed with the Responsible Medical Officer and other team members. The Care Coordinator was obviously following an agreed management approach. The fact that this approach did not adhere to the pathway laid out by the LEO CAT Operational Policy is not due to the lack of clinical supervision and support that the Care Coordinator received.

The fact that Mr X's care pathway did not adhere to the LEO CAT Operational policy is quite clear. The clinical witnesses who gave evidence to the Independent Investigation did not feel that Mr X presented any particular problems and, that on reflection, his clinical management was in anyway compromised. If this was the prevailing view of the clinical team during the time that Mr X was receiving his care and treatment then it would have been unlikely that clinical or caseload supervision would have lead to his case being managed differently.

13.4.3. Conclusions

Mr X was referred to the LEO CAT by his GP and was seen nine days later (it is worth noting here that the LEO CAT service did not met its referral guidelines in as much that all non-urgent referrals were supposed to have been seen and assessed within two working days)[131]. He was seen by his allocated Care Coordinator on seven occasions including his initial assessment and did not attend on two occasions. He was discussed in three Multi-Disciplinary clinical review meetings.

On the 29 July 2006 the Care Coordinator compiled a good initial assessment but did not appear to take into account the significance of Mr X's presenting symptoms and importantly did not follow up Mr X's YOT history. Mr X was a young man who clearly was very unwell and the Independent Investigation Team wondered whether an alternative approach was warranted at this stage. In effect Mr X was left untreated and unseen by a psychiatrist for another week.

The Investigation Team were concerned that the Care Coordinator attempted to engage a client, who continued to present as psychotic and with no insight, in structured relapse prevention exercises when it was clear he was in no fit state to participate. It is difficult to understand what the LEO CAT service was trying to achieve with Mr X during the time he spent with them. The role of the LEO CAT was to provide a comprehensive and rapid assessment. A good beginning was made on the 29 June 2006 but no subsequent information was actually gained following this date. The LEO CAT Operational Policy stated that the service would assess;

1. the presenting clinical problem;
2. full assessment of clinical and social risk;
3. clinical signs and symptoms;
4. comprehensive assessment of psychosis; to include
5. course, duration and severity;
6. triggers, aggravating factors and predisposing factors;
7. co-morbid conditions;
8. interventions sought and used;
9. level of need –required of input;
10. unsafe or intolerable behaviours;
11. interpersonal relationships;
12. social supports (actual and potential);
13. current environmental/material supports;
14. previous psychiatric history;
15. substance misuse;
16. willingness to engage[132]

It would appear that the assessment process for Mr X got stuck somewhere around point five on the list above. Instead of moving on to assess the other points on the list when Mr X's condition prevented the use of formal measures, the Care Coordinator persisted with the assessment of Mr X's psychosis. This was to the detriment of the production of a comprehensive, holistic and timely care and treatment plan, in that none was ever ultimately formulated, and also may have prevented Mr X from being transferred to an alternative service that could have more appropriately treated him.

It was recognised that Mr X's progress was linked not only with his compliance to his prescribed medication, but also to the reduction of his substance misuse. However at no time was consideration given to supporting Mr X and his mother in a substance misuse reduction programme. It was perhaps naive to believe that Mr X's apparent reduction in cannabis and skunk during July 2006 would be a permanent thing considering that he had a three-year history of substance misuse to overcome.

The Care Coordinator was aware at the first meeting on the 29 July 2006 that Mr X's mother was the main carer for a disabled husband who attended day care and that there was a younger child within the home environment. It was also recognised from an early stage in the assessment that Mr X's mother was providing regular and substantial care for Mr X through ensuring that he attended his appointments and took his medication. This did not provoke the initiation of a carer assessment or any reference to potential Child in Need thoughts. This is clearly not in keeping with either the LEO Team or CPA policy. However the Independent Investigation Team recognise that the Care Coordinator did signpost Mr X's mother to the Carer's Information Group, however in no way can this be seen as an alternative approach to formal and structured carer assessment.

It is accepted by the Independent Investigation Team that not all aspects of an individual's life can be ascertained by healthcare professionals. The Care Coordinator did manage to identify a great deal of relevant and useful information about Mr X and his family. What this Investigation struggled to understand was the lack of follow through in terms of risk. For example, the Care Coordinator was aware that Mr X was attending the YOT but did not attempt to discuss this with his mother who was present at several subsequent sessions, nor is there reference to any discussion with Mr X about why he was attending nor was any attempt made to contact the YOT.

Basically none of the leads mentioned and recorded at Mr X's initial assessment were followed through which is an intrinsic part of the role of the Care Coordinator. The CPA that Mr X received from the LEO CAT did not comply with its own guidelines on:

- rapidity of assessment;

- communication with GP's;
- working with families;
- assessment of risk;
- holistic assessment and care planning.

With the benefit of hindsight it is possible to understand that Mr X's psychiatric condition was at best partially treated (in that the only intervention he received was medication the effectiveness of which was never appropriately ascertained). Shortly after the time of Mr X's arrest on the 6 September 2006 an independent forensic assessment stated that 'he was severely mentally ill, suffering from schizophrenia'[133].

His Honour Judge McKinnon at the sentencing hearing stated that:

'you are ...to be sentenced for a most grave offence of manslaughter, otherwise a clear case of murder but for the severity of your psychiatric state at the time. Your plea to manslaughter has been accepted by the Crown because all the psychiatrists in the case [acting for both defence and prosecution] are of one mind as to your state of mind'[134].

It is clear that there was a breakdown in the LEO CAT service user pathway regarding Mr X's care and treatment. In effect the LEO CAT service was intended to act as an assessment, treatment and triage service and failed to do so in a timely manner. Mr X was clearly too unwell to comply fully with the assessment processes being offered within the LEO CAT and an alternative treatment and service route should have been considered at this time. The failure to do so ensured that Mr X's mental illness was partially treated at best and his mental state was judged by both the prosecution and defence forensic psychiatrists as directly contributing to the events of the 5 September 2006. The Independent Investigation Team had to consider 'what did the Trust know at the time' and 'what should they have known at the time'? It is our view that the Trust *could not* have predicted the events of the 5 September 2006, however with the information known to them at the time more could have been done to treat Mr X's condition and engage with him more appropriately.

- ***Key Causal Factor Number One. The failure to institute an appropriate CPA, assessment and treatment programme for Mr X ensured that his mental illness was***

partially treated. Judge McKinnon found Mr X's mental illness was a direct causal factor in the death of Mrs Tulloch.

- ***Service Issue Number One. The Trust appointed an individual who held a clinical caseload and conducted clinical duties whilst not holding a qualification recognised in the United Kingdom.***

13.5. Critical Issue Number Five. Carer Assessment and Carer Involvement

13.5.1. Context

The recognition that all carers, especially those of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status[135]. It also provided for carers who give a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It also provides that services take into account information from a carer's assessment when making decisions about the cared for persons type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to carers[136]. It also gave carers the right to an assessment independent of the person they care for.

In addition The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs[137]. Also that it facilitated co-operation between authorities in relation to the provision of services that are relevant to carers.

In particular regarding mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) states that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;

- have their own written care plan which is given to them and implemented in discussion with them.

13.5.2. Findings

It is apparent from Mr X's clinical record that his mother was able to attend several of the sessions that were held with the LEO CAT Care Coordinator. She was able to give the Care Coordinator a substantial history that framed a large part of the initial assessment that was made. It is also apparent that Mr X's mother did not give the Care Coordinator his full history and omitted on the first occasion to mention his previous contact with the YOT CAMHS service and did not mention his previous acts of violence. However Mr X's mother did give the Care Coordinator *enough* information that, had all of the leads been followed through, Mr X's full history could have become swiftly known.

Had the LEO CAT worked more closely with Mr X's family it may have been possible for them to have undertaken a thorough assessment and care planning process in a timelier manner than what actually occurred. The LEO CAT Operational Policy 2002 actively promoted family working within the context of the clients own home. This was not offered and did not occur. Why this should not have been the case is puzzling because it was known that:

- Mr X only attended appointments if his mother brought him and was reluctant to engage;
- that Mr X's mother sometimes could not park her car and therefore could not attend sessions with her son;
- that Mr X's father was a wheelchair user and that his mother as his main carer;
- that Mr X's problems appeared to have started when his father became disabled, therefore suggesting a family dynamic issue;
- that Mr X had a younger sister living in the family home with him, which should have prompted a safeguarding assessment;
- that Mr X's understanding of his disorder was slight and that his understanding of his medication requirements was limited;
- that Mr X had a significant substance misuse problem.

Many assumptions appear to have been made by the LEO CAT service. Namely that Mr X's mother understood his condition and diagnosis, the importance of his compliance with his medication, the warning signs of any deterioration in his condition, and the content of the Contingency Plan.

Assumptions were also made regarding Mr X's ability to attend appointments at the LEO CAT because of his mother's assistance, and his adherence with his medication regimen because his mother was prompting him to take it. There was an over reliance on Mr X's mother during an early stage of his engagement with the LEO CAT service. No time was taken or effort made to build a relationship up with Mr X's mother and his family in their home context.

The Care Coordinator told the Independent Investigation Team when questioned about carer assessments that Mr X's condition had been explained to his mother and that she had been referred to a carer's group. The Independent Investigation Team felt that this response lacked a degree of insight, and that the answer fell short of what we were hoping to hear, namely, that Mr X's mother had been offered a full carer assessment in accordance with the National Service framework 1999 and the Carer Acts as listed above.

The Independent Investigation Team was able to meet with Mr X's mother on two occasions during the course of the investigation process. During this time she was able to affirm the fact that Mr X's father is a wheelchair user and that she is his main carer. She was also able to confirm that no home visits were ever offered to her, that no carer assessment ever took place and that the information she was given regarding her son's medication was in the form of a leaflet. Regardless of what the LEO CAT services may have thought, Mr X's mother was not completely clear what the nature of her son's mental health problems were or exactly what the medication was meant to achieve. Mr X's mother was not involved in any aspect of his care planning and, from memory, was not aware of the existence or content of the contingency plan

13.5.3. Conclusions

There are four main areas of concern. These are:

- Carer Assessments;

- information giving and communication with the family;
- family involvement in the care planning process;
- over reliance on family members.

Carer Assessments. As Mr X was under the care of a multi-disciplinary mental health team within a mental health trust, it should have been possible as part of the assessment and review process to identify whether Mr X had any carers who warranted an assessment and possibly help in their own right. It is the view of the Independent Investigation Team, especially in the light of the fact that Mr X's father had a disability that this should have been made a priority.

Information and Communication. Although members of the LEO CAT service thought that they had explained Mr X's condition and treatment to his mother, she remained confused and uncertain. When confronted with the fact that a close family member has a serious mental illness there can be no replacement for rapport building and direct regular communication and support. This is particularly relevant when the service user is an adolescent.

Family Involvement in Care Planning. Mr X's family did not appear to have had any direct involvement with the drafting of the contingency plan and had no idea as to what either the short or long term clinical plan was for Mr X. As a result they felt more like spectators rather than direct contributors to Mr X's care and treatment. They did not know what to expect and waited to be guided by the Trust services.

Over reliance on Family Members. In the light of the above three points it is clear that the LEO CAT placed too much reliance on Mr X's mother at a time when she was still trying to understand the full implications of her son's condition.

It is the view of the Independent Investigation Team that the LEO CAT could have engaged better with Mr X's family. This engagement should have been more direct, home-based and focused upon Mr X's family's social context and need. This lack of engagement could have had a direct impact on his non-attendance at appointments between 9 August and the 31 August 2006, a time when we know that Mr X had ceased taking his medication. Too many assumptions were made about Mr X's family situation and not enough was done to build a

rapport with them. **This is particularly relevant considering the fact that Mr X was extremely unwell and lacking in insight.**

- ***Contributory Factor Number Six. The LEO CAT did not effectively engage with the family of Mr X. This meant that the family remained unclear about his mental illness, his medication and his future clinical plan of care. This lack of clarity and engagement left both Mr X and his family in a vulnerable situation. The absence of carer assessment exacerbated this situation.***

13.6. Critical Issue Number Six. Service User Involvement in Care Planning

13.6.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

'*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*'[138].

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that 'people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care'. It also states that it will 'deliver continuity of care for a long as this is needed', 'offer choices which promote independence' and 'be accessible so that help can be obtained when and where it is needed.

13.6.2. Findings

It is clear from Mr X's clinical record that the LEO CAT Care Coordinator continuously made attempts to engage with Mr X and to involve him in the assessment process. It is also clear that the Care Coordinator was starting to engage and involve Mr X in the preparation of his care plan by asking him the 'three magical Questions'[139].

However it is also clear that Mr X was too unwell and lacking in insight to engage meaningfully with this process.

13.6.3. Conclusion

Mr X was too unwell to engage meaningfully with the assessment process that was followed. The care planning process was not initiated with Mr X because the Care Coordinator had not completed her assessment. It is the view of the Independent Investigation Team that the Care Coordinator had the skills and experience to have been able to achieve this had Mr X been better able to comply.

13.7. Critical Issue Number 7. Cultural Diversity

13.7.1. Context

Black and Minority Ethnic (BME) individuals often appear to be subject to a paradoxical effect when accessing mental health services. The paradox is that many BME groups actively avoid mental health services and yet these same groups are represented by a significantly high presence within the mental health system. Research informs us that current mental health services within the United Kingdom have been based on a westernised model of psychiatry. It is a fact that some cultures accept the notion of mental illness more readily than others, these cultures will access mental health services and accept treatment programmes. Other cultures may be reluctant to consider the notion of mental illness with issues such as cultural stigmatisation, fear of the unknown, and basic communication and language difficulties becoming barriers to accessing help[140].

Over the past six years a considerable amount of literature has been published regarding the needs of BME individuals, and their families, who require access to mental health services. This literature includes the Government's response to the death of David Bennett in 1998. David Bennett was a 38-year-old African-Caribbean patient who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff[141]. The Independent Inquiry into David Bennett's death raised many issues and identified failures regarding mental health services failing to understand cultural diversity.

It was stated within the Department of Health's *Delivering Race Equality in Mental Health Care* (2005) action plan that healthcare organisations must challenge discrimination, promote equality and respect human rights, and that organisations must enable all members of the

population to access services equally[142]. The Government's expectation for the future of mental health services is set out below.

The vision for Delivering Race Equality is that by 2010 there will be a service characterised by:

- *less fear of mental health services among BME communities and service users;*
- *increased satisfaction with services;*
- *a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;*
- *a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;*
- *fewer violent incidents that are secondary to inadequate treatment of mental illness;*
- *a reduction in the use of seclusion in BME groups;*
- *the prevention of deaths in mental health services following physical intervention;*
- *more BME service users reaching self-reported states of recovery;*
- *a reduction in the ethnic disparities found in prison populations;*
- *a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;*
- *a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and*
- *a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.*

13.7.2. Findings

The Independent Investigation Team knows that the Trust workforce within the Lambeth Directorate is drawn from a wide variety of multi-cultural backgrounds. This however on its own does not necessarily mean that services will always provide a culturally appropriate and sensitive approach to a service user or their family.

In the interests of learning the Independent Investigation Team would like to make the following observations with regard to cultural diversity and culturally sensitive mental health services.

1. Clinical witnesses to this Investigation did not seem to think that Mr X's substance misuse raised his levels of risk significantly. It became apparent that this view was taken as the result or some comparative assumption about what was regarded as 'normal within Lambeth'. It is clear that Mr X was not always being viewed as an individual when assessing his substance misuse problems and it is possible that his problems were minimised as a result.
2. The Independent Investigation Team got the impression when interviewing clinical witnesses that involvement with the YOT was not unusual for young people in Lambeth. It is possible that this view was responsible for Mr X's YOT history not being followed up. We do not know whether this assumption could subconsciously have been made because of Mr X's race. However Mr X's family have had no previous history with the police. Mr X's two elder sisters have both been to university. Youth offending would most definitely not have been regarded as normal within Mr X's family.

3. It is a fact that many people from black African and Afro-Caribbean cultures are ambivalent regarding mental illness. It is also a fact that people from BME communities often view mental health services within the United Kingdom with an element of distrust and fear. This may explain why Mr X's mother did not mention her son's previous mental health history on the 29 June 2006 when interviewed by the LEO CAT Care Coordinator.

13.7.3. Conclusions

The three observations listed above are drawn from 'impressions' rather than from 'facts'. It is difficult sometimes for mental health services to know what the appropriate cultural approach should be with individuals from BME communities. This Investigation is not stating that Trust personnel were in anyway culturally inappropriate with regards to the care and treatment that they offered Mr X and his family. However we are left with the impression gained from witness interviews that certain assumptions were made about Mr X and that he was not perhaps assessed and viewed as an individual. When questioned some witnesses referred to Mr X's drug habit as being normal for the area. It must be remembered, for example, that substance misuse is not always something that can be regarded as 'normal' simply because of a person's race, age or history of offending. The substance misuse has to

be seen and dealt with according to the impact that it has on the individual, their mental health, and the concerns of that that person's family.

Ambivalence regarding mental illness is not only the preserve of people from BME communities. All health and social care professionals should endeavour to build up a good rapport with families and to do everything that is within their gift to maintain sound channels of communication.

13.8. Critical Issue Number 8. Safeguarding Children

13.8.1. Context

One in four adults will experience mental health problems. Many of these people will be parents, parents-to-be, grandparents, other family members, or will have regular access to children[143]. Parental mental illness in particular can have a detrimental effect on the health and well being of a child. The Department of Health and the Royal College of Psychiatry advise that systems should be in place to ensure timely assessment, review and support[144].

There is a significant legislative framework in place to both protect and safeguard children. There is also a significant series of Inquiry recommendations and Department of Health Guidance relating to both the protection and safeguarding of children, much of which was in place during the time that Mr X was receiving his care and treatment from the Trust.

The 2005 policy was made available to the Independent Investigation Team, it stated that:

'A child is defined under the Children Act 1989 as anyone under the age of 18 years. Staff should remember, young children,... may be particularly vulnerable and in need of protection'[145]

The Trust 2005 policy is comprehensive and understands fully that safeguarding children is not simply a matter of protecting against emotional, physical and sexual abuse, but is about promoting wellbeing and ensuring that children thrive in situations where mental illness afflicts family members.

13.8.2. Findings

Both Mr X and his sister were under the age of 18 years when Mr X received his care and treatment from both the YOT CAMHS and the LEO CAT. There is no mention at all in Mr X's record whether or not safeguarding needs were considered either for him or for his sister.

The LEO CAT Care Coordinator was aware from the very first meeting that was held with Mr X and his mother on the 29 June 2006 that he had a younger sister who was living with him in the family home.

If the LEO CAT workers had pursued Mr X's YOT history they would have been aware that Mr X had a history of violence and aggression and that he had also been violent within the family home. From the evidence presented to the Independent Investigation Team Mr X's sister was never directly at risk from any of Mr X's behaviours. However it is surprising that Mr X's mental illness, which was severe, was never assessed in relation to its impact upon his younger sister which must have been considerable. The LEO CAT is a service that describes itself as 'youth friendly' and seeks to provide assessment within the context of a young person's home environment. Part of the LEO CATs function was to assess the service user's interpersonal relationships; with regard to Mr X's sister this was clearly not done.

In assessing how well the Trust policies and procedures safeguarded Mr X the Independent Investigation Team noted the following issues regarding his safety and welfare:

YOT CPN

- The original referral to the YOT CAMHS service from Mr X's YOT Officer stated that Mr X's Mother had 'worries for her and her family's safety'[146];
- Mr X had been in the habit of going for walks in the middle of the night;
- Mr X had a significant substance misuse problem;
- Mr X was often unkempt;
- Mr X lost a great deal of weight;
- Mr X was sometimes violent, abusive and aggressive (at school, at college and in his home which could have led to him injuring other people, and they in turn injuring him);

- Mr X's mother was not always sure where got he got the money from to pay for his drugs;
- Mr X had no insight and was displaying significant psychotic symptoms.

At no time did the YOT CPN consider Mr X's safety or wellbeing to be an issue specifically in the light of Mr X's young age.

LEO CAT Care Coordinator

- Mr X had a significant substance misuse problem;
- Mr X had no insight and was displaying significant psychotic symptoms.

As had been mentioned several times already, the LEO CAT workers did not enquire into Mr X's YOT history. If this had been done then the LEO CAT workers would also have been aware of all of the risk factors regarding Mr X's own safety. This should have formed a key part of any clinical assessment and care planning process within the LEO CAT[147].

13.8.3. Conclusions

The Independent Investigation Team do not think that either Mr X or his sister were at risk from psychological, physical or emotional abuse. Neither was there any indication that the children were being neglected. Safeguarding issues cannot be seen as having had any direct causality regarding the events of 5 September 2006.

However it is the view of the Independent Investigation Team that the case of Mr X raises a significant service issue. Nowhere in Mr X's clinical record were any potential safeguarding assessments or needs mentioned for either Mr X's sister or himself regarding their safety or welfare. It is clear that this issue never even occurred to any member of the clinical team providing care and treatment for Mr X either in the YOT or in LEO CAT.

It is a fact that Mr X's mother sought help for her son on several occasions because she was concerned for his welfare and knew that he was unwell. Mr X's mother clearly felt that she could not manage his condition on her own and sought professional assistance.

It is also a fact that Mr X's clinical team identified several factors that would indicate he was a child placed at risk by his mental illness and behaviours. At no time was any practical help or support given to Mr X or to his family to ameliorate these risks. Medication was the only tangible assistance offered to him over a thirteen month period.

- ***Service Issue Number Two. No safeguarding children assessments were undertaken for either Mr X or his sister even thought there were significant indicators evident to suggest that the wellbeing of both children could be compromised.***

13.9. Critical Issue Number 9. Interagency Communication and Working

13.9.1. Context

'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion.'[148]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme approach when used effectively should ensure that both interagency communication and working takes place in a service user centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and have a history of criminal offences cannot be met by one agency alone[149]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively[150]. The Department of Health *Building Bridges* (1996) sets out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required. This level of expectation was firmly in place during the time that Mr X first came to the attention of mental health services in Lambeth.

13.9.2. Findings

There are two significant interagency failures that occurred during Mr X's time with the Trust. The first interagency failure occurred between the secondary and primary care

interface, and the second failure occurred between the YOT CAMHS and LEO CAT interface.

Communication with Primary Care. Mr X's GP first referred Mr X to the Rapid Response Team in Lambeth on the 29 September 2005. This referral was appropriately re-directed to the Lambeth Child and Adolescent Mental Health Service. On receipt of this referral the Manager of the Child and Adolescent Team telephoned Mr X's mother and once it had been ascertained that he was already seeing Mr AQ at the YOT decided that the referral did not need to proceed further. At no time did the Manager telephone the GP from whom the referral had been received. This was a poor decision because it was clear from the referral letter that the GP was concerned about Mr X's increasing violence and aggression in his home. There is no evidence in the clinical record made available to the Independent Investigation Team that the GP received any correspondence from the Trust regarding this decision.

The second GP referral took the form of a letter sent on the 12 June 2006 and received by the LEO CAT on the 21 June 2006. There is no explanation to be found that can explain why there was this delay between the sending and receipt of the letter. It is clear from this letter that the GP had identified the possibility of an early psychosis. It is noted in the clinical record that two attempts were made by the Care Coordinator to contact Mr X's GP by telephone. On the first occasion he was out making home visits and on the second occasion there was no response from the surgery. There is no evidence that any further attempts to contact were made by the LEO CAT to Mr X's GP. When the Independent Investigation Chair and Nurse Team Member visited the Surgery we examined Mr X's GP-held record and could find no communication of any kind from the LEO CAT. The GP had no further communication regarding Mr X until after the events of 5 September 2006. This must be seen as an unsatisfactory state of affairs particularly for a service such as the LEO CAT that prides itself on its relationship building with GPs and also in the light of providing care and treatment to a child.

Communication between the YOT CAMHS and the LEO CAT. Basically there was no communication between either of these services. The YOT CAMHS were obviously unaware of the LEO CAT involvement with Mr X. The reason why Mr X's mother did not provide the

necessary information is unclear. However services that are delivered to children should not rely on family members to ensure that communication between agencies occurs.

This lack of communication led to a bizarre series of appointments and entries on to the EPJS system. Mr X was seen by the LEO CAT on the 29 June 2006 and by the YOT CAMHS on the 30 June 2006. On the 16 August 2006 the YOT CAMHS were anxious because they had not seen Mr X for two weeks, and the LEO CAT also failed to engage with Mr X during this same period.

The lack of communication between the YOT CAMHS and the LEO CAT is even more worrying because the embedded CAMHS service at the YOT and the LEO CAT were part of the same Trust Clinical Directorate. The fact that a child could be seen by two separate services in the same directorate and have no links made is of great concern particularly considering the recommendations set out by the Laming Inquiry following the death of Victoria Climbie.

One of the reasons for this lack of communication put forward by the Trust Internal Investigation is that Mr X's name had been entered onto the EPJS incorrectly by the YOT CAMHS and this in effect rendered him 'invisible' to the LEO CAT service. The Independent Investigation Team however believes that the main reason why communication failed is because the LEO CAT Care Coordinator did not follow up Mr X's known YOT involvement.

13.9.3. Conclusions

Communication regarding Mr X's care and treatment was managed poorly throughout the entire period that he received services from the Trust. National expectation and local policy guidance was quite clear, and by 2006 should have been embedded well within all NHS Trusts providing services to children.

The fact there were several issues regarding interagency communication over a period of twelve months regarding Mr X's care and treatment would suggest that during 2005 and 2006 both national policy expectation and local policy guidance were not embedded within the Trust.

- ***Key Contributory Factor Number Seven. The failure to communicate between agencies and services ensured that essential information regarding Mr X's history and risk were not known. This had a direct influence on how he was perceived by the LEO CAT service and how his care pathway was managed.***

13.10. Critical Issue Number 10. Documentation

13.10.1. Context

'The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.
The Act works in two ways. ... it states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *Fairly and lawfully processed*
- *Processed for limited purposes*
- *Adequate, relevant and not excessive*
- *Accurate and up to date*
- *Not kept for longer than is necessary*
- *Processed in line with your rights*
- *Secure*
- *Not transferred to other countries without adequate protection*[151]*,*

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Act. All records should be archived in such a way that they can be retrieved and not lost. All records pertaining to individual mental health service users should be retained by NHS Trusts for a period of 20 years from the date that no further treatment was considered necessary; or eight years after the patient's death if the patient died while still receiving treatment.

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professional have adopted similar guidance.

The GMC states that:
'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off [152]*'*

Pullen and Loudon writing for the Royal College of Psychiatry state that:
'Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised[153]*'*

13.10.2. Findings

Mr X's clinical record provides a clear narrative that gives a detailed account of what occurred during each of his clinical appointments with both the YOT CAMHS and the LEO CAT services. The clinical record however reflects the fact that Mr X's numerous appointments, a total of 25 over a 13 month period, failed to result in a full assessment or any kind of coherent plan of care.

When the Independent Investigation Team read through Mr X's LEO CAT records it became apparent that several of the entries had not been contemporaneously made. Between the 29 June and the 5 September 2006 four significant entries in Mr X's clinical record were entered retrospectively after the events of 5 September 2006. During this period Mr X had been seen on seven occasions, therefore over 50% of his face-to-face appointments were not entered into his clinical record appropriately.

The four retrospective entries were made:

- for the 5 July 2006 by Dr EI (it is not clear whether this entry was made from memory or from a notebook) on the 7 September 2006;
- for the 25 July 2006 by Dr K from memory on the 12 September 2006;
- for the 9 August by Ms JN from a notebook on the 15 September 2006;
- for the 17 August 2006 by Ms JN from a diary on a date in September 2006[154].

The reasons given for the retrospective entries are as follows:

- slow running of the EPJS;
- pressure of work;
- misplacing of notebooks.

The two doctor entries were made between 9 and 7 weeks after the consultations with Mr X. These entries suggest that both Mr X and his mother were happy and prepared to adhere to his medication regimen (5 July 2006 meeting 7 September 2006 entry) and that Mr X appeared to be making progress (25 July 2006 meeting 15 September entry).

Obviously this is a far from satisfactory state of affairs for a number of reasons.

1. The Independent Investigation Team have had to seriously consider the weight of the statements regarding Mr X's supposed compliance and progress as these entries were made after the death of Mrs Tulloch. It could be argued that health care professionals would resist stating that they felt Mr X was *not* compliant and *not* making progress once a homicide had taken place. This diminishes the reliance that can be placed on the record.

2. Mr X's records were not complete during the period of time that he was receiving his care and treatment from the LEO CAT. Clinical records exist so that health care professionals can communicate in a clear and timely manner. If significant chunks of Mr X's clinical record had not been written during the period that he received his care treatment this represents poor practice. This places the service user at risk.

3. The Electronic Patient Journey System (EPJS) was slow during this period of time. The Independent Investigation Team heard from clinical witnesses that the system was difficult to access and slow when in use. The LEO CAT used and still uses an electronic record system. It is a far from satisfactory state of affairs when clinicians cannot enter patient data contemporaneously because the electronic system is too slow. This compromises both the clinician and the Trust.

4. The fact that individuals were able to input clinical data on an electronic system retrospectively creates a system that is open to misinterpretation and potential abuse.

13.10.3. Conclusions

The Independent Investigation Team did not feel that the retrospective clinical record entries in this particular case were sinister in nature. This is because the clinicians qualified their late entries and made it clear that they were not made contemporaneously. However this late recording of clinical data is poor practice and runs counter to what should be expected of healthcare professionals. The Trust corporately has to bear most of the responsibility for this because the EPJS was not functioning appropriately at the time.

- ***Service Issue Number Three. Some of Mr X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry in this case has potentially left both the healthcare professionals and the Trust vulnerable.***

13.11. Critical Issue Number 11. Clinical Supervision and Clinical Leadership

13.11.1. Context

The NHS Management Executive defined clinical supervision in 1993 as:

'….a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations'[155]

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

Throughout the entire period that Mr X received his care and treatment from the Trust sound clinical supervision guidelines were in place. The 2002 Trust guidelines differentiated clearly between clinical supervision and managerial supervision and gave clear definitions for both. Clinical Supervision was described in the following way;

'It is a key component of quality improvement as it provides an opportunity for practitioners at all levels to review practice in a regular and systematic way. Therefore, "clinical supervision" could be seen to be "at the heart of clinical governance' [156]

Managerial supervision was described thus:
'It is a planned process, establishing the accountability of the worker in the organisation, ensuring tasks are carried out to a satisfactory, safe standard in line with organisational objectives and promoting the workers professional development...It involves... implementation of government, local and Trust policies.'[157]

The Trust 2002 guidelines suggested that clinical supervision should occur no less than once a month for a duration of no less than one hour.

13.11.2. Findings

YOT CAMHS

It is not possible to ascertain what clinical supervision or caseload supervision Mr AQ was subject to. Neither he nor Ms CT, his manager at the time, were available to be interviewed by the Independent Investigation Team. There is no evidence that the Internal Investigation Team were able to successfully address the issue of clinical supervision and so what occurred cannot now be known.

It is clear that the YOT CAMHS Consultant Psychiatrist had concerns regarding both Mr AQ's competence and the running of the YOT CAMHS; this is evidenced by the interviews that she gave to both the Independent and the Internal Investigation Teams. This Consultant voiced her concerns to Ms CT directly in the summer of 2006 because she had concerns regarding Mr AQ's ability to 'pick up' on psychopathology and risk. It would appear that a meeting did not subsequently take place to explore these concerns and, more importantly, to address them. The Independent Investigation Team received the impression that Trust clinicians were not aware of how to raise concerns regarding either the performance of colleagues or issues regarding the running of services and that managers were often not easy to access.

It would appear that none of the concerns regarding Mr AQ's performance were managed appropriately and that he was allowed to continue working with the YOT CAHMS clients. There was a difference of opinion to be found amongst the clinical witnesses that the Independent Investigation Team interviewed. Some witnesses felt that the YOT CAHMS client group represented 'the bottom of the tier' and as such did not present a high risk group. Other witnesses however felt that this group represented some of the highest risk young

people in the Borough. This lack of agreement is problematic as any service should have a coherent strategic view regarding client risk.

It is the view of the Independent Investigation Team that the YOT CAMHS clients did in fact represent a significantly high risk group of young people and as such supervision arrangements and performance management should have been clear and easy to operate for all YOT CAMHS workers.

The Independent Investigation Team learnt that clinicians could not easily access managers and that the roles and responsibilities of lead clinicians and managers were no longer clear during this period. The YOT CAMHS appeared to function in isolation from all of the other CAMHS and LEO services with the Borough of Lambeth leaving clinicians with flawed communication systems. The Independent Investigation Team was told by clinical witnesses that managers were difficult to access as 'paths seldom crossed' and meetings were often difficult to arrange.

LEO CAT

Clinical supervision within the LEO CAT appears to have occurred in a regular manner with the management and meeting structure also ensuring that all cases were effectively supervised 'in real time' within the multidisciplinary team in an appropriate way. It is clear that the Care Coordinator was able to discuss Mr X's assessment, care and treatment plan. It is also clear that the Care Coordinator did not act without the full agreement of the multidisciplinary team and that all decisions taken regarding Mr X were team decisions.

13.11.3. Conclusions

During the period that Mr X was receiving his care and treatment it would appear that the YOT CAMHS was functioning with locum workers who were not receiving clinical supervision. The new Consultant Psychiatrist that provided two sessions a week to the YOT CAMHS did not feel that Mr AQ had a sufficient level of skill to assess and triage high risk cases. The client caseload within the YOT CAMHS was described by some clinical witnesses as containing young people with 'the highest risk' in the Borough. It does not appear that during 2005 and 2006 that the YOT CAMHS workers had the necessary skills, the necessary supervision, or the necessary clinical leadership to work and deliver services in such an environment.

The concerns of the YOT CAMHS Consultant regarding the management of the YOT CAMHS service and the skills of Mr AQ were not addressed in a timely manner by the service manager. This lack of action is regrettable, but in itself did not contribute to the fact that Mr X's condition remained untreated at this stage, as the manager had not been alerted to any concerns quickly enough for her to have acted in such a way that could have benefitted Mr X. There appears to have been no tangible clinical leadership within the YOT CAMHS during this period.

Regular clinical and caseload supervision may well have assisted Mr AQ in deciding when to trigger a medical referral for Mr X. This may well have altered Mr X's long term treatment pathway and more positively affected his prognosis.

The Independent Investigation Team felt that the LEO CAT worked as a strong and cohesive unit underpinned by a sound operational service policy. However in 2005 and 2006 the YOT CAMHS, CAMHS and LEO services all worked more or less in isolation from each other. Clinical leadership was sporadic and services lacked cohesion, vision, and a culture of collaborative working. This left individual clinicians vulnerable and isolated and this had to have had a negative effect on the quality of care that service users received.

- ***Key Contributory Factor Number Eight. The absence of clinical supervision and clinical leadership in the YOT CAMHS ensured that Mr AQ did not have the support and professional guidance that he required. This had an impact on the quality of the care and treatment that Mr X subsequently received.***

- ***Key Contributory Factor Number Nine. YOT CAMHS, CAMHS and LEO services all worked more or less in isolation from each other. Clinical leadership was sporadic and services lacked cohesion, vision and a culture of collaborative working. This left individual clinicians vulnerable and isolated and this had to have had a negative effect on the quality of care that service users received.***

13.12. Critical Issue Number 12. Adherence to National and Local Policy and Procedure

13.12.1. Context

Evidence-based practice has been defined as '*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.*[158]' National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of clinical governance which is explored in section 14.14 below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

13.12.2. Findings

The Independent Investigation Team examined a comprehensive list of Trust policies and procedures. The policies and procedures most pertinent to this investigation were those

pertaining to operational policy, risk assessment, CPA, clinical supervision, safeguarding children and record keeping. It was the view of the Independent Investigation Team that these policies and procedures were comprehensive and reflected both national guidelines and best practice.

What became apparent during the course of this investigation was that the clinical witnesses, when interviewed, had a very poor understanding of what was actually contained within both their corporate and local policies and procedures. Clinical witnesses described to the Independent Investigation Team on many occasions practices that ran counter to Trust policy and procedure. The impression that was given to this Investigation was that clinicians did not feel bound by policy and procedure in any way and that 'gut feeling' was more important.

The Independent Investigation Team learnt that Trust policies and procedures were disseminated via organised training sessions and that all policies and procedures were easily accessible to all clinical staff. The Independent Investigation Team also learnt that services delivered within the Lambeth Directorate were, and are, subject to regular audit.

What this Investigation found was that in 2005 and 2006 the YOT CAMHS, CAMHS and LEO services all worked more or less in isolation from each other. Clinical leadership was sporadic and services lacked cohesion, strategic vision and a culture of collaborative working.

13.12.3. Conclusions

The Independent Investigation Team observes that there appeared to be a culture within the Lambeth CAMHS and LEO services of non adherence to Trust policy and procedure. This is not good practice or an advisable stance for any clinician to take. Clinical witnesses appeared to disagree one with another about what should constitute a strategic vision. As the evidence emerged to this Investigation it became clear that the initiatives of individuals often became the 'chosen way forward'. Whilst individual initiative has to be applauded when it occurs in the absence of corporate strategy it can become counterproductive.

It is unclear what role clinical audit played in the performance management and scrutiny of clinical governance processes within these services during the period that Mr X received his care and treatment.

- ***Key Contributory Factor Number Ten. Clinical practice within the Trust did not conform to internal policies and procedures.***

13.13. Critical Issue Number 14. Clinical Governance Processes

13.13.1. Context

'Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish'[159]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

Prior to, and during, 2006 the South London and Maudsley NHS Foundation Trust had a Clinical Governance and Risk Management sub-committee that reported to the Trust Board. This sub-committee represented an integrated approach to clinical governance and risk management which was in line with national expectation and guidance. During the period in which Mr X received his care and treatment from the Trust the Commission for Health Improvement, and subsequently the Healthcare Commission, externally monitored the Trust and provided independent ratings for its performance.

13.13.2. Findings

During the period that Mr X received his care and treatment from the Trust it was evident that several systems failed to work effectively, particularly with regard to CPA, risk assessment and documentation. As has been stated above, the Trust had sound clinical policies and procedures in place. It is evident from independent Clinical Negligence Scheme for Trusts (CNST) assessments and reviews by the Healthcare Commission that clinical staff were receiving the appropriate training and development in these areas in order to facilitate full implementation of Trust policy and procedure.

During the course of the Independent Investigation the Team accessed the external reports authored by the Healthcare Commission. These reports confirm that the Trust had sound

clinical governance processes in place. For example for the year 2002/2003 the Trust was rated a 5 for its CPA systems implementation. A 5 signified that the Trust was performing significantly above the national average in this area[160]. Other more recent independent reports from the Healthcare Commission also confirm that the Trust has a consistently high level of service performance with all of the required checks and balances in place within the system.

The Trust has always instituted a robust series of clinical audits as evidenced to the Independent Investigation Team. During the course of this Investigation over 1,000 pages of documentary evidence was considered by the Team which was relevant to the issue of the Trust clinical governance systems. However it is clear that in the case of Mr X aspects of his care and treatment did not meet internal Trust standards and were not detected via Trust clinical governance processes.

13.13.3. Conclusions

When conducting an Investigation of this kind it has to be remembered that the care and treatment of a single service user is being examined. This examination no matter how detailed can only yield a certain degree of insight into the workings of an organisation that treats nearly 40,000 service users each year. On examination the Trust clinical governance processes between 2005 and 2006 were found to be perfectly adequate by this Independent Investigation Team, this finding takes into account the many external reports that examined the Trust's systems during this period.

It is a salutary lesson that all health related agencies need to consider; sometimes systems may be excellent but cannot demonstrably be effective 100% of the time. When reviewing why the Trust clinical governance systems did not appear to work effectively in this particular case the Independent Investigation Team had to consider the following possibilities:

- team culture;
- 'the exception that proves the rule';
- the effect of Mr X not being seen by 'mainstream services'.

Team culture. It was evident from clinical witness interviews that a great deal of reliance was placed on 'gut instinct' when reaching clinical decisions. Policies and procedures did not appear to have a central position in the hearts and minds of some of the people that were

interviewed by this Investigation Team. Although it is not possible to generalise, it may be that this played an important part in the non-adherence to Trust policy and procedure that was evidenced by the care and treatment that Mr X received. It may also be possible that this culture affected the rigor with which audit data was collected, analysed and then acted upon.

The exception proving the rule. Between 2005 and 2006 most Trusts would not automatically audit every single case file when determining the effectiveness of a system, it is entirely possible that Mr X's case file was never subject to audit. It is possible that Mr X's case file depicts a general state of affairs that existed within the Lambeth Directorate, but this is not borne out by Trust audit data. There will always be a small percentage of cases that do not reflect general best clinical practice; it is possible that Mr X was simply one of these.

The effect of Mr X not being seen by 'mainstream services'. Mr X did not receive an adequate or timely clinical assessment at the inception of his period of care and treatment with the YOT CAMHS. The failure to instigate this basic building block of care ensured that Mr X was not offered a treatment programme in accordance with his first episode of psychosis. Mr X was then seen by the LEO CAT for a period of some eleven weeks. During this period he was not risk assessed or appropriately offered a CPA.

Neither the YOT CAMHS or the LEO CAT could be seen as traditional 'mainstream' services. Perhaps if they had been Mr X's care and treatment would have followed a more traditional pathway in accordance with Trust Policy and Procedure.

The Independent Investigation Team concludes that the clinical governance systems within the Trust were sound during the period that Mr X was receiving his care and treatment even though they failed to detect key clinical service issues in the management of his case.

14. Findings and Conclusions

The backdrop of organisational change

The South London and Maudsley NHS Foundation Trust is a large organisation, representing the amalgamation into one working unit of several mental health services within a geographical area of South London. Inevitably, as the Trust began establishing its new corporate identity from 1999 onwards, there were numerous re-organisational processes, not the least those associated with the successful bid to become a Foundation Trust, which was attained in 2006. In parallel, there was the move towards integration of health and social care within mental health, which was happening nationally. Another major process change during the period that Mr X was receiving his care and treatment was the move from a paper-based record keeping system towards an electronic patient record.

It is a matter of speculation as to the degree to which these process changes impacted on the turbulence that affected the Lambeth Directorate and the clinical effectiveness of their work. However organisational change is usually recognized as being a disruptive process to operational services and the findings regarding the care and treatment that Mr X received from the Trust have to be understood in this context.

Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

4. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the homicide that occurred on the 5 September 2006. In the realm of mental health service provision it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

5. **Contributory Factor.** The term is used in this report to denote a process or a system that that failed to operate successfully thereby leading the Independent Investigation

Team to conclude that it made a direct contribution to the breakdown in Mr X's mental health and/or the failure to manage it effectively.

6. **Service Issue.** The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 5 September 2006, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

Key Causal Factors

The Independent Investigation Team found one key causal factor relating to the care and treatment of Mr X and the subsequent events of September 2006. The key causal factor identified by this Investigation relates to the partially treated mental state of Mr X. His Honour Judge McKinnon ruled that Mr X committed his offences on the grounds of diminished responsibility as a direct result of his paranoid schizophrenia.

- ***Key Casual Factor Number One. The failure to institute an appropriate CPA, assessment and treatment programme for Mr X ensured that his mental illness was partially treated. His Honour Judge McKinnon found Mr X's mental illness was a direct causal factor in the death of Mrs Tulloch.***

Contributory Factors

The Independent Investigation Team found ten factors that contributed to the less than effective care and treatment package that Mr X received.

- ***Key Contributory Factor Number One. The failure to manage the ongoing assessment, care, risk and treatment needs of Mr X whilst receiving care from the YOT CAMHS meant that his mental illness was untreated. This extended period of time where his condition remained untreated ensured that his mental illness continued to worsen. Mr X's mental state was considered by the Court when sentencing him to have played a major factor in the events of 5 September 2006.***

- ***Key Contributory Factor Number Two. Mr X's condition was not adequately assessed, managed and monitored during the period that he received his care and treatment from the LEO CAT. This ensured that his condition remained partially treated.***

- ***Key Contributory Factor Number Three. Failure to provide an early diagnosis and treatment package led to Mr X's condition worsening over a period of time. This delay prevented a coherent package of care and treatment being delivered in a timely manner.***

- ***Key Contributory Factor Number Four. The failure to adequately monitor Mr X's adherence to his treatment plan contributed to the escalation of his condition in the days preceding the events of the 5 September 2006.***

- ***Key Contributory Factor Number Five. The lack of a detailed risk assessment conducted in the full light of Mr X's psychiatric and forensic history prevented a coherent plan of care and treatment from being developed. This ensured that Mr X remained an unknown quantity and that his condition was only partially treated.***

- ***Contributory Factor Number Six. The LEO CAT did not effectively engage with the family of Mr X. This meant that the family remained unclear about his mental illness, his medication and his future clinical plan of care. This lack of clarity and engagement left both Mr X and his family in a vulnerable situation. The absence of a carer assessment exacerbated this situation.***

- ***Key Contributory Factor Number Seven. The failure to communicate between agencies and services ensured that essential information regarding Mr X's history and risk were not known. This had a direct influence on how he was perceived by the LEO CAT service and how his care pathway was managed.***

- ***Key Contributory Factor Number Eight. The absence of clinical supervision and clinical leadership in the YOT CAMHS ensured that Mr AQ did not have the***

support and professional guidance that he required. This had an impact on the quality of the care and treatment that Mr X subsequently received.

- ***Key Contributory Factor Number Nine. YOT CAMHS, CAMHS and LEO services all worked more or less in isolation from each other. Clinical leadership was sporadic and services lacked cohesion, vision and a culture of collaborative working. This left individual clinicians vulnerable and isolated and this had to have had a negative effect on the quality of care that service users received.***

- ***Key Contributory Factor Number Ten. Clinical practice within the Trust did not conform to internal policies and procedures.***

Service Issues

The Independent Investigation Team found three service issues whilst examining the care and treatment that Mr X received.

- ***Service Issue Number One. The Trust appointed an individual who held a clinical caseload and conducted clinical duties whilst not holding a qualification recognised in the United Kingdom.***

- ***Service Issue Number Two. No safeguarding children assessments were undertaken for either Mr X or his sister even thought there were significant indicators evident to suggest that the wellbeing of both children could be compromised.***

- ***Service Issue Number Three. Some of Mr X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry in this case has potentially left both the healthcare professionals and the Trust vulnerable.***

Conclusions

The care and treatment that Mr X received between 2005 and 2006 did not provide a comprehensive package that treated his condition effectively and adequately monitored him with regard to relapse.

The Trust had excellent policies and procedures during this period of time, but they were not always adhered to. This non adherence meant that Mr X did not receive a risk assessment or a CPA package. There was a high degree variance regarding how Mr X's case management was viewed he was seen as a child by the YOT CAMHS service, and as an adult by the LEO CAT service. The fact remains that under the guidance of the Children Act Mr X was legally a child throughout his entire period of care and treatment with the Trust and should have been treated accordingly.

Mr X was not seen by what could be described as 'mainstream services'. During the year that he received care and treatment from the Trust it would appear that he was always either waiting to be assessed, or waiting to be referred onto the most appropriate service. The fact that risk assessment and CPA did not ever formally 'kick in' for Mr X was explained by clinical witnesses as being due to fact that 'these processes would occur on referral'. Mr X was not referred to the services that were supposed to provide these basic building blocks of care. As a result his care and treatment was not provided in either a coherent or a timely manner. The prescription of medication alone, which is all Mr X ever received, can never be seen as the provision of a comprehensive care and treatment package. The fact remains that over a period of 13 months Mr X was seen on 25 occasions. At the end of this period it would appear that his assessment was not judged to be complete and his care package not developed. This cannot be seen as a satisfactory state of affairs considering that Mr X was severely ill and suffering from a psychosis, later to be confirmed as paranoid schizophrenia.

It is the case here that, despite excellent policies and procedures and sophisticated clinical governance systems, the basic building blocks of clinical practice which form the most essential components of patient care were not respected. Nothing can take the place of a detailed patient history set within the context of a sound and ongoing relationship with the service user. Whilst every effort was made to engage with Mr X by both the YOT CAMHS and the LEO CAT this insufficiently translated itself into action.

Clinical witnesses from the LEO CAT that were interviewed by the Independent Investigation Team stated that Mr X was 'still being assessed' at the time of the death of Mrs Tulloch. These same witnesses acknowledged that a risk assessment should have been undertaken and would have been in the fullness of time, as would a formal approach to the YOT. It is unclear when this would have occurred, it is the view of the Independent

Investigation Team that these were the kind of actions that ought to have occurred with immediate effect and definitely not some three months after referral.

The YOT CAMHS CPN and the LEO CAT Care Coordinator demonstrated sound rapport building skills. The LEO CAT Care Coordinator also demonstrated a conscientious approach to her work. It is not the view of the Independent Investigation Team that the actions or omissions of these two workers were key to Mr X's condition being partially treated. These two workers worked within a system of services that did not communicate well and did not adhere to either corporate or local policy guidance. It is evident that neither service appeared to be able to respond to the needs of an individual and responded to Mr X's needs based on the assumption of his 'relative' risk when compared to other people on the extant caseload. This was clearly not best practice.

The Trust clinical witnesses laid great store by the view that they could not have predicted the death of Mrs Tulloch on the 5 September 2006 and that nothing in Mr X's history, either known or not known at the time, could have made any difference to his assessed level of risk and any resulting plan of care, and that as such the case was handled appropriately and that nothing could have been done differently. The Independent Investigation Team would like to make the following clear:

- we agree that Mrs Tulloch's death could not have been predicted whether the LEO CAT had taken a full history from the YOT CAMHS or not;

- we would like to acknowledge the fact that it is very difficult to treat patients who do not wish to be treated and who may not cooperate and that even with perfect systems it is not always possible to prevent an individual's mental health deteriorating;

- the Independent Investigation Team do believe that Mr X's case should have been managed in a more coherent and timely manner during the 13 months that he received his care and treatment from the Trust. A total of 25 appointments over a thirteen month period should have yielded a comprehensive care package for this young man. It did not. During the vast majority of this period Mr X's condition was untreated and grew worse. His condition was treated with medication during the last nine weeks of

his contact with the Trust and it is known that he was not compliant for the last two weeks of this period. Whether Mrs Tulloch's death could have been predicted or not it is not the only issue here. This alone cannot inform whether or not Mr X received the full care and treatment package that he required. The Independent Investigation Team recognise that services cannot always successfully treat patients with a mental illness, however in the case of Mr X it would appear that many avenues of potential treatment were left unexplored and more could have been done.

- It is a fact that Mr X's mental state directly contributed to the death of Mrs Tulloch. This is the expert opinion of both the Defence and Prosecution Forensic Psychiatrists that gave evidence to His Honour Judge McKinnon at Mr X's sentencing hearing. It was also the judgement of His Honour Judge McKinnon when he passed sentence on Mr X.

Regardless of whether Mrs Tulloch's death was predictable or preventable, the fact remains that Mr X did not receive an adequate package of care from the Trust.

15. South London and the Maudsley NHS Foundation Trust's Response to the Incident and the Internal Investigation

The following section sets out the Trust response to the events of September 2006.

15.1. The Trust Serious Untoward Incident Process

The Trust has a robust serious untoward incident policy. This policy clearly sets out the required procedure following an incident and also sets out the responsibilities of all Trust personnel[161]. The policy details clear instructions for the support of service users and their carers, victims and their families, and staff.

The most serious events are graded as being either class A, B or C incidents. A class A incident is one that results in a death and can include acts of homicide or suicide. The events of September 2006 perpetrated by Mr X were graded collectively by the Trust as being a class A incident and was managed accordingly.

The Trust sets out a three-stage investigation process for class A incidents. It is as follows:

1. **Level One - Fact Finding Report.** This is completed within 48 hours of the incident occurring. This report includes details of those involved in an incident and contains a brief chronology of the antecedents of the events.

2. **Level Two – Internal Investigation (Structured Investigation Report).** This is a full investigation using structured investigation methodology. This second-stage investigation can be conducted at either a departmental or directorate level. It can also be internally commissioned as an independent internal investigation which can be conducted outside of the department or directorate where the incident occurred.

3. **Level Three – Board Level Inquiry (BLI).** This is a full investigation such as is found at level two of the process but with an additional review from the Trust Board. The purpose of the BLI is to take a broader view of the incident and to ensure full Trust Board scrutiny occurs.

15.2. The DLT Internal Management Report

On the 8 September 2007 an Internal Management Review was commissioned by Executive Director, Ms PD on behalf of the Lambeth Safeguarding Children Board Executive Committee. It was decided that this was an appropriate response because the threshold was not reached for a Serious Case Review. The review was an interagency review with input from the Youth Offending Team, the Youth Justice Board, the South London and Maudsley NHS Foundation Trust and the Metropolitan Police.

This report found identified issues regarding the coordination of provision of service and transparency of supervision of staff within the matrix management setting of the YOT CAMHS staff. This report identified the unsatisfactory situation whereupon Mr X had been identified as requiring follow up by Mr AQ (the YOT CAMHS CPN) on three occasions between the 24 March 2006 and the 30 June 2006 with no resulting actions occurring. This report concluded that there was no causal relationship between the involvement of Trust services and the events of 5 September 2006.

The learning from this review was:

- there was a lack of supervision within the YOT CAMHS;
- there was no multi-agency forum to manage risk for staff to refer clients.

The recommendations were:

- that a risk management panel should be convened within the YOT with permanent CAMHS membership;
- that the YOT CAMHS reviewed clinical supervision arrangements;
- ‘that a YOT referral panel was implemented to discuss al health referrals from YOS officers to agree priority risk and treatment’.

This report was commissioned 12 months after the death of Mrs Tulloch. It is not clear why this delay occurred.

15.3. The Trust Internal Investigation (Structured Investigation Report)

This report was commissioned on the 8 September 2006 and was completed on the 20 December 2006. The Investigation Team comprised the CAHMS Clinical Director and the Clinical Director of Lambeth Adult Mental Health Services. They were assisted by the Trust Investigation Facilitator. The report was commissioned by Child and Adolescent Mental Health Services, Lambeth Adult Mental Health Services and the Assistant Director of Clinical Governance and Patient Safety.

Comment

It is the view of the Independent Investigation Team that the membership of the Internal Investigation should have been comprised with at least one individual who did not actually have direct management responsibilities for the services under examination.

The Terms of reference for the Internal Investigation were to examine:

- communications between teams within the organisation and with external agencies;
- the adequacy of the service provided including care, treatment, risk assessments and medication;
- the engagement with the family and the service's understanding of the family's circumstances;
- record keeping, especially the duplication of files and security of information post incident;
- child protection/safety issues as defined by the Working Together to Safeguard Children 2006 Guidelines – Appendix Two;
- service strengths as well as areas of concern;
- areas of concern that were particularly influential on the outcome of the incident.

The Internal Investigation was also charged with making recommendations on the basis of the findings and to agree an action plan designed to reduce the risk of a similar incident occurring again.

Findings of the Trust Internal Investigation (Structured Investigation Report)

Key Findings – Strengths

- *'Mr X was referred to the embedded CPN in YOT when concerns began to emerge about his mental health;*
- *LEO CAT responded quickly to a referral from Mr X's GP in June 2006. His mother and GP were contacted for fact finding immediately. He was seen for first assessment within one week and was reviewed by the Team Consultant within two weeks and started on medication;*
- *The Investigators wish to commend the thoroughness of the assessment carried out on the 29 June 2006;*
- *Record keeping was of a good standard and both teams involved utilising secure electronic records.'*[162]

Key Findings – Areas of Concern

- *'communication within the Adolescent Team especially in the area of referrals, leading to a GP referral being directed away from the Adolescent Team;*
- *communications between the medical team and the management team in the Adolescent Team;*
- *the investigators were concerned about a lack of escalation of Mr X's case from the YOT CPN. The documentation indicates that his mental state was deteriorating from March 2006 but he was not referred for Consultant review. However the team have not been able to discuss this with the CPN as he was unavailable for interview;*
- *there was no communication with the probation service by LEO CAT to establish Mr X's index offences or forensic history although it was noted that Mr X was treated by LEO CAT for a very short time (six weeks);*
- *neither the Adolescent Team nor LEO CAT was aware of the involvement of the other in Mr X's care;*
- *There was no link between the YOT diary system and the Trust Electronic Patient Journey System.'*[163]

The Internal Investigation found that Mr X had been in contact with the LEO CAT for six weeks and that a rigorous assessment had occurred with the full input of Mr X's mother and GP.

The Independent Investigation Team note that not all of the findings listed above by the Internal Investigation were accurate. These inaccuracies are listed in the comment box below.

Comment
The Independent Investigation Team, in the interests of accuracy, would like to note the following information regarding the above listed findings. ***First.*** *Mr X was not seen that quickly after the GP referral. The GP referral letter was dated the 12 June. The letter was date stamped as being received on the 21 June and Mr X was seen for the first time on the 29 June eight days after the letter was date stamped by the LEO CAT Department.* ***Second.*** *Record keeping could not be described as being of an acceptable standard as several key entries had not been contemporaneously made.* ***Third.*** *Mr X was in contact with the LEO CAT for a period of eleven weeks, not six.* ***Fourth.*** *No contact was made by the Trust to Mr X's GP at all, and no assessment occurred in conjunction with primary care services.*

Internal Investigation Conclusions

The Internal Investigation Team felt that there were organisational problems within the Adolescent Team which extended to the management of the embedded workers in the YOT. It was felt that these problems may have contributed to the fact that Mr X did not receive an earlier introduction to medication.

It was concluded that Mr X was judged appropriately to have been a low risk and that this view was unlikely to have changed even had all of the YOT CAMHS information been known. It was the conclusion of the Internal Investigation Team that Mr X's actions were wholly unpredictable and that no causal factors could be found to link the care and treatment that Mr X received and the incident.

The Independent Investigation Team concur with the findings of the Internal Investigation Team regarding the management of the embedded YOT workers and the fact that this had an impact on the efficiency of the Team.

The Independent Investigation Team does not believe that the Internal Investigation was rigorous enough in identifying where services could be improved using Mr X's actual pathway as a worked example of how a young person was 'processed through the system'. The Internal Investigation Team appeared to focus mainly on the notion of predictability and determined the adequacy of Mr X's care and treatment through this particular lens.

15.4. The Trust Board Level Inquiry

The Board Level Inquiry was held on the 26 July 2007. The Panel consisted of a Non-Executive Director, the Deputy Director of Nursing and a Clinical Director based in Croydon. In attendance to the Panel were the Board level Inquiry coordinator and the Clinical Development Lead.

The Terms of reference for the Board Level Inquiry (BLI) were intended to:

1. '*examine the facts relating to the serious untoward incident with a view to learning lessons and making recommendations;*
2. *examine the available case notes and documentation and to interview staff and relevant others;*
3. *examine any matters that arise highlighting good or poor practice where appropriate;*
4. *scrutinise the local Internal Investigation/Local Management Report and amend the contents of the report accordingly'*.[164]

The Issues Discussed at the Inquiry

- the incident and the events that led up to the incident;
- the Internal Investigation Process ;
- staff support;
- the Service Level Agreement between the YOT and the CAMHS;
- the dynamics within the Lambeth CAMHS;
- the working arrangements between the Lambeth CAMHS and the LEO CAT;

- contact with relatives and carers;
- the appropriate adult role;
- treatment and care;
- risk assessment documentation;
- Child Protection/Chapter Eight Review;
- Electronic Patient Journey System.

Board Level Inquiry Conclusions

The Board Level Inquiry concluded that, despite the seriousness of the incident, there had been no deficiencies in the care and treatment provided to Mr X by the LEO CAT, and that the service sought to work closely with Mr X and his principal carer, his mother.

The Independent Investigation Team view regarding the rigour of the BLI is that several important issues were raised but not fully explored. These issues are set out below.

Service Level Agreement between the YOT and the CAMHS. The BLI identified this as having been an issue. The BLI also noted 'with concern' the lack of specificity within the current service level agreement particularly regarding the involvement from Consultant Psychiatrists and other professionals. However how this actually impacted upon the long term treatment outcome for Mr X was not considered as it appears the primary focus of the Inquiry was to identify whether or not the quality of the service at the YOT could have impacted upon the events that led to Mrs Tulloch's death. The quality of the care and treatment that Mr X received was not really examined.

Team Dynamics within the Lambeth CAMHS. The BLI were 'concerned' to hear about the past difficulties in the relationship between management and clinicians in Lambeth CAMHS. The BLI Panel was pleased to hear that these issues were being addressed. The panel expressed surprise that the YOT was not using assessment tools that should be routinely deployed to identify people requiring further assessment from mental health services. This surprise however did not appear to translate into any examination into how this omission may have impacted upon Mr X and his longer term treatment outcomes.

Treatment and Care. The BLI heard that Mr X's condition appeared to have improved whilst under the care of LEO CAT and that he had been compliant with his medication. With the benefit of hindsight it was obvious that any improvement to Mr X's mental state was perhaps illusory and that he was not compliant with his medication. Whilst the LEO CAT may not have been able to identify these concerns at the time, the BLI should have applied a more rigorous analysis to these circumstances to ascertain what, if any, learning there was to be had.

Risk Assessment and Documentation. The BLI heard that the formal risk assessment documentation had not been completed, but that a *full* assessment had been conducted and formulated into a care plan. The BLI heard that the clinical team had discussed Mr X and had not considered him to be a high risk at the time. The Independent Investigation Team found this conclusion to be unsatisfactory. Mr X had no risk assessment completed in accordance with Trust policy and procedure, the clinical witnesses that were interviewed by the Independent Investigation Team stated that there was no care plan for Mr X or completed CPA because his assessment process *had not* been concluded. The fact remains that after a 13 month period Mr X had an incomplete assessment, no care plan and no CPA documentation. The Independent Investigation Team heard from clinical witnesses that at the time of the events of the 5 September 2006 Mr X was still regarded as being in the red zone because his assessment had not been concluded. There is no recorded evidence that we have seen to support the notion that the clinical team felt Mr X to be a low risk as the conclusions reached at the team meeting were not recorded.

Electronic Patient Journey System. The BLI noted that this system was slow and that on occasions inputted data appeared to 'disappear form it'. However the BLI did not propose any recommendations to try and correct this situation.

The Independent Investigation Team conclude that a more searching BLI should have occurred that not only assessed how the care and treatment Mr X received contributed to the events of the 5 September 2006, but also assessed how the care and treatment package offered to Mr X may have affected his longer term clinical outcomes. The BLI identified correctly many serious issues but failed to confront them in a manner that could lead to service-based learning and change.

15.5. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006[229]. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done[230].

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

Following the incident on the death of Mrs Tulloch on the 5 September 2006 Mr X's mother had some degree of direct communication with individuals from the LEO CAT. However no contact was made with her with regard to the Internal Investigation process. The Trust considered the Memorandum of Understanding between the NHS and the Chief Officers Association and was mindful that contact with the family may compromise the Police Investigation. As a result the family of Mr X did not know what internal investigation processes had been instituted by the Trust and did not see either the Internal Investigation report or the Board Level Inquiry Report.

The family of Mrs Tulloch received no communication from the Trust regarding any aspect of the Internal Investigation process, neither have they seen any Internal Investigation reports.

The Independent Investigation Team concluded that the Trust did not communicate effectively with either the family of Mr X or with the family of Mrs Tulloch in accordance with national best practice guidelines. It is a fact that neither family knew what any of the Internal Investigation processes had yielded and that no counselling or support had been offered to them.

The Trust published a *Being Open* Policy in September 2008. The Trust acknowledges that further clarity is required about how it should engage with the families of the victims of alleged homicide in situations where the Police are involved in concurrent criminal investigations.

The Independent Investigation Team has noted that despite the Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006, there remains a high degree of uncertainty as to how to implement the guidance. It is the view of the Independent Investigation Team that NHS London, as the Strategic Health Authority, should work with the Metropolitan and City Police Forces to ensure that the Memorandum of Understanding is reviewed regarding its implementation in London. There is a recommendation to this effect in Section 19 below.

The Trust understands that this is an area of working that it could have managed better. Since the inception of the Independent Investigation the Trust CEO, accompanied by senior Executive Directors of the Trust Board, met with the family of Mrs Tulloch to express their condolences, to give information and to offer support.

15.6. Staff Support

The Clinical Witnesses to the Independent Investigation stated that they felt that they had been supported well throughout both the Internal and Independent Investigation processes.

15.7. Trust Internal Investigation/ Board Level Inquiry Recommendations

The Trust Structured Investigation Report set out the following recommendations:

1. *An operational policy/service level agreement between Lambeth CAMHS and the Youth offenders team is required to give guidance on the roles and responsibilities of the embedded CPN's and to provide them with clear lines of accountability.*

2. *When partner health professionals (especially GPs) refer young people to Lambeth CAMHS with possible psychotic conditions, they should be offered a psychiatric assessment within two weeks, cases with high risk factors will need to be seen more urgently.*

3. *In the long term Lambeth CAMHS plan to develop further training to ensure a wider range of staff with the requisite skill to complete these assessments.*

4. *Supervision of the YOT CPN worker to be reviewed as part of the Lambeth Adolescent Service Review.*

5. *Teams must have systems in place to ensure that all referrals are reviewed by the multi-disciplinary team, including medical staff. Where there is a need for referrals to be screened and actioned quickly by staff acting alone, the review may take place after initial action.*

6. *It is recommended that risk assessment documentation is completed routinely by LEO CAT staff as part of the assessment process.*

7. *It is recommended that all staff who create new patient records on the Electronic Patient Journey System are advised of the necessity to use 'wildcard' searches when creating new records to identify potential duplicate records.*[165]

The Trust Board Level Inquiry recommended that the Structured Investigation considered the following:

1. *The panel noted that recommendation one referred to 'an operational policy/service level agreement, but wished to point out that they were two separate issues...As such the panel suggest that this is made clear within the recommendation. In addition the panel would suggest the wording be changed from 'CPN' to 'CAMHS staff involved in delivering care within the Youth Offending Team' as it was felt that guidance was required around all roles and not just the community psychiatric nurse.*

2. *The panel were in agreement that the wording in recommendation three should be changed to 'CAMHS training is implemented to ensure that all staff are competent to undertake the tasks required of them'.*

3. *The panel would also suggest that recommendation four be modified to state that 'Lambeth CAMHS set up systems to ensure that trust Supervision guidelines are being adhered to' and that this recommendation should be actioned by the Lambeth CAMHS lead Clinician.*

4. *The panel felt that recommendation five should highlight the need to ensure that all referrals are dealt with appropriately by the person best placed and skilled to take up the referral and conduct the assessment. The panel questioned the appropriateness of every referral having to be reviewed by the multi-disciplinary team as stated within the report. The panel recommend that the investigation team re-consider the wording and devise a recommendation which will allow Lambeth CAMHS to review its mechanisms for reviewing and dealing with referrals.*

5. *The panel agreed that recommendation six should be dropped from the list as work on risk assessment was currently underway. Further that the recommendation was merely requesting that staff undertake a task which is already required of them as part of their role.*

6. *The panel felt that rather than recommending that staff who create patient records are advised to do 'wildcard searches,' that the recommendation request that IT devise a solution which would allow staff, when creating a new file, to be presented with near matches on the creation of every new file in order to reduce the risk of duplicates.*

7. *The panel suggest that recommendation eight be split into two, the first to address the training (which would become recommendation seven) and second to state that the Lambeth Borough Director and CAMHS Director review and revise working arrangements of LEO CAT Team and Lambeth CAMHS (which would then become recommendation eight).*

The panel also made the following supplementary observations and recommendations:

8. *The panel recommend that Service Directors ensure that the Board level Inquiry coordinator receives an updated recommendations table highlighting progress made and action taken, against each recommendation within the structured investigation report, prior to a Board Level Inquiry covering their area/remit. This information should be presented in the action grid template format.*

9. *Lambeth Borough Manager to arrange a debriefing session for all Adolescent Team Staff, as well as arrange support sessions for Adolescent Section Manager with the Trust Chaplain.*

10. *The panel recommend that further work is undertaken on the SLA between CAMHS and the Youth Offending Team/Service. The document should clearly define the service to be delivered and commissioned as well as how this will be monitored. In addition the document should also clearly state the roles, expectations of staff, (including psychiatry inpu0 and the level of competency required.*

11. *The panel recommend that consideration be given to the ways in which the Trust engages and involves family and carers (including victims) as part of the investigation and Board level Inquiry in homicide cases. The panel also recommend that this should be clearly defined as part of the Trust Incident Policy. The panel also recommend that the Serious Untoward Monitoring Committee monitor the progress of this item.*

15.8. Progress against the Trust Internal Investigation Action Plan

The implementation of the action plan arising from the Mr X internal investigation has been conducted using the established processes used for all Trust serious untoward incidents (SUIs) in Lambeth and in other Trust Directorates.

SUI panels are established in each Trust Division and Directorate. The panels meet at a minimum on a quarterly basis to review incidents and the investigation reports within their service area. The findings of investigations and the recommendations arising from these are scrutinised and agreed at the panel. Recommendations are put into an action plan, which is monitored at the Directorate Clinical Governance Committees.

The local Clinical Governance Committees, which are chaired by the relevant Clinical Directors, endorse the recommendations from the SUI Panels and monitor the action plans arising from these recommendations. All recommendations are then added to the Directorate action plans.

The action plans are active documents which identify the context of change, clear goals and implementation plans, for example timescales and the names of staff delegated to lead the changes. The action plans are owned by the Clinical Governance Committees and it is the responsibility of the committees to ensure regular review through to completion.

A recent development (2008) is that Trust wide recommendations are reviewed and discussed at the quarterly Trust Clinical Risk Committee (CRC). The CRC is also responsible for allocating actions and monitoring the implementation of the recommendations. The action plan arising from this is then circulated to the Directorate Clinical Governance Committees for information.

Furthermore actions arising from the investigations and inquiries into SUIs are raised and/or monitored as necessary by other means and in other forums:

- The analysis of SUI data frequently identifies themes which are then subject to wider initiatives, not specific to any single recommendation. Some of these are identified in the annual SUI report to the Trust Board.

- The Trust is subject to external scrutiny and sends reports and responses to organisations such as the National Patient Safety Agency and the Care Quality Commission.

- Increasingly the Trust is asked to provide information to commissioning Primary Care Trusts and the Strategic Health Authority - NHS London. The Trust welcomes the involvement of these organisations as a means of ensuring transparency and enhancing opportunities to improve services and reduce risks to patient safety.

In the case of Mr X the action plan arising from the Internal Investigation and the Board level Inquiry were monitored and reviewed at the Lambeth Clinical Governance Committee. The Lambeth Clinical Governance Committee is chaired by the Lambeth Clinical Director and meets on a monthly basis. The Clinical Director has also taken the lead in overseeing and monitoring the implementation of the action plans. A number of actions were completed, not only as a result of the interventions of the Clinical Governance Committee but were also assimilated into the natural cycle of policy development, for example, the review of the Trust Care programme Approach Policy and the Trust Framework for Clinical Risk Assessment and Management of Harm Policy.

Because of the fact that there were several patient related homicides in Lambeth in a relatively short time a decision was made in April 2007 to amalgamate the action plans arising from all Lambeth homicide investigations. It was agreed that the Mr X action plan was reviewed jointly with another case as a standing item at the Clinical Governance Committee in June 2008. This decision was reached to help ensure that information was shared about the progress of the investigation and where necessary any clinical matters raised by the investigation teams could be dealt with promptly.

Specific progress against the Mr X internal investigation recommendations and action plan implementation

1. **An operational policy/service level agreement between Lambeth CAMHS and the Youth offenders team is required to give guidance on the roles and responsibilities of the embedded CPN's and to provide them with clear lines of accountability.**

Implementation of recommendation 1.

A new service level agreement was signed between the CAMHS and the YOT service on the 10 June 2007. This service level agreement was reviewed on the 12 November 2008. The embedded CAMHS YOT workers are currently comprised of three staff including a Consultant Psychiatrist. This service level agreement provides full guidance with regard to the roles and responsibilities of all embedded CAMHS workers.

2. **When partner health professionals (especially GPs) refer young people to Lambeth CAMHS with possible psychotic conditions, they should be offered a psychiatric assessment within two weeks, cases with high risk factors will need to be seen more urgently.**

Implementation of recommendation 2.

A new system for referral has been developed by one of the CAMHS Consultant Psychiatrists and has been approved by the Trust and in place since 12 November 2008. The Trust reports that this new system is working effectively. At the time of writing this report the Trust planned to send out GP and Partner Agency Information Packs. It is unclear what audit processes have been deployed to assess well this new process is working.

3. **In the long term Lambeth CAMHS plan to develop further training to ensure a wider range of staff with the requisite skill to complete these assessments.**

Implementation of recommendation 3.

The Child and Adolescent Mental Health Service has delivered a series of training sessions for YOT staff to increase their awareness of mental illness. This training programme is ongoing and is being developed to include local Magistrates who have also requested it. A comprehensive training programme and training log has been developed to support an ongoing need in this area.

4. **Supervision of the YOT CPN worker to be reviewed as part of the Lambeth Adolescent Service Review.**

Implementation of recommendation 4.
Clinical Supervision for the embedded YOT CAMHS workers is now undertaken by the newly appointed CAMHS Team Leader for the YOT. The clinical supervision records are held by the CAMHS Team Leader and are available for external scrutiny if required.

5. **Teams must have systems in place to ensure that all referrals are reviewed by the multi-disciplinary team, including medical staff. Where there is a need for referrals to be screened and actioned quickly by staff acting alone, the review may take place after initial action.**

Implementation of recommendation 5.
The evidence for this recommendation needs to be seen in the light of the actions implemented for recommendation 2 (please see above). In addition there is a reworked CAMHS policy on referrals and the new CPA policy (2008).

6. **It is recommended that risk assessment documentation is completed routinely by LEO CAT staff as part of the assessment process.**

Implementation of recommendation 6.
An audit completed on the 12 November 2008 demonstrated that the Lambeth CAMHS had 100% compliance with regard to completion of risk assessment on the Electronic Patient Record. It is not clear whether the Trust has audited the quality of these assessments and checked to ensure that all risk assessments are a dynamic part of care planning.

7. **It is recommended that all staff who create new patient records on the Electronic Patient Journey System are advised of the necessity to use 'wildcard' searches when creating new records to identify potential duplicate records.**

Implementation of recommendation 7.
This is now an Electronic Patient Journey System 'tip'. These tips advise clinicians how to avoid creating a duplicate record. Duplication still can occur and cannot be removed by a 'wholesale fix'. The checks require clinicians to identify duplicates and then rectify the situation. Regular supervision provides an opportunity to remind staff to identify any record keeping anomalies.

The Trust Board Level Inquiry recommended that the Structured Investigation considered the following:

1. **The panel noted that recommendation one referred to 'an operational policy/service level agreement, but wished to point out that they were two separate issues...As such the panel suggest that this is made clear within the recommendation. In addition the panel would suggest the wording be changed from 'CPN' to 'CAMHS staff involved in delivering care within the Youth Offending Team' as it was felt that guidance was required around all roles and not just the community psychiatric nurse.**

Implementation of recommendation1.
A new service level agreement was agreed on the 10 June 2007 together with a revised operational policy. This would appear to be functioning effectively, however there is no independent audit evidence to directly support this notion.

2. **The panel were in agreement that the wording in recommendation three should be changed to 'CAMHS training is implemented to ensure that all staff are competent to undertake the tasks required of them'.**

Implementation of recommendation 2.
The Trust has in use measures for competency. Appraisal and supervision measure these competencies. It is unclear exactly how this works in practice at the current time and has been explored in more detail in the Independent Investigation recommendations in the section below.

3. **The panel would also suggest that recommendation four be modified to state that 'Lambeth CAMHS set up systems to ensure that trust Supervision guidelines are being adhered to' and that this recommendation should be actioned by the Lambeth CAMHS lead Clinician.**

Implementation of recommendation 3.
This recommendation does not seem to appear within the Trust action plan.

4. **The panel felt that recommendation five should highlight the need to ensure that all referrals are dealt with appropriately by the person best placed and skilled to take up the referral and conduct the assessment. The panel questioned the appropriateness of every referral having to be reviewed by the multi-disciplinary team as stated within the report. The panel recommend that the investigation team re-consider the wording and devise a recommendation which will allow Lambeth CAMHS to review its mechanisms for reviewing and dealing with referrals.**

Implementation of recommendation 4.
The Board Level Inquiry did not endorse the idea that all referrals should be reviewed by the multi-disciplinary team. However the clinical teams did introduce a system to do this anyway, (please see recommendations 2 and 5 above from the Internal Investigation).

5. **The panel agreed that recommendation six should be dropped from the list as work on risk assessment was currently underway. Further that the recommendation was merely requesting that staff undertake a task which is already required of them as part of their role.**

6. **The panel felt that rather than recommending that staff who create patient records are advised to do 'wildcard searches,' that the recommendation request that IT devise a solution which would allow staff, when creating a new file, to be presented with neat matches on the creation of every new file in order to reduce the risk of duplicates.**

Implementation of recommendation 6.
The Trust Information Technology Team was consulted about this and did not believe that such a system was possible. There is no automatic way of linking 'near matches', a concept which is not easily defined. The information Technology Team has taken the approach of putting advice tips onto the system. (Please see recommendation 7 above from the Internal Investigation).

7. **The panel suggest that recommendation eight be split into two, the first to address the training (which would become recommendation seven) and second to state that the Lambeth Borough Director and CAMHS Director review and**

revise working arrangements of LEO CAT Team and Lambeth CAMHS (which would then become recommendation eight).

Implementation of recommendation 7.
The Trust developed a YOT CAMHS care pathway across the tiers which also comprised a psychosis referral pathway. A training programme has also been developed to support the implementation of the pathway. At the time of writing this report the Trust has yet to audit the effectiveness of this new pathway and training programme.

The panel also made the following supplementary observations and recommendations:

8. **The panel recommend that Service Directors ensure that the Board level Inquiry coordinator receives an updated recommendations table highlighting progress made and action taken against each recommendation within the structured investigation report, prior to a Board Level Inquiry covering their area/remit. This information should be presented in the action grid template format.**

Implementation of recommendation 8.
The Trust Director of Nursing has been responsible for ensuring that local SUI panels and clinical governance committees receive local serious untoward incident recommendations in action plan grid templates prior to Board Level Inquiries. It is now possible for Service Directors to report on the progress of Internal Investigation action plans directly to the Board Level Inquiry.

9. **The Lambeth Borough Manager to arrange a debriefing session for all Adolescent Team Staff, as well as arrange support sessions for adolescent section manager with the Trust Chaplain.**

Implementation of recommendation 9.
A meeting with key individuals was held after the incident occurred. It has now been confirmed that the adolescent Section Manger met with the Trust Chaplain to ascertain how best support could be given. An incident support leaflet is now available to all staff at the

outset of any Investigation process. In September 2008 a Supporting Staff Policy was ratified and has been rolled out across the Trust.

10. **The panel recommend that further work is undertaken on the SLA between CAMHS and the Youth Offending Team/Service. The document should clearly define the service to be delivered and commissioned as well as how this will be monitored. In addition the document should also clearly state the roles, expectations of staff, (including psychiatry input and the level of competency required.**

Implementation of recommendation 10.
This has been covered by the actions undertaken for the Internal Investigation (please see recommendation 1 above).

11. **The panel recommend that consideration be given to the ways in which the Trust engages and involves family and carers (including victims) as part of the investigation and Board level Inquiry in homicide cases. The panel also recommend that this should be clearly defined as part of the Trust Incident Policy. The panel also recommend that the Serious Untoward Monitoring Committee monitor the progress of this item.**

Implementation of recommendation 11.
A new Being Open Policy was ratified by the Trust Board in September 2008. The Trust had endeavoured to meet with both perpetrator and victim families following serious untoward incidents. However on accession, particularly with homicides, the police have instructed the Trust to desist. The Trust are currently attempting to work through this difficulty via the Trust wide Police Liaison Committee for discussion and to set up protocols.

16. Notable Practice

During the course of the Independent Investigation several areas of notable practice were identified. It is the view of the Independent Investigation Team that other Mental Health Trusts could benefit from the work that has been undertaken by the South London and Maudsley NHS Foundation Trust.

16.1. The Electronic Patient Journey System (PJS)

The Electronic Patient Journey System (EPJS) is a web browser enabled electronic clinical record application. The system was originally developed in 2003 with a commercial partner. The aim was to support the implementation of a newly standardised clinical process (the Patient Journey) across Trust services and to enable the interim enhancement of the Trust's existing patchwork of electronic information systems prior to the arrival of the all encompassing National Care Record Service in 2010.

The vision was for a single electronic application to be used across the Trust by all clinical and administrative staff to improve the co-ordination of care, reduce clinical risk and enable the information needs of the Trust to be met more effectively as well as assist transition to the National Care record Service at some point in the future.

Prior to EPJS, a multiplicity of legacy systems existed across the Trust, together with the use of paper records, no single source of operational clinical information was available.

The implementation of EPJS allowed the rationalisation of over five existing electronic systems and ensured that the primary source for all clinical documentation was now accessible from within one system within all 200 geographical locations across the Trust.

The EPJS contains a range of content including the ability to document not only demographic details, but also assessment, care planning, risk assessment, outcome measures, clinical noting, Mental Health Act administration, National Treatment Agency recording and specialised Child and Adolescent Mental Health Service documentation.

EPJS links directly with the Trust's pharmacy, contracting and bed state systems to provide real time integration with the Trust's business and administrative applications.

EPJS underpins the Trust's reporting framework, IRS, enabling a range of activity and performance measures to be directly linked to the Trust's front-line clinical processes.

In addition, the EPJS is now the source of clinical data for use by the Trust's research partners at the Institute of Psychiatry. In a groundbreaking application annonymised EPJS clinical data can now be interrogated by research staff, enabling significant improvements in the research processes.

EPJS has now been implemented across all Trust services. Some key facts include:

- PJS now contains nine million documents;
- It is used on a daily basis by 2,500 individual staff;
- 110,000 system transactions are undertaken by staff users over a 24 hour period;
- At peak periods 195 separate transactions, on average, are undertaken every minute, and 1,120 logins are, on average, concurrently active at any on time.

EPJS is now widely used in ward rounds and for clinical supervision. A Child and Adolescent Mental Health Services EPJS audit tool is used to measure completion and quality of the clinical record.

Given the delays with the national NHS Information technology programme, EPJS will continue to be developed by the Trust. Exciting developments are planned for EPJS over the next few years, building on the clinical, research and business needs of the Trust. It would appear that no other current application can match the functionality of the EPJS.

16.2. The Integrated Reporting Solution (IRS)

The Trust's Integrated reporting Solution (IRS) is a computer information system that provides Trust staff and Primary Care Trusts with access to a wide range of information on clinical activity, finance and human resources. The information in the IRS is extracted from the EPJS, and the human resource and finance systems. The IRS does not replace these

systems which are needed to support operational processes, it simply extracts data from them and stores it in a format from which it can be reported on easily. These reports provide clinical teams with a wide range of information to manage their clinical activity, finances and staff resources more effectively. IRS plays a vital role in enabling the Trust to undertake extensive data mining of its information and using it to support continuous service improvement. It is one of three major information technology investments made by the Trust, the others being EPJS and the new digital data network.

There are several different ways in which the IRS provides information. These are:

- The Trust's IRS Intranet site, an important information route for Trust staff;
- The Trust's Primary Care Trust Extranet (for PCTS);
- The development of specific reports by staff located in the information department and the Directorates.

Summary reports are available to all staff that are able to log on to the Trust's network. For ease of use, these have been divided into a number of logical groups which can be accessed via a series of menus. Summary reports show the current position at any given time and are updated weekly. There is no restriction on access to these. All summary reports can be printed out if required.

Manager and clinicians at different levels in the organisation are able to monitor activity and access clinical records at the individual, team, directorate and Trust-wide levels through IRS. Summary reports currently include:

- brief risk screens;
- child need and risk screens (compliance with completion);
- service user employment status;
- service user CPA reviews;
- data quality, e.g. GP, NHS Number etc. details;
- patient not seen in three months flags;
- service user physical/nutritional health screens (compliance with completion).

The Independent Investigation Team found that the IRS system was able to evidence the Trust's current compliance with both local policy and national expectation. The reports that

the system is able to yield is impressive. **The system allows for an in-depth interrogation of most facets of the Trust's clinical functioning in a very thorough and immediate manner.**

16.3. Trust Policies, Procedures and Guidelines

It is the view of the Independent Investigation Team that the Trust had a comprehensive suite of policies, procedures and guidance which was current, clear and evidence-based. In recent times the Trust has made a determined effort to ensure that new policies, procedures and guidelines are introduced to the organisation in conjunction with training events and information.

The training session, 'Making CPA More Meaningful' provides a clear and professional approach that sets out both Trust statutory duty and individual healthcare professional responsibility. The programme is service user focused and supports the recovery approach.

16.4. Lambeth Carers Strategy

The Lambeth Carers Strategy is a new approach which was introduced into the Trust in 2008. This strategy was developed in full consultation with local Voluntary Groups, the Local Authority and NHS partners. The strategy is easy to understand and based on thorough research and understanding of the Borough of Lambeth. **The independent Investigation Team commend this strategy to any other NHS organisation that may undertaking the review of an existing strategy, or the development of a new one.**

17. Lessons Learned

The South London and Maudsley NHS Foundation Trust is a large organisation that provides care and treatment to 32,000 service users each year. The Trust has a well-deserved reputation as being both a sound service provider and a proven research-based innovator.

The findings within this report conform to those of most other Independent Investigations conducted in recent years. Issues raised regarding risk assessment, the Care Programme Approach, clinical supervision, the quality of documentation and organisational change are all common factors to found in the Independent Investigation Report literature across the country.

There are several lessons to be learnt from this particular Independent Investigation. First, it is essential that all NHS clinicians adhere to both national guidance and local policy and procedure. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect. The failure to abide by policy and procedure ensures that the safety nets of care are not effectively in place. This puts the service user at risk and places the clinician in a vulnerable and often indefensible position. The Trust had, and continues to have, sound policies and procedures. However it remains a corporate, local management and individual worker responsibility to ensure that they are used at all times and that audit assures the Trust Board that this is in fact occurring.

Second, all NHS Trust processes serve a single purpose, to assess and appropriately treat patients in a timely manner. All service users should have a coherent case management plan. In the case of Mr X the Independent Investigation Team believe the single most significant finding was that he was seen 25 times in total over a period of 13 months, but was not in receipt of either a complete assessment or care and treatment plan. When a person is being seen on such a regular basis it can be easy for clinical teams to assume that somehow ‘everything is under control’, however meetings alone do not assist in treating mental illness. Clinicians need to remain focused and retain a sense of clarity about what they are trying to achieve and when.

Thirdly, national Independent Investigation and Inquiry Reports over the past fifteen years regularly cite the failure to communicate as being a primary causal factor in less than perfect care and treatment plans being instigated. It remains unclear why this failure continues to occur in Trusts across the country. In the case of Mr X failure to communicate appropriately ensured that his GP did not know what was happening to him and that his full history was not known to the LEO CAT. Whilst this will not have had a direct causal outcome on the events of the 5 September 2006, it most probably did ensure that the quality of the care and treatment that Mr X received was compromised.

Fourthly, throughout this investigation it has been apparent that the clinical teams providing mental health services to children and young people suffered from a distinct lack of clinical leadership and coherent management processes. The Independent Investigation Team was able to ascertain from the Trust Internal Investigation and Board Level Inquiry archives that there was a certain amount of unrest within the CAMHS service during the period that Mr X received his care and treatment. The clinical witnesses that were interviewed by the Independent Investigation Team were highly professional and did not use their interviews as an opportunity to be overly critical of either their colleagues or of Trust processes, but it became clear that the individuals that gave evidence to this Investigation often found work-based issues difficult to resolve and remedial actions difficult to implement between 2005 and 2006. All senior Trust personnel within this service must take note of this; poor clinical leadership leads to poor standards of care and treatment. This is quite possibly the key contributor to the fact that Trust policy and procedure was often not adhered to, detected and performance managed.

18. Recommendations

The Independent Investigation Team worked with the Trust to formulate the recommendations arising from this inquiry process. The events of September 2006 occurred over three years ago. It is evident that the Trust has been able to develop many processes and strategies since the dates on which the serious untoward incidents occurred that have either partially or fully addressed many of the issues identified by the Independent Investigation.

The recommendations that the Independent Investigation Team have developed in response to its inquiry are set out below under a brief synopsis of each finding. The progress that the Trust has already made has been taken into account. As a result the recommendations developed by the Independent Investigation Team are intended to support the Trust's strategic direction and take into full consideration the fact that all of the internal investigation actions have already been implemented.

18.1. Recommendations Relating to Key Causal Factor Number One and Contributory Factors Numbers One, Two, Three, Four and Five, and Service issue Number Two

To recap: Key Causal Factor One and Contributory Factors One, Two, Three, Four and Five are set out below. These factors directly relate to all aspects of Mr X's general case management, care and treatment.

- **Key Casual Factor Number One.** The failure to institute an appropriate CPA, assessment and treatment programme for Mr X ensured that his mental illness was only partially treated. His Honour Judge McKinnon found Mr X's mental illness was a direct causal factor in the death of Mrs Tulloch.

- **Key Contributory Factor Number One.** The failure to manage the ongoing assessment, care, risk and treatment needs of Mr X whilst receiving care from the YOT CAMHS meant that his mental illness was untreated. This extended period of time where his condition remained untreated ensured that his mental illness continued to worsen. Mr X's mental state was considered by the Court when sentencing him to have played a major factor in the events of 5 September 2006.

- **Key Contributory Factor Number Two.** Mr X's condition was not adequately assessed, managed and monitored during the period that he received his care and treatment from the LEO CAT. This ensured that his condition remained partially treated.

- **Key Contributory Factor Number Three**. Failure to provide an early diagnosis and treatment package led to Mr X's condition worsening over a period of time. This delay prevented a coherent package of care and treatment being delivered in a timely manner.

- **Key Contributory Factor Number Four.** The failure to adequately monitor Mr X's adherence to his treatment plan contributed to the escalation of his condition in the days preceding the events of the 5 September 2006.

- **Key Contributory Factor Number Five.** The lack of a detailed risk assessment conducted in the full light of Mr X's psychiatric and forensic history prevented a coherent plan of care and treatment from being developed. This ensured that Mr X remained an unknown quantity and that his condition was only partially treated.

- **Key Contributory Factor Number Ten.** Clinical practice within the Trust did not conform to internal policies and procedures.

- **Service Issue Number Two.** No safeguarding children assessments were undertaken for either Mr X or his sister even thought there were significant indicators evident to suggest that the wellbeing of both children could be compromised.

Recommendation Number One. A number of the findings relate to core practice that would be expected and required of community staff, for example, managing and undertaking thorough risk assessments, completing clinical documentation and completing forensic risk histories. The Trust should develop core competencies for community staff, including medical staff, which will include the requirements for staff to work to established policy and procedure and to specify what actions need to be undertaken. The core competencies should be completed with care coordinators as part of the appraisal process. Team managers should

also work towards core competencies which ensure that they know what is expected of them as part of their management role.

Recommendation Number Two. The potential of the Trust IRS system should be maximised to ensure that it delivers a focussed breakdown by team and by care coordinator to be available on the:

- completion of Care Programme Approach reviews;
- completion of risk assessments;
- completion of child in need risk screens;
- frequency that carer assessments are offered.

Recommendation Number Three. A policy review took place during 2008. The policy review included a review of the brief risk screen. The revised Policy on the Framework for Clinical Risk Assessment and the Management of Harm was ratified in September 2008. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

Recommendation Number Four. The Trust's Care Programme Approach Policy was reviewed during 2008 in light of new Department of Health Guidance. A revised Trust Care Programme Approach Policy was published in September 2008. The policy contains details of the Trust response to the needs of carers. The revised policy was publicised to staff through line management channels, and Directorate Clinical Governance Committees. The Trust should conduct a full audit following the publication of the Independent Investigation Report to ensure that the revised policy is operating effectively and that any further revisions are made as necessary.

18.2. Recommendations Relating to Contributory Factor Number Six

To recap: Contributory Factor Six is set out below.

- **Contributory Factor Number Six.** The LEO CAT did not effectively engage with the family of Mr X. This meant that the family remained unclear about his mental

illness, his medication and his future clinical plan of care. This lack of clarity and engagement left both Mr X and his family in a vulnerable situation. The absence of a carer assessment exacerbated this situation.

Recommendation Number Five. The Lambeth Carer Strategy is a new approach which was introduced into the Trust in 2008. This strategy was developed by local Voluntary Groups, the Local Authority and NHS agencies. The strategy is easy to understand and based on thorough research and understanding of the Borough of Lambeth. This strategy has made a robust attempt to engage with ethnic minority groups within the Borough to ensure its relevance and success. The Trust should conduct an audit against the effectiveness of this strategy on the publication of this report and make any necessary revisions. The audit should as a basic minimum:

- determine how many carer assessments have been offered;
- determine how many carer assessments have been accepted;
- determine the ratio of carer assessments taken up by BME carers;
- determine the quality and effectiveness of the resulting care plans.

18.3. Recommendations Relating to Contributory Factor Number Seven

To Recap: contributory Factor Seven is set out below.

- **Key Contributory Factor Number Seven.** The failure to communicate between agencies and services ensured that essential information regarding Mr X's history and risk were not known. This had a direct influence on how he was perceived by the LEO CAT service and how his care pathway was managed.

Recommendation Number Six. Existing policies and procedures regarding the liaison with the YOT/probation should be reviewed in the light of the lessons learned from the Mr X case and revised accordingly.

Recommendation Number Seven. A new system for referral has been developed by one of the CAMHS Consultant Psychiatrists, has been approved by the Trust and has been in place since 12 November 2008. The Trust reports that this new system is working effectively. At

the time of writing this report the Trust planned to send out GP and Partner Agency Information Packs. It is unclear what audit processes have been deployed to assess how well this new process is working. It is recommended that this process is reviewed specifically in the light of communications with GPs and audited to this effect within six months of the publication of this report.

18.4. Recommendations Relating to Contributory Factors Numbers Eight, Nine and Ten

To recap: Contributory Factors Numbers Eight, Nine and Ten are set out below.

- **Key Contributory Factor Number Eight.** The absence of clinical supervision and clinical leadership in the YOT CAMHS ensured that Mr AQ did not have the support and professional guidance that he required. This had an impact on the quality of the care and treatment that Mr X subsequently received.

- **Key Contributory Factor Number Nine.** YOT CAMHS, CAMHS and LEO services all worked more or less in isolation from each other. Clinical leadership was sporadic and services lacked cohesion, vision and a culture of collaborative working. This left individual clinicians vulnerable and isolated and this had to have had a negative effect on the quality of care that service users received.

Recommendation Number Eight. The existing clinical supervision policy should be reviewed and an audit conducted to ascertain its effectiveness. Any necessary revisions should then be made.

Recommendation Number Nine. All Team Leaders/Managers should have key responsibilities regarding clinical and caseload supervision in their job descriptions and should be appraised to ascertain their performance in this area.

Recommendation Number Ten. Trust clinical supervision processes should be directly linked to extant Trust professional regulation processes to ensure that any notifications of poor practice are acted upon with immediate effect.

18.5. Recommendation Relating to Service Issue Number One

To recap: Service Issue Number One is set out below.

- **Service Issue Number One.** The Trust appointed an individual who held a clinical caseload and conducted clinical duties whilst not holding a qualification recognised in the United Kingdom.

Recommendation Number Eleven. The Trust's Human Resources department should have in place a system of identifying transferable qualifications of overseas trained psychologists and ensure that qualifications, skills and experience are commensurate with current United Kingdom requirements.

18.6. Recommendation Relating to Service Issue Number Three

To recap: Service Issue Number Three is set out below.

- **Service Issue Number Three.** Some of Mr X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry in this case has potentially left both the healthcare professionals and the Trust vulnerable.

Recommendation Number Twelve. The Trust should conduct an audit within the Lambeth-based CAMHS to assure the Trust Board that clinical records are being contemporaneously made.

Recommendation Number Thirteen. The Trust Information Technology Team to ensure that clinical records cannot be amended by any member of a clinical team following a serious untoward incident.

18.7. Recommendations Outstanding from the Trust Internal Investigation Processes

Recommendation Number Fourteen. That the Service Level Agreement ratified on the 10 June 2007 between the CAMHS and the Lambeth YOT is audited to ensure it is working properly and is fit for purpose.

Recommendation Number Fifteen. That the system introduced in November 2008 for referral to the Lambeth CAMHS is fully audited to confirm that it is working well and is fit for purpose.

18.8. Recommendations Relating to the Trust's Internal Investigation and Learning Lessons Processes

The following recommendations have been developed jointly between the Independent Investigation team and the Trust.

Recommendation Number Sixteen. The Trust acknowledges the far reaching nature of the independent investigation and the opportunity that this provides for organisation-wide learning. The Trust should arrange learning feedback sessions to enable the findings of this investigation to be raised with a wide audience and to help ensure that lessons are learnt.

Recommendation Number Seventeen. The Trust should develop strategies to ensure that condolence; support and advice are offered to the families / loved ones of the victims of homicide without this endangering the police investigation and judicial processes, and that the Being Open Policy is reviewed as necessary and fully implemented.

Recommendation Number Eighteen. Structured investigations and Board Level Inquiry reports should be thoroughly examined to ensure that the recommendations are SMART. Examination should take place prior to the report's submission to the Serious Untoward Incident (SUI) Panel, at the SUI Panel and at any Board Level Inquiry. The Board Level Inquiry should have an examination of the recommendations as a routine part of the inquiry terms of reference.

Recommendation Number Nineteen. The findings of the independent investigations should be raised and discussed at:

- forthcoming Child Safeguarding conferences;
- in Trust newsletters and Patient Safety Bulletins;
- Police Liaison Committees.

Recommendation Number Twenty. Where there are actions arising from investigations into in-patient suicides and homicides the action plans should automatically be made a standing agenda item at the relevant Clinical Governance Committee(s).

Clinical Governance Committees should, as part of their terms of reference, include an examination and review of any newly ratified Trust policies and procedures. An audit process should be in place to ensure that the policies and procedures are subsequently audited with involvement from clinical staff that are at the point of patient care.

Recommendation Number Twenty-one. The current nursing practice assessment visits should continue on an annual basis. The terms of reference for the visits should be reviewed and amended in light of the findings of the independent investigations.

Recommendation Number Twenty-two. The terms of reference for structured investigations and Board Level Inquiries should include an examination and assessment of compliance with Trust Policy and Procedure which includes:

- Care Programme Approach;
- Risk assessment and management of harm framework;
- Clinical records standards.

18.9. Recommendation for the NHS London Strategic Health Authority

It was apparent during the course of this investigation that the Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006, was not clearly understood by either the Trust or the Police Service. A high-level discussion needs

to take place to avoid further confusion in the future and to ensure that victims' families are communicated with in a timely and helpful manner.

Recommendation Number Twenty-three. NHS London, the London Strategic Health Authority, should engage in discussions with the Metropolitan and City Police Forces to ensure that the Memorandum can be implemented effectively. This will support recommendation 17.

Glossary

Aripiprazole	**Aripiprazole** is an atypical antipsychotic drug licensed for the treatment of schizophrenia
Cardex system	An old fashioned system of keeping a chronological entry log to record a patient's progress. This system traditionally does not include an active plan of care.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner
Case management	The process within the Trust where a patient is allocated to a Care Coordinator that is based within a Community Mental Health Team
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by or in relation to NHS patients treated by or on behalf of those NHS bodies
CORE-OM	A psychological therapy assessment
Decision Tree	A simple tool advocated by the National Patient Safety Agency to support Investigation Team analysis.
Delusion	A delusion is a belief that is clearly false and that indicates an abnormality in the affected person's content of thought
Delusional disorder	Delusional disorder is a psychiatric diagnosis denoting a psychotic mental illness that involves holding one or more non-bizarre delusions
DNA'd	This means literally 'did not attend' and is used in clinical records to denote an appointment where the service user failed to turn up.
Early Onset Team	The aims of this service are to improve clinical and social outcomes through early identification, assessment, treatment and support of people with psychosis using a multi-disciplinary framework. The service is usually provided for people aged between 16 and 35 years of age

Enhanced CPA	This was the highest level of CPA that person could be placed on prior to October 2008. This level requires a robust level of supervision and support
Electronic Patient Journey System (EPJS)	The Trust electronic clinical records system
Fishbone	A simple tool advocated by the National Patient Safety Agency to support Investigation Team analysis.
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition[234]
National Treatment Agency	The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England
Paranoid Schizophrenia	This causes its victims to lose touch with reality. They often begin to hear, see, or feel things that are not really there (hallucinations) or become convinced of things that simply are not true (delusions). In the paranoid form of this disorder, they develop delusions of persecution or personal grandeur[235]
Primary Care Trust	An NHS primary care trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place
PSYRATS	Psychotic Symptom Rating and Assessment Scale
Risk assessment	A formal assessment that systematically identifies the risk an individual poses to both themselves and to others
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment[236]
Section 17 leave	Allows a responsible Medical Officer to grant a detained patient under their care the permission to leave the mental health hospital premises where are currently being detained

Section 117	This applies to all patients who have been detained under a Section 3 of the MHA (83) once they have been discharged from hospital. The section 117 ensures that robust aftercare is provided in a community context
Service User	The term often preferred by users of mental health services instead of the word patient
SHO (Senior House Officer)	A grade of junior doctor between House officer and Specialist registrar in the United kingdom
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant
Standard CPA	Denotes a lower level than enhanced CPA that requires lower levels of input from the Care Coordinator
Thought disordered	This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other
Tiers	Services for child and adolescent psychiatry are set out in tiers. Tier One compromises primary healthcare professional such as GPs youth workers and teachers. Tier Two comprises health care professionals usually working in a community setting and comprises child psychiatrists, community nurse specialists etc. Tier three specifically treats children with specific mental illness and disorders usually in a multi-disciplinary and clinic setting Tier four comprises highly specialist services, often residential for children and young people with sever mental illness.
TTOs	A prescription which is prepared for a patient to take out or away. Literally medication ‘to take out’

Notes

1. HSG (95) 27
2. Investigation Archive Case Details File 1. (Sentencing Hearing transcription, 2nd April 2007) P. 34
3. Investigation Archive Case Details File 1. (Sentencing Hearing transcription, 2nd April 2007) PP. 34-56
4. Investigation Archive Clinical File 1. P.11
5. Investigation Archive Clinical File II A PP28-29
6. Investigation Archive Clinical File II A P. 35
7. Investigation Archive Clinical File II A P. 35
8. Investigation Archive YOT Internal Investigation. P. 23
9. Investigation Archive Clinical File II A P.36
10. Investigation Archive YOT Internal Investigation. P. 23
11. Investigation Archive Clinical File II A. P.28
12. Investigation Archive YOT Internal Investigation. P. 24
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14. Investigation Archive YOT Internal Investigation File. P.52
15. Investigation Archive YOT Internal Investigation. P. 24
16. Investigation Archive Clinical File I. P. 6
17. Investigation Archive YOT Internal Investigation. P. 58
18. Investigation Archive Clinical File I. P. 8
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20. Investigation Archive Clinical File I. P. 7
21. Investigation Archive Clinical File I. P. 9
22. Investigation Archive Clinical File I. P. 10
23. Investigation Archive Clinical File I. P. 14
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26. Investigation Archive Clinical File I. P. 12
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30. Investigation Archive Clinical File I. P. 33
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32. Investigation Archive Clinical File I. P. 34
33. Investigation Archive Clinical File I. P. 34
34. Investigation Archive Clinical File I. P. 34
35. Investigation Archive Clinical File I. P. 35
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37. Investigation Archive Clinical File I. P. 35
38. Investigation Archive Clinical File I. P. 36
39. Investigation Archive Clinical File I. P. 36
40. Investigation Archive Clinical File I. P. 37
41. Investigation Archive Clinical File I. P. 37
42. Investigation Archive Clinical File I. P. 37
43. Investigation Archive Clinical File I. P. 38
44. Investigation Archive Clinical File I. P. 38
45. Investigation Archive Clinical File I. P. 38
46. Investigation Archive Clinical File I. P. 38
47. Investigation Archive Internal Trust Report File I (B). P.208
48. Investigation Archive Internal Trust Report File I. P.98
49. Investigation Archive Internal Trust Report File I. P.98
50. Investigation Archive Internal Trust Report File I. P.66
51. Investigation Archive Internal Trust Report File I. P. 97
52. Investigation Archive Electronic Clinical Record B. PP. 221-222
53. Investigation Archive Clinical File I. P. 38
54. Investigation Archive Electronic Clinical Record B. P. 221
55. Investigation Archive Electronic Clinical Record B. PP. 220-221
56. Investigation Archive Electronic Clinical Record B. P. 220
57. Investigation Archive Electronic Clinical Record B. P. 220
58. Investigation Archive Electronic Clinical Record B. P. 220
59. Investigation Archive Electronic Clinical Record B. P. 219
60. Investigation Archive Electronic Clinical Record B. P. 219
61. Investigation Archive Internal Trust Report File II A. P. 88
62. Investigation Archive Electronic Clinical Record B. P. 218
63. Investigation Archive Electronic Clinical Record B. P. 218

64. Investigation Archive Electronic Clinical Record B. PP. 217-218

65. Investigation Archive Internal Trust Report File I. P.86

66. Investigation Archive Internal Trust Report File I. P. 67

67. Investigation Archive Electronic Clinical Record B. P. 217

68. Investigation Archive Electronic Clinical Record B. P. 216

69. Investigation Archive Electronic Clinical Record B. P. 216

70. Investigation Archive Electronic Clinical Record B. P. 216

71. Investigation Archive Electronic Clinical Record B. PP. 215-216

72. Investigation Archive Electronic Clinical Record B. PP. 214-215

73. Investigation Archive Internal Investigation File II B. P321

74. Investigation Archive Internal Investigation File II B. P324

75. Investigation Archive Internal Investigation File II B. P304

76. Investigation Archive Clinical File I. P. 14

77. Investigation Archive Internal Investigation File II B. P325

78. Investigation Archive YOT Internal Investigation. P. 24

79. Investigation Archive Clinical File I. P. 12

80. Investigation Archive Internal Investigation File II B. P326

81. Investigation Archive Internal Investigation File II B. P326

82. Investigation Archive Internal Investigation File II B. P326

83. Investigation Archive Internal Investigation File II B. P329

84. Investigation Archive Internal Investigation File II B. P331

85. Investigation Archive Internal Investigation File II B. P332

86. Investigation Archive Internal Investigation File II B. P332

87. Investigation Archive Internal Investigation File II B. P333

88. Investigation Archive Clinical File I. P. 38

89. Investigation Archive Internal Trust Report File I. PP.66 and 99

90. Investigation Archive Internal Investigation File II B. P335

91. Clinical Witness Interview Transcriptions.

92. Clinical Witness Interview Transcriptions

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94. Norman R.M.G, Lewis S, Marshall M (2005) Duration of untreated psychosis and its relationship to clinical outcome. *British Journal of Psychiatry*, **187 (suppl. 48).** s19-s23

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Appendix One

Timeline for the Independent Investigation of the Care and Treatment of Mr X

Date	Event	Source
9 October 1988	Mr X was born	
	At the age eight Mr X was arrested for graffiti writing, at the age of ten he was cautioned for separate offences of burglary and theft.	Clinical File II A P.28
23 April 2004	Mr X was convicted for the first time at the age of 15 for possession of class C drugs and given a three month referral order	Clinical File 11 A
16 July 2005	Mr X was convicted of robbery, was given a referral order and had to pay a fine of £20.00	Clinical File II A
10 August 2005	Mr X was convicted of common assault	Clinical File II A P.28
10 August 2005	Mr X was referred to a community nurse embedded within the Lambeth Youth Offending Team. This was due to a breach of Combination Rehabilitation and Punishment Order. Mr X's mother explains that due to his deteriorating mental health he was not attending his community service appointments.	File 1. PP.66 & 110. Internal Trust Report
22September 2005	Mr AQ from the YOT telephoned the mother of Mr X to offer a mental health assessment. Mr AQ was informed that the earliest Mr X could be available was the 28 August 2005.	File 1 Page 110. Internal Trust Report
29 September 2005	Mr AQ from the YOT held a fifteen minute interview with Mr X at the request of his mother. EM presented with a history of isolation and withdrawal, he had punched a wall and generally had behaved	File 1 Pages 66 & 110. Internal Trust

	bizarrely. The impression after the interview was that a mental health assessment was required to highlight any mental health issues.	Report
	On the same day Mr X was referred to the Lambeth Rapid Response Team by his GP for an opinion and an assessment, this was redirected to the Lambeth CAMHS team.	
30 September 2005	Referral considered by CAMHS team	
3 October 2005	The decision was made following a phone call to Mr X's mother that Mr X did not require an appointment with the CAMHS team as he was already being seen by the YOT CPN. Should there have been better communication at this stage? Why was the mental health assessment not carried out as identified as necessary by Mr AQ? It would appear that both the GP referral and the YOT CPN's concerns were not acted upon and medical assessment was made at this stage. Why not?	
6 October 2005	Mr X's mother was contacted by WP to say that as a GP referral had been made, and that Mr X was being seen by the YOT CPN his community order breach outcome would be assessed accordingly.	File 1 Page 106. Internal Trust Report
13 October 2005	Mr X attended an appointment with Mr AQ. Mr X denied any mental health issues, hearing voices etc. Job seekers allowance and college placement was discussed	File 1 Page 106. Internal Trust Report
20 October	Mr AQ prepared a mental health assessment report using information from both Mr X and his mother.	File 1 Page 105.

2005	There was no evidence of thought disorder or paranoia. Mr X did lack spontaneity and concentration. Mr AQ also met with Mr X's mother to reassure her that Mr X would have regular CPN inputs.	Internal Trust Report
3 November 2005	Meeting between Mr AQ and Mr X. Mr X appeared relaxed.	File 1 Page 104. Internal Trust Report
12 December 2005	Mr AQ and Mr X met. Mr X appeared to be in a positive mood.	File 1 Page 103. Internal Trust Report
22 December 2005	Mr AQ and Mr X met. Mr AQ felt that there was marked progress. Mr X appeared to have good eye contact. Mr X was due to start a college course January 2006.	File 1 Page 103. Internal Trust Report
29 December 2005	Mr AQ and Mr X met.	File 1 Page 103. Internal Trust Report
20 January 2006	Mr AQ and Mr X met. Apparently Mr X had missed a previous appointment due to his college course.	File 1 Page 103. Internal Trust Report
2 February 2006	Mr AQ and Mr X met.	File 1 Page 103. Internal Trust Report

10 February 2006	Mr AQ and Mr X met.	File 1 Page 103. Internal Trust Report
24 February 2006	Mr X did not keep his appointment with Mr AQ. The reason for this is not given.	File 1 Page 103. Internal Trust Report
2 March 2006	Mr X did not keep his appointment with Mr AQ. The reason for this is not given.	File 1 Page 103. Internal Trust Report
10 March 2006	Mr AQ and Mr X met. Mr AQ reminded Mr X about both his missed and future appointments.	File 1 Page 103. Internal Trust Report
22 March 2006	Mr X made an unscheduled visit to see Mr AQ. He appeared vague and confused about his appointment pre-planned for the 24 March 2006. Mr X had no insight about having been expelled from his course for hitting the teacher. His speech appeared patchy and unrelated.	File 1 Page 102. Internal Trust Report
24 March 2006	Mr AQ and Mr X met. Mr X was unkempt and fidgety. He was vague but admitted to spending £50 a week on cannabis. Mr AQ noted a marked deterioration in Mr X's mental state. Mr AQ noted that he would arrange for Mr X to have a Consultant Psychiatrist's opinion.	File 1 Page 102. Internal Trust Report
31 March 2006	Mr AQ and Mr X met, but due a fire alarm incident the meeting had to be cancelled. An appointment was arranged for the 7 April 2006	File 1 Page 102. Internal Trust

		Report
March 2006	It appears that Mr AQ did not proceed with his medical referral. The Internal Trust Report states that this is the time that Mr X's mental health began to decline and that it was clear why the YOT team CPN took no action.	File 1 Page 72. Internal Trust Report
5 April 2006	Mr X attended the YOT unscheduled. He had become confused regarding his appointment on the 7 April. He said that he couldn't sleep, but denied hearing voices. He could not concentrate and appeared to be puzzled and bewildered. He denied substance abuse. The plan was for Mr X to try and be in bed by midnight and to spend more time out of doors in order to get some exercise.	File 1 Page 102. Internal Trust Report
7 April 2006	Mr X's mother telephoned Mr AQ and left a message for him to call her back. Mr X's mother said that she could hear him laughing in his room. Mr AQ and Mr X met. Mr X's mother also attended. Concerns were raised about Mr X's deteriorating health. His mother had noticed a weight loss and also the fact that he was only sleeping for 3 hours at night. Mr X admitted to having taken cocaine a week previously. The plan was to monitor for another week before referring to a consultant. Mr X's mother was asked to keep the YOT updated as to the state of Mr X's mental state.	File 1 Page 101. Internal Trust Report
21 April 2006	Mr AQ and Mr X met. Mr AQ described Mr X as distant. Mr X's mother was concerned about where he was getting his money from. Mr AQ notes that Mr X was distant with poor speech and poor recall. Mr AQ decided to conduct a mini mental state assessment in one week's time.	File 1 Pages 100-101. Internal Trust Report

	Why was Mr AQ planning to delay conducting an assessment? He had already raised concerns and had decided to refer for medical advice on the 24 March which it appeared he did not do.	
28 April 2006	Mr AQ and Mr X met. Mr AQ describes Mr X as unkempt with poor eye contact and a patchy train of thought.	File 1 Page 100. Internal Trust Report
5 May 2006	Mr X turned up to met with Mr AQ but it was the wrong day.	File 1 Page 100. Internal Trust Report
12 May 2006	Mr X arrived for his appointment with Mr AQ. Mr X was informed that he was not there but that he could see the duty worker. Mr X left after being assured that Mr AQ would be told of his visit. It is not clear why Mr AQ was not available to meet with Mr X. Mr X had been deteriorating. It would have been a wise precaution to have ensured a person was prepared for Mr X's appointment and there to see him.	File 1 Page 99. Internal Trust Report
2 June 2006	Mr X missed his appointment with Mr AQ. His case worker was informed.	File 1 Page 99. Internal Trust Report
9 June 2006	Mr AQ and Mr X met. Attempts were being made to find Mr X another college course.	File 1 Page 99. Internal Trust Report

12 June 2006	Mr X and his mother saw their GP to ask for help. Mr X was smoking skunk on a daily basis and had been doing so for several years. Mr X was reported as hearing sounds, not voices, and also having visual hallucinations.	File 1 Page 99. Internal Trust Report
	Mr X was referred to the LEO team by his GP.	File 1 Page 66. Internal Trust Report
22 June 2006	The LEO CAT called Mr X's GP. They could not get through and could not leave a message	File 1 Page 98. Internal Trust Report
23 June 2006	The LEO CAT called Mr X's GP. They could not get through and could not leave a message.	
26 June 2006	A LEO CAT meeting was held where Mr X's case was discussed. It was thought that he may be displaying early signs of psychosis, perhaps as a result of smoking cannabis.	File 1 Page 66. Internal Trust Report
27 June 2006	Phone call made to Mr X's mother by LEO CAT. Mr X's mother told the team that she had been worried about Mr X for a year, which was when he had first started hearing voices. A meeting time was arranged for the 29 June 2006.	File 1 Page 97. Internal Trust Report
29 June 2006	Mr X was assessed by the Lambeth Early Onset Crisis Assessment Team. The clinical records document the impression that Mr X had been suffering prodromal symptoms for one year and that he had a four month history of positive psychotic symptoms.	File 1. PP.62 & 66 Internal Trust Report
	NB: the LEO CAT were told about Mr X's involvement with the YOT..	

30 June 2006	Mr X was seen by Mr AQ who wanted to arrange for him to be assessed by a CAMHS psychiatrist. The internal report suggests that there is no evidence that this was ever offered to Mr X. Mr AQ felt that Mr X had the residual symptoms of some schizoform disorder. Mr AQ was planning to refer Mr X to Dr CP	File 1 Pages 66 & 95. Internal Trust Report
3 July 2006	A LEO CAT team meeting heard that Mr X was hearing voices from a radio and thought he could read minds.	File 1 Page 95. Internal Trust Report
5 July 2006	Mr X, accompanied by his mother, was seen by the LEO CAT psychiatrist, Dr EI. This was to discuss his medication and to arrange for blood monitoring tests. Mr X was prescribed Aripiprazole tablets 5mg O/D by Dr I for 7 days. The plan was for this medication to be increased to 10 mg if tolerated.	File 1 Pages 66 & 94 Internal Trust Report
7 July 2006	Ms JN contacted Mr X's mother to see how he was tolerating the medication. Mr X's mother said that he was more clam. She was reminded to call if she had difficulties and that Mr X's next appointment was on the 10 July at 12 noon.	File 1 Page 93. Internal Trust Report
12 July 2006	Blood tests were taken to screen for organic illness	File 1 Page 92. Internal Trust Report
18 July 2006	Ms JN telephoned Mr X's mother to see how he was doing and to offer another appointment. An appointment was set for 19 July at noon.	File 1 Page 92. Internal Trust Report

19 July 2006	Mr X and his mother attended the appointment with Ms JN. Mr X did not appear to want to be present and his mother answered most of the questions. Mr X appeared distracted and appeared to be having hallucinations. Mr X stated that she had been giving Mr X his medication every day.	File 1 Page 91. Internal Trust Report
25 July 2006	Reviewed by Ms JN and RK. Mr X attended with his mother. His medication was reviewed. He appeared to be more relaxed and said that he had been cutting back on his cannabis intake. His medication was increased to Aripiprazole 10 mg. This as dispensed for one week. His next appointment was set for the 1 August 2006.	File 1 Page 92. Internal Trust Report
27 July 2006	Contingency plan was drawn up so that the LEO services could do a home visit if needed or if Mr X was to disengage from services.	File 1 Page 88. Internal Trust Report
1 August 2006	Mr X did not attend his booked appointment	File 1 Page 87. Internal Trust Report
7 August 2006	Ms JN telephoned Mr X's mother to book an appointment for the 8 August 2006 (not certain if this appointment was kept)	File 1 Page 86. Internal Trust Report
10 August 2006	Mr X invited to healthy living group	File 1 Page 86. Internal Trust Report
16 August	The YOT community nurse discussed Mr X's case with the CAMHS Consultant Psychiatrist. Mr X had	File 1. P.67.

2006	missed several sessions with the YOT team in early August. The psychiatrist suggested that further work was required in order to formulate the case. No further plans were indicated in the notes. The contingency plan was not put into action. No home visit was made.	Internal Trust Report
21 August 2006	Mr X did not attend his appointment with Ms JN. Ms JN panned to contact Mr X the next day.	File 1 Page 86. Internal Trust Report
22 August 2006	Telephone call made to Mr X's mother. A voicemail was left stating that Ms JN would call again the next day.	File 1 Page 86. Internal Trust Report
24 August 2006	Ms JN called 'numerous times' throughout the day to no response. A message was left on the answer machine for Mr X or his mother to contact the LEO team.	File 1 Page 86. Internal Trust Report
Approx 24 August 2006	Mr X says that he stopped taking his medication in a statement given to the police.	File 1. P.23
31 August 2006	Mr X was reviewed and was accompanied to the meeting by his mother. She did attend the meeting with him. He said that he had been attending his course and that he was not as confused as he had previously been. Mr X had the effects of cannabis discussed with him. Mr X was seen by Ms JN. Mr X and his mother said he was taking his medication, but that he had missed one tablet that week. Mr X was due to have his medication reviewed by the consultant on the 6 September 2006.	File 1 Page 85. Internal Trust Report
5 September 2006	Mr X stabbed Ms CT to death whilst she was walking on her way to work at around nine o'clock in the morning	File 1. P.36
6 September	Mr X attended the front desk of the Kennington Police Station with his father and uncle, and a solicitor.	File 1. P.41

2006	Mr X confessed to the killing of Ms CT. Blood test taken at Police Station revealed Mr X had taken cannabis some time beforehand. Mr X was due to be reviewed by the mental health team on this day.	
20 December 2006	Trust internal Investigation report was completed in its final draft.	File 1. P.61.Trust Internal report
2 April 2007	Mr X was sentenced for the offence of manslaughter, otherwise a clear case of murder, diminished by the severity of Mr X's mental state at the time of the offence. The sentence of the court was that a hospital order be made under section 37 of the Act with a restriction order under section 41 of the Act without limit of time.	File 1. P. 59
1 October 2007	This case was reviewed by the London Borough of Lambeth Safeguarding Board who agreed that this case did not require a serious case review, but that the partnership should review the case in order to learn any lessons.	File 1 Page 67. Internal Trust Report