Independent Investigation into the Care and Treatment Provided to Mr. D by the Barnet, Enfield and Haringey Mental Health Trust and the Haringey Teaching Primary Care Trust

A report for NHS London

March 2009

NHS London

Contents

Investigation Team preface..... 3
Condolences to the family of Mr. EM..... 5
Acknowledgement to the Survivors..... 6
Executive Summary..... 7
Incident description and consequences 16
Background and context to the Investigation..... 18
Terms of Reference..... 20
The Investigation Team..... 23
Investigation methodology..... 24
Information and evidence gathered..... 31
Profile of the Mental HealthTrust services..... 33
Chronology of events..... 38
Timeline and investigation of the critical issues..... 66
Further exploration and root causes..... 68
Findings..... 127
Barnet, Enfield and Haringey MHT and Haringey TPCT response to the incident and the internal investigation..... 135
Notable practice..... 146
Lessons learnt..... 147
Recommendations..... 149
Glossary..... 151
Notes..... 153
Appendix One - Timeline..... 161
Appendix Two - Internal Report Recommendations…….. 173

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. D 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 Mr. EM and the stabbing of five other members of the public on the 23 December 2004. Mr. D was subsequently arrested and convicted as the perpetrator of these offences.

Mr. D received care and treatment for his mental health condition from the Barnet, Enfield and Haringey Mental Health Trust and a General Practice within the Haringey Teaching Primary Care Trust. It is the care and treatment that Mr. D received from these organisations that is the subject of this investigation.

In order to investigate in a rigorous and robust manner it has been necessary to revisit the circumstances leading up to the events of the 23 December 2004. We would like to acknowledge the pain and distress of victims and their families in having to relive and re-examine their experiences. We would also like to acknowledge the pain and distress of Mr. D's family who have assisted this investigation in a thorough and consistent manner. The Investigation Team were aware that several years have passed and apologise for any further distress caused by the setting up of this Investigation.

Despite an inquest and subsequent criminal proceedings, the process of an in-depth Investigation is often the only way in which the families of both perpetrator and victim can find out the truth concerning a homicide. 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 have all done 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 Trusts' senior management who have granted access to facilities and individuals throughout this process.

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 Family of Mr. EM

The Investigation Team would like to extend their condolences to the wife and children, family and friends of Mr. EM who died. We would like to acknowledge the contribution that they made to this Investigation. It is our sincere wish that this report provides no further occasion for additional pain and distress.

We hope that this report has addressed the outstanding issues and questions that the family has raised with the Team and have waited four years to have investigated.

3. Acknowledgement to the Survivors

Five members of the general public were critically injured by Mr. D on the 23 December 2004. This was a life changing event for all of them. Not all of the survivors have wished to participate in the Investigation for understandable reasons. The Investigation Team recognise and respect the decision of those who did not wish to take part.

Communication around previous traumatic events is always difficult and emotionally provocative. Therefore we acknowledge with gratitude the determination and personal effort of those survivors who have supported the Investigation throughout. The contribution that they made was invaluable.

We hope that this report has addressed the outstanding issues and questions that the survivors raised with the Team and have waited four years to have investigated.

4. Executive Summary

Introduction

The Independent Investigation into the care and treatment of Mr. D was commissioned by NHS London Strategic Health Authority pursuant to *HSG (94)27*. This investigation was asked to examine a set of circumstances associated with the death of Mr. EM and the stabbing of five other members of the public on the 23 December 2004. Mr. D was subsequently arrested and convicted as the perpetrator of these offences.

Mr. D received care and treatment for his mental health condition from the Barnet, Enfield and Haringey Mental Health Trust and a General Practice within the Haringey Primary Care Trust. It is the care and treatment that Mr. D received from these organisations that is the subject of this investigation.

Incident Description and Consequences

On the 23 December 2004 Mr. D took his father's car and drove around Haringey. Within the space of 90 minutes he had fatally stabbed one person and seriously wounded five other members of the general public. When arrested he said that *"a bird told me to kill …. people. I have heard these voices for two years and they have got worse recently".*

On the 24 March 2006 Mr. D was sentenced and detained at Broadmoor Hospital on Section 41 of the Mental Health Act (1983) without limit of time. At the time of writing this report Mr. D remains in Broadmoor Hospital.

Terms of Reference

An independent investigation should demonstrate and promote good practice by being open and honest when addressing any shortfall in service provision to service users and carers. The national introduction of a Clinical Governance Framework (1999) of setting standards, sharing information and developing partnerships should already have encouraged a culture of openness. Services for patients and improved quality of care should flourish thus moving away from the 'blame culture' historically

prevalent in many NHS Trusts. The main outcome must be to increase public confidence and to promote professional competence.

Therefore such an investigation should establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar happening. To enable this task to be carried out, the Investigation Panel used the following Terms of Reference

1. To examine the mental healthcare received by Mr. D in the context of his life history, taking into account any issue raised by cultural diversity which may appear to be relevant, in order to obtain a better understanding. In particular:

(i) The extent to which Mr. D's care was provided

a) In accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23, and local operational policies.

b) The extent to which his prescribed care plans were:

- effectively drawn up
- delivered and
- complied with by Mr. D

(ii) The appropriateness and quality of any assessment, care, treatment plan and supervision having regard to his past history to include:

- Medication
- Staff responses to service user and carer concerns
- Involvement of Mr. D and his family in the appropriateness of his care plan
- Range of treatments and interventions considered
- Social care interventions
- Reliability of case notes and other documentation

(iii) His assessed risk of potential harm to himself and others compiling a comprehensive chronology of events leading to the homicide and stabbings of December 2004. This to include specifically:

- risk of Mr. D harming himself and others
- training of clinical staff in risk assessment
- systems and procedures in place at the time of Mr. D's contact with services

2. To 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.

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

4. To review the serious untoward incident policy and resultant internal investigation into the care of Mr. D already undertaken by Haringey Teaching Primary Care Trust, any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal investigation and to assess the effectiveness of their implementation.

5. To consider such other matters as the public interest may require.

6. To consider any other matters arising during the course of the investigation, which are relevant to the occurrence of the incident or might prevent a reoccurrence

7. To prepare an independent report by the Health and Social Care Advisory Service (HASCAS), for the London Strategic Health Authority (known as

NHS London), Haringey Teaching Primary Care Trust, and any other relevant bodies. This report will include recommendations which link with the recommendations proposed by VERITA in their investigations

8. To use root cause analysis as appropriate, for the purpose of enabling lessons to be learnt rather than the apportionment of blame or liability

9. To ensure that any action plan takes full account of the progress that both NHS Trusts have made since the completion of the internal investigation

Findings and Conclusions

The Investigation Team recognised that between 2000 and 2004 many national initiatives were in an embryonic stage of local implementation. The Investigation Team also recognised that the secondary care services in question were subject to both reconfiguration and reorganisation, factors that can destabilise clinical delivery. That being said the consistent critical factors that have been identified by this investigation are:

1. the clinical management of Mr. D: diagnosis, medication and treatment;
2. risk assessment and care planning;
3. care programme approach (CPA);
4. community Mental Health Team involvement;
5. secondary and primary care interface;
6. quality of clinical documentation and communication;
7. service user engagement and involvement;
8. carer assessment and support;
9. cultural diversity and language;
10. clinical leadership and supervision;
11. organisation and management of mental health services.

Key Causal Factor Number 1. Failure to use the Mental Health Act effectively.

On two occasions Mr. D was admitted under a section of the Mental Health Act. It is the view of the Investigation Team that the Mental Health Act could have been used to better effect that it in fact was.

Key Causal Factor Number 2. Failure to engage with Mr. D and his family.
The failure to engage with Mr. D is a hallmark of the care and treatment that he received. The Investigation Team considers this to be a significant factor that runs throughout all of the other critical issues and causal factors identified and analysed. During Mr. D's contact with mental health services in Haringey no concerted effort was made to develop an enduring therapeutic relationship with either him or his family.

Key Causal Factor Number 3. Failure to manage the ongoing care, risk and treatment needs of Mr. D. This had a direct bearing on the breakdown of the mental health of Mr. D in 2004 and the delay in marshalling responsive services that would have been able to help and support him.

Key Causal Factor Number 4. Lack of adequate risk assessment that formed part of a dynamic care and management plan process. Mr. D's third admission was the opportunity for the inpatient clinical team to have recognised a distinct pattern of risk behaviours. Mr. D's risk assessments were not always coherent or complete.

Key Causal Factor Number 5. Failure to provide a coherent CPA process which was able to provide ongoing assessment, monitoring and treatment of Mr. D in the community. It is the view of the Independent Investigation Team that the CPA process employed by the Barnet, Enfield and Haringey Trust was flawed in many ways during the period that Mr. D received his care and treatment from the Trust

Key Causal Factor Number 6. Failure to provide adequate Care Coordination in the Community leading to a lack of assessment, monitoring and case management. This had a direct bearing on the breakdown of the mental health of Mr. D in 2004 and the delay in marshalling responsive services that would have been able to help and support him.

Key Causal Factor Number 7. Poor communication and clinical record keeping practice contributed to Mr. D "slipping through the safety net of care". Throughout the period of time that Mr. D received his care and treatment from Barnet, Enfield and Haringey Mental Health Trust the Investigation Team noted that there were distinct issues with regard to communication and clinical documentation.

Key Causal Factor Number 8. Poor review and performance management of repeat prescription protocols and care pathways within Haringey Teaching Primary Care Trust. There was an absence within the health system of clear and workable protocols and care pathways to ensure that service users with enduring mental health problems were managed appropriately once discharged back into primary care contexts. The situation as it stood between 2000 and 2004 has to be regarded as the responsibility of both commissioners and service providers.

Key Causal Factor Number 9. The absence of a carer assessment contributed to the isolation of Mr. D's family. This meant that when the family entered a crisis situation with Mr. D they had no established relationship with a healthcare worker who could support them. Mr. D's parents did not have a carer assessment conducted at any stage during Mr. D's care and treatment with Barnet Enfield and Haringey Mental Health Trust. Mr. D's mother came onto the ward at St. Ann's Hospital on several occasions during Mr. D's admissions. However no relationship appears to have been built up with her, possibly exacerbated by communication and language difficulties.

Key Causal Factor Number 10. A culturally insensitive service was offered to Mr. D and his family between 2000 and 2004. This played a direct role in the breakdown of Mr. D's health and compounded the failure to provide timely interventions when both he and his family required it.

Key Causal Factor Number 11. Poor supervision and performance management practices ensured poor standards of care to go undetected. This was exacerbated by dislocated service design that did not encourage seamless working between internal departments and external agencies.

Barnet, Enfield and Haringey Mental Health Trust had a range of adequate policies and procedures in place between 2000 and 2004. However the organisation suffered from a lack of clinical leadership and sound performance management procedures. Services appear to have been provided and monitored in silos allowing variations in standards of good practice to go undetected and unchallenged. This was probably exacerbated by organisational change and reconfiguration.

Notable Practice

The Investigation Team would like to acknowledge all of the hard work that has gone into creating a comprehensive series of action plans following the internal investigation report.

The JSIG has achieved a whole systems process of both implementing and monitoring significant service transformation. It is encouraging to see how such major change can be brought about when sound project management and partnership working are brought together.

Barnet, Enfield and Haringey have achieved significant progress with regard to addressing BME issues in their locality. Both Trusts have demonstrated how organisations can learn from serious untoward incidents and attempt to meet the challenges in a proactive manner.

The Investigation Team understands that both Trusts acknowledge more work needs to be done and that there is no room for complacency. However the work achieved by both Trusts can be seen as an exemplar process that other London Trusts may be able to learn and benefit from.

Recommendations

1. **That the JSIG forms a time-limited operational implementation group to ensure that all outstanding actions on the action plan are brought to a conclusion within a six month period of the publication of this report.**

2. **That Barnet, Enfield and Haringey Mental Health Trust ensures that the learning which has taken place jointly with the Haringey Teaching**

Primary Care Trust as a result of both the Internal and Independent Investigations into the care and treatment of Mr. D is shared throughout the whole organisation and with other health and social care partners.

3. **That the CPA Policy is reviewed against the most recent Clinical Audit and Effectiveness Report regarding the overall quality of CPA documentation, and that the Barnet, Enfield and Haringey Mental Health Trust ensures that individual practitioners are monitored via supervision and personal development plans to assure the Trust Board that they are practicing to an effective standard.**

4. **That Barnet, Enfield and Haringey Mental Health Trust audit the quality of service delivery of the newly reconfigured CMHTs in the light of the findings of the Independent Investigation Report.**

5. **That Haringey Teaching Primary Care Trust and Barnet, Enfield and Haringey Mental Health Trust review their Serious Untoward Incident Policy in the light of the findings of this report to ensure that the spirit of the National Patient Safety Agency guidance *Being Open* is fully met.**

6. **That Barnet, Enfield and Haringey Mental Health Trust review its clinical supervision strategy and makes explicit how it forms part of the professional regulatory framework within the organisation.**

7. **That Barnet, Enfield and Haringey Mental Health Trust take the findings of fact from this report to further investigate the quality of care and treatment given to Mr. D by the Care Coordinator. This should include consideration of any support that the said Care Coordinator should have received in order to ascertain whether there were any systems failures that prevented the individual from practising in accordance with both national and local policy and procedure. The Trust should also review all of the Care Coordinator's previous caseload to assure the Trust Board that there are no other cases that require urgent remedial action to be taken. The Trust will be expected to act in accordance with its internal**

policies and procedures in determining any further actions that need to be taken.

8. **In light of the fact that the Care Coordinator has not contested the evidence that suggests amendments were made to Mr. D's clinical records, that Barnet, Enfield and Haringey Mental Health Trust act in accordance with both national and local policy and procedure with regards to this matter.**

5. Incident Description and Consequences

On the morning of the 23 December 2004 Mr. D took the keys of the family car and drove around Haringey.

At around 7.45 am Mr. D attacked Mr. S from behind. Mr. S received four stab wounds, two to the back, one to the abdomen and one to the right arm. Mr. S called out for help which distracted Mr. D and Mr. S was able to break away[2].

Following the attack on Mr. S, Mr. D got back into his car and drove to a hardware store in Tottenham where he purchased a boning knife. At around 8.40 am Mr. D attacked Mr. L who was walking to work. Mr. L received stab wounds to the front left lower lumber region. Mr. D walked away after attacking Mr. L[3].

The third attack took place at 8.45 am. Ms. C was attacked whilst getting off her bicycle after having been apprehended by Mr. D. Mr. D stabbed Ms. C in the upper right chest. She was found collapsed on the ground[4].

At 8.55 am Mr. D approached Mr. R.D from behind. Mr. D tapped him on the shoulder and stabbed Mr. R.D in the abdomen when he turned around[5].

The fifth attack took place outside a petrol station. Mr. D stabbed Mr. A in the lower left back before running away[6].

The sixth and final attack took place at 9.15 am. Mr. D stabbed Mr. EM a total of seven times. Mr. EM collapsed and died of his injuries[7].

Mr. D was arrested outside his family home in the family car. On being arrested and cautioned Mr. D was taken to Tottenham Police Station.

On the 27 December 2004 Mr. D was charged with one count of murder, contrary to common law, five counts of attempted murder, contrary to Section 1(1) of the Criminal Attempts Act 1981 and one charge of assault, occasioning actual bodily

harm contrary to Section 47 of the Offences Against the Person Act 1861 (the assault was against a Police Officer). He appeared in court and was remanded to HMP Belmarsh to await his trial. Mr. D was detained in the healthcare centre before being transferred to Broadmoor Hospital on the 29th March 2005. Mr. D was reported as telling a Prison Officer *"the world was created for his happiness and when he dies the world will end".* God had told him to *"go and kill the bad people"*[8].

2nd March 2006 Mr. D was convicted of manslaughter due to diminished responsibility, five counts of attempted murder and one count of actual bodily harm.

24th March 2006 Mr. D was committed to Broadmoor Hospital on Section 41MHA (1983) without limit of time. The Judge when passing sentence said

> *"I am not in a position to apportion blame, but it is the greatest sadness that you stopped taking your medication and the warnings were not quickly heeded"*[9]

At the time of writing this report Mr. D remains in Broadmoor Hospital.

6. Background and Context to the 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, 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"*.

Since 2005 the criteria for conducting such an investigation include:

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 minimise the possibility of a reoccurrence of similar events, and to make

recommendations for the delivery of Mental 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 we have tried throughout this report to base our 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. It is important that this case has been fully investigated by an impartial and independent Investigation Team.

7. Terms of Reference

An independent investigation should demonstrate and promote good practice by being open and honest when addressing any shortfall in service provision to service users and carers. The national introduction of a Clinical Governance Framework (1999) of setting standards, sharing information and developing partnerships should already have encouraged a culture of openness. Services for patients and improved quality of care should flourish thus moving away from the 'blame culture' historically prevalent in many NHS Trusts. The main outcome must be to increase public confidence and to promote professional competence.

Therefore such an investigation should establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar event from happening. To enable this task to be carried out, the Investigation Team used the following Terms of Reference

10. To examine the mental healthcare received by Mr. D in the context of his life history, taking into account any issue raised by cultural diversity which may appear to be relevant, in order to obtain a better understanding. In particular:

(iv) The extent to which Mr. D's care was provided

a) In accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23, and local operational policies.

b) The extent to which his prescribed care plans were:

- effectively drawn up;
- delivered;

and

- complied with by Mr. D.

(v) The appropriateness and quality of any assessment, care, treatment plan and supervision having regard to Mr. D's past history to include:

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

(vi) Mr. D's assessed risk of potential harm to himself and others compiling a comprehensive chronology of events leading to the homicide and stabbings of December 2004. This to include specifically:

- the risk of Mr. D harming himself and others;
- the training of clinical staff in risk assessment;
- the systems and procedures in place at the time of Mr. D's contact with services.

11. To 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.

12. To review and assess compliance with local policies, national guidance and statutory obligations including the appropriateness of the use of the Mental Health Act (1983) regarding admission, discharge and the granting of leave and compliance with human rights legislation.

13. To review the serious untoward incident policy and resultant internal investigation into the care of Mr. D already undertaken by Haringey Teaching Primary Care Trust. To also review any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal investigation and assess the effectiveness of their implementation.

14. To consider such other matters as the public interest may require.

15. To consider any other matters arising during the course of the Investigation, that are relevant to the occurrence of the incident or might prevent a reoccurrence.

16. To prepare an independent report by HASCAS, for the London Strategic Health Authority (known as NHS London), Haringey Teaching Primary Care Trust, and any other relevant bodies. This report will include recommendations which link with the recommendations proposed by VERITA* in their investigations.

17. To use root cause analysis as appropriate, for the purpose of enabling lessons to be learnt rather than the apportionment of blame or liability.

18. To ensure that any recommendations take full account of the progress that both NHS Trusts have made since the completion of the internal investigation.

***** VERITA is an organisation that was commissioned by NHS London to conduct two other Independent Investigations into the care and treatment of individuals provided by BEHMHT. These Investigations were conducted at the same time as the HASCAS Investigation. It was agreed at the outset that the recommendations from all three Investigations would be considered jointly.

8. The Investigation Team

This Investigation was undertaken by the following team of professionals who are independent of the healthcare services provided by the Barnet, Enfield and Haringey Mental Health Trust and the Haringey Teaching Primary Care Trust.

Commission Lead and Project Manager	
Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service
Investigation Team Chair	
Jane Mackay	Independent Management Consultant specialising in homicide investigations and serious untoward incidents
Investigation Team Members	
Dr. Jed Boardman	Consultant Psychiatrist in Social Psychiatry, South London and Maudsley NHS Trust and Health Services and Population Research Department, Institute of Psychiatry
Tina Coldham	Service User Consultant, Health and Social Care Advisory Service
Helen Waldock	Director of Nursing, Health and Social Care Advisory Service
Dr. Tim Saunders	General Medical Practitioner
Independent Advice to Panel	
Ashley Irons	Solicitor, Capsticks Royal College of Nursing, Legal Support Support also given by the Mental Health Lead, Royal College of Nursing

9. Investigation Methodology

NHS London commissioned this Independent Investigation under the Terms of Reference set out in section 6 of this report. This Investigation was led by a project manager from the Health and Social Care Advisory Service (HASCAS). A meeting to discuss the procedure to be followed was held between NHS London and HASCAS on 20 November 2007.

On the 11 December all members of the victim's family were written to. All survivors were also written to on this date. The letters sent detailed the forthcoming role of HASCAS in leading the Independent Investigation into the care and treatment of Mr. D. All members of the victim's family and all survivors were invited to meet with HASCAS and to become involved in the development of the Investigation Terms of Reference. A schedule of meetings is set out below in Table One.

Mr. D and the family of Mr. D were written to with the support of an interpretation service. Both Mr. D and his family were invited to meet with HASCAS to discuss the forthcoming investigation and to become involved in the development of the Terms of Reference. Please see Table One.

In January 2008 HASCAS received written consent from Mr. D permitting access to his clinical records. A careful analysis was made of these records together with the Internal Investigation Report to determine the required skills and experience of the Independent Investigation Team. The Team was then recruited.

The Chief Executives of both the Mental Health Trust and the Teaching Primary Care Trust met with the Project Lead and the Investigation Team Chair on the 22 January 2008 to discuss how the process would be undertaken. At this stage a preliminary identification was made regarding further documentary evidence that the Investigation Team would require.

Table One

Victim's Family, Survivor and Perpetrator Family Witnesses

Date	Witness	Interviewers
17 January 2008	Ms. C	Androulla Johnstone
22 February 2008	Mr. L	Androulla Johnstone & Jane Mackay
25 February 2008	Mr. & Mrs. D	Androulla Johnstone & Jane Mackay with an interpreter in attendance
3 March 2008	Mrs. S, Mrs. P and Ms. R	Androulla Johnstone Jed Boardman Tina Coldham Jane Mackay Helen Waldock Tim Saunders With a stenographer in attendance
14 March 2008	Mrs. M, Ms. M and Mr. M	Androulla Johnstone, with a note taker in attendance
3 April 2008	Mr. D	Androulla Johnstone & Jed Boardman with an interpreter in attendance

All documentation received by the Investigation Team was indexed and paginated. A timeline of critical events was compiled and is contained within this report.

All witnesses were written to four weeks in advance of their interviews detailing the Terms of Reference of the Investigation, the areas that the Investigation Team would be questioning them about, and the operational process and timeline of the work. All

witnesses to the Investigation were invited to attend an informal meeting on the 18 February 2008 to meet the Investigation Project Lead, Investigation Chair and the HASCAS solicitor from Capsticks. During this meeting the process was explained and a question and answer session conducted.

Evidence was received from a total of 27 individual witnesses orally over a period of eight days during February, March and April 2008. 11 of these witnesses have been listed in Table One. The 15 remaining witnesses had either, direct clinical contact with Mr. D, undertook managerial responsibility for the local mental health services or had been involved with the internal review. Please see Table Two:

Each Interview was recorded and a transcript prepared. The transcript was forwarded to each individual in order for it to be checked for accuracy and also for any additional information to be added to it. It is the amended versions that have been used as evidence in this Investigation.

The Investigation Team were not able to interview all of the individuals involved in the care and treatment of Mr. D. Due to the passage of time many of the witnesses that the Team would have liked to have called were either living abroad or were no longer contactable. Every effort was made to contact everyone who comprised Mr. D's clinical care team between the beginning of 2000 and the end of 2004.

Table Two

Witnesses Interviewed by Investigation Team

Date	**Interviewee**	**Interviewers**
21 February 2008	Nurse 1 Nurse 2 Manager 1	Androulla Johnstone Jed Boardman Tina Coldham Jane Mackay Helen Waldock Tim Saunders

22 February 2008	Dr. No.1 Nurse 3 **NB: All references to a CPN or Care Coordinator in this report denote this individual unless otherwise stated. Both titles are used reflecting the different roles deployed by this same individual during the Care and Treatment of Mr. D.**	Androulla Johnstone Jed Boardman Tina Coldham Jane Mackay Helen Waldock Tim Saunders
25 February 2008	Manager 2	Androulla Johnstone & Jane Mackay
3 March 2008	Manager 3 Manager 4 (Chair of Internal Investigation) Manager 5 (PCT Director) Manager 6 (PCT) Manager 7 (MHT DN)) Manager 8 (MHT CEO)	Androulla Johnstone Jed Boardman Tina Coldham Jane Mackay Helen Waldock Tim Saunders
25 April 2008	GP 1 GP 2 GP 3 GP 4	Androulla Johnstone Jed Boardman Jane Mackay Helen Waldock Tim Saunders

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 learned 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 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 process 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 utilised 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 avoids generalisations and seeks to use 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.

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.

10. Information and Evidence Gathered (Documents)

During the course of this Investigation over 4,000 pages of documentation were received by the Investigation Team. The documentation received comprised the following:

1. Barnet, Enfield and Haringey clinical records for Mr. D, 2000 - 2004
2. General Practice clinical records for Mr. D (photocopy only available to Investigation), 1990 - 2004
3. West London Mental Health Trust, Broadmoor Hospital clinical records for Mr. D (this archive includes all forensic history, police and court records), 2005 to present day
4. Haringey TPCT Internal Investigation Report
5. Haringey TPCT correspondence with victim's family and survivors
6. Haringey TPCT correspondence with perpetrator's family
7. Haringey TPCT Internal Investigation archive, including initial 72 hour incident report
8. Barnet, Enfield and Haringey MHT and Haringey TPCT legal correspondence
9. Media transcripts and newspaper articles
10. Joint Strategic Implementation Group minutes and action planning
11. Barnet, Enfield and Haringey Clinical Strategy document
12. CPA policies for 1996, 2003 and 2005
13. Barnet ,Enfield and Haringey admission criteria 1996
14. Appraisal and Planning Development Guidelines 2003
15. Barnet, Enfield and Haringey Eligibility Criteria for Accessing Services 2003
16. Haringey CMHT duty service specification 2005
17. Barnet, Enfield and Haringey Consent to Examination and Treatment Policy 2003
18. Barnet, Enfield and Haringey Criteria for admitting to Inpatient Services 1996
19. Barnet, Enfield and Haringey Patient Records Management 2002
20. Commission of Healthcare Improvement Report 2003
21. Mental Health Act Commission reports from 2000

22. Barnet, Enfield and Haringey Independent Review into Serious Untoward Investigation Procedures September 2007

23. Print-out of Mr. D's PNC record, previous charges, court appearances and convictions

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

25. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected death of 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

26. Guidelines for the NHS: *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm:* a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006

11. Profile of the Mental Health Trust Services

Barnet, Enfield and Haringey Mental Health Trust (the Trust) was established in April 2001, following the merger of Barnet Community Healthcare NHS Trust, Enfield Community Care NHS Trust and Haringey Healthcare NHS Trust. The Trust provides secondary mental health services to the residents of Barnet, Enfield and Haringey as well as parts of Cheshunt and some parts of south Hertfordshire. The Trust's budget to deliver services is £184m and it employs over 2,600 staff with 4 out of 5 providing direct patient care. Staff provide care to several thousand patients each year and there are 700 beds occupied at any one time. The Trust 2006-2007 Annual General Report states the following:

"There are just over 800,000 people currently living in the London Boroughs of Barnet, Enfield, and Haringey. Recently revised projections suggest an overall 15% rise in our local population, which is significantly higher than the London average. As one of the most ethnically and socially diverse areas in the country, we are rich in cultural diversity with contrasts of affluence and 'inner city' deprivation. The population is changing and growing with more people from black and minority ethnic communities - in some areas it is likely to reach a 50:50 ratio by the next census. There are predicted to be over 200 different spoken languages across the three boroughs with significant numbers of people who are refugees and travellers. In some parts, unemployment is twice the national average and is as high as 40% amongst young black men. Our local population is significantly younger than average, especially in Haringey where nearly three- quarters are under 45 and only 10% over 65".

People are provided with care and treatment in hospitals, community mental health centres, clinics, local authority premises, prisons and their own homes – 80% of the Trust's work takes place in the community.

At the time of our investigation the Trust Board comprised an 'acting' Chief Executive and 'acting' Director of Nursing. A new Trust Chairman was appointed on the 1st April 2008 and there were two vacant Non Executive Director positions. The Board has since appointed both a substantive Medical Director and Chief Executive. The

services are organised around the three London Boroughs of Barnet, Enfield and Haringey, but for the purposes of this report we are only concerned with Haringey.

11.1 Profile 2000 - 2003

It was difficult to understand how the Trust actually worked during this time as there remained little extant organisational memory for this period. The Independent Investigation Team ascertained the following information from witnesses.

The senior team in Haringey consisted of a Clinical Director with two Locality Managers, one for the east of the borough and one for the west of the borough. These two managers had responsibility for the wards, community services and the day hospital. The structure also had a Lead Nurse, an Associate Medical Director for adult mental health services and another Associate Medical Director for specialist services. At that time, in the Local Authority, there was a Service Manager for mental health services, but this post was outside the management structure and social workers, although part of the CMHT, were managed through the Local Authority. There were CMHTs based in Hornsey and Highgate and another covered Wood Green. The highest managerial post below the Locality Manager was that of 'Team Leader', a relatively junior post. In 2003 the Directorate moved away from Locality Managers to appointing Assistant Directors, one managing the community-based services and the other managing the inpatient services as well as being the Lead Nurse. The CMHTs were 'roughly' sectorised but also linked to individual general practices. At this time the Consultant Psychiatrist, who became the community based consultant for Mr. D was based at St Ann's Hospital rather than with the CMHT.

General Practitioners referred their patients to a central point at the CMHT and each day there was a 'duty' practitioner who dealt with emergency MHA assessments and more routine referrals were dealt with at the weekly staff meeting and then allocated for a comprehensive needs assessment. In addition to this service an Emergency Reception Centre dealt with most patients who 'walked-in' wanting to see a doctor urgently.

Patients were admitted to sectorised wards. If a need for ongoing care from a care coordinator was identified, a referral from the ward to the appropriate team was made and there was an expectation that the newly allocated care co-ordinator would attend the ward.

There was an expectation that following an inpatient discharge, service users were returned back to the GP and/or step down care to the Psychiatric Outpatients Department. This was seen as a way of containing the CMHT's anxiety, especially if a psychiatrist continued to have contact with a patient, even if this meant the psychiatrist ended up with an unrealistically high caseload.

11.2. Transition

CMHTs only became fully integrated in 2003 in terms of line management and professional support which was not without its difficulties. Staff expressed concern at the time about losing their professional autonomy. During this period operational frameworks between community teams and ward-based services were put into place especially around the expectations of the allocation of care coordinators.

In 2005 a new standardised duty system was developed. A pan-Trust CPA policy was also introduced in 2003 that standardised the systems that professionals were expected to work to.

11.3. Profile of Present Day Services

There has been a significant reorganisation of community services since October 2007. One of the key aims of this reorganisation was to improve the interface between primary and secondary care. The new structures provide the following to service users:

- *"Creates a single point of entry to all secondary care (adult) services on a 24 hour seven day per week basis.*
- *Physical and clinical improvement to the Place of Safety (S136 suite).*
- *The START service as 'expert' makes the decision as to where referrals are signposted after they are logged on the electronic system.*
- *The START service offers assessment and short term treatment to service users. In its first six months the service assessed 500 people but only had to*

pass 25 service users on to enhanced care in the Support and Recovery Teams.

- *The new service structure provides an integrated psychological therapies service for the first time in all teams in the Directorate;*
- *There are better formal and informal links with Primary Care. There is an agreed Primary Care interface Protocol that describes the relationship and responsibilities between primary and secondary care. Meetings take place between clinicians and primary care leads. There is also an agreed escalation process for disagreements.*
- *Ongoing audit in the service has identified a number of service users that will stepped down from secondary care to primary care in a managed way. Further developments in the mental health service include 'well being clinics' which will communicate closely with GPs re-prescribing of depot medication and physical health care issues".*

Support to Primary Care

The Haringey Teaching Primary Care Trust has appointed eight Graduate Mental Health Workers, and there is a formal interface agreement with the Mental Health Trust. Formal training to support staff in primary care has been provided. A RMN trained family therapist with Cognitive Behavioural Therapy training manages this team and provides clinical supervision. In addition meetings with key GPs are held and four GPs take a lead for mental health issues in Haringey. Regular meetings are held between the GPs, the Consultant Psychiatrists and the Team Managers. GPs can also attend 'community services' meetings, which have been set up to bring clinicians and managers together to discuss further service development requirements.

The main remit of the primary care mental health workers is to divert patients from secondary care. If there are concerns about a patient they can refer to the START (Short-Term Assessment and Treatment Service) team based at St Ann's Hospital. These teams are multidisciplinary and include Approved Social Workers (ASWs).

Secondary Care Community Provision

The START Team takes on all referrals throughout Haringey, including both routine and urgent long-term mental health problems. On the whole this team see patients who are new or might need just six months of professional input. There are three START Teams, which mirror the Community Mental Health Teams, this makes for a smoother handover once the initial six months of care and treatment have been given.

Community Mental Health Teams focus their work with patients who are on enhanced CPA. These teams work to address the actions in care plan reviews, to engage with patients and help them find an appropriate occupation or education programme.

Currently, in Haringey, two Assistant Directors are responsible for those patients who although ready for discharge from inpatient settings do not have an allocated care co-ordinator. Patients are now given the name of a worker who will visit or telephone within seven days of discharge. The Haringey TPCT monitors this contact as it is a commissioning-based performance indicator; a financial penalty is levied if this activity does not take place.

Team Managers are now in place replacing the roles of Team Leaders. They have a stronger clinical background with more experience and work more closely with the Consultant Psychiatrists. There is also a much stronger expectation that supervision is in place, either in groups or individually. In February 2008 when this Investigation commenced it was noted that there was still room for improvement and areas for further development that were identified by witnesses to the Investigation Team are set out as follows:

a) team training in dealing with SUIs;
b) CPA;
c) role of the care co-ordinator;
d) risk assessment;
e) practical aspects of policy and procedures ;
f) service user and carer centered services development.

The Independent Investigation Team understands that all of the above bulleted points have since been addressed by well-documented action plans within both the Haringey Teaching Primary Care Trust and the Barnet, Enfield and Haringey Mental Health Trust.

12. Chronology of Events

This Forms Part of the RCA First Stage

Background Information

The Investigation Team would like to acknowledge that Mr. D gave his full consent for this investigation to have unrestricted access to his clinical record. The family of Mr. D were interviewed and supplied the Investigation Team with information through an interpreter. It is important to note that Mr. D's physical history and conditions are mentioned in some detail in this report as his somatic presentation was a key feature of his psychiatric condition. It will not be possible to fully appreciate Mr. D's psychiatric history without these inclusions.

Mr. D was born in East Turkey on 8 January 1975, the oldest of three siblings. Mr. D's family were Turkish nationals of Kurdish origin[10].

1990

Mr. D's first contact with health services was when he registered as a new patient with a General Practice on 7 March 1990.

Mr. D had completed his education in Turkey aged 12; however on arriving in England his schooling resumed, he had difficulty in settling in because of language difficulties. In 1990 Mr. D was hurt in the school playground in what appears to have been a racially motivated attack. As a result he was found a place in another school and recommenced his education there in September 1990[11].

Mr. D developed a history of truancy at his new school.

1992

When Mr. D was 17 years of age and in the sixth form he was once again assaulted at school. In this assault Mr. D sustained a broken nose. The police were not involved with this incident. As a result Mr. D left school and enrolled in computer classes at his local college. Mr. D left this course after a few months[12].

Mr. D visited his GP on four occasions with minor physical ailments.

1993

9 April 1993. Mr. D attended the A&E department at the Whittington Hospital with an injury to his arm. It was X-rayed and as there was neither dislocation nor a fracture, he was given a bandage sling.

12 July 1993. Mr. D was referred to the Ear, Nose and Throat Department at the Whittington Hospital to have some 'correction' to his nose which had been broken the year previously. He was referred again on the 2 November 1993 as he was suffering from nosebleeds. As there was no clinical need to have any corrective surgery he was discharged.

Mr. D's father secured a job for him in a dry cleaning store. Mr. D passed his driving test on the second attempt and used his father's car to travel to work. The owner of the shop, who was friend of Mr. D's father, saw Mr. D rolling cannabis cigarettes. He advised Mr. D not to use cannabis and also told Mr. D's parents. Mr. D lost interest in the job and he left[13].

1994/1995

During this period Mr. D's parents became aware that he was smoking cannabis in the house and in the family car[14].

1995

Mr. D visited his GP on two occasions to discuss a skin condition[15].

1996

20th February 1996. Mr. D's GP received a letter from the A&E Department at the North Middlesex Hospital regarding an intervention. Clinical records show that Mr. D missed an appointment with his GP on 2nd April 1996[16].

1997

Mr. D used his father's car to work as a mini-cab driver. As a consequence he was out at all times during the day and night. His parents noticed that he was drinking alcohol, taking home bottles of whisky, which he drank on his own in his bedroom. He spent more and more time on his own and hardly ate meals with the family. The mini-cab business was owned by a group of Somalian men and it was at this time that Mr. D started using Khat. Khat is a plant, which is chewed and is reported as having an amphetamine-like effect. The consumption of Khat is not illegal. The chewing of Khat is culturally acceptable and openly practised in the Somalian community. Mr. D took plants home on daily basis and spent more time in his room[17].

1998

18 December 1998. Whilst Mr. D was driving along the road, he allegedly drove over the foot of a 37 year old male pedestrian. This pedestrian removed one of the car's wing mirrors. Mr. D stopped his car and chased the man. When he caught up with him, Mr. D assaulted him by hitting his head against a brick wall causing a cut to his forehead. He was charged with Actual Bodily harm (ABH) and was remanded in custody at HMP Pentonville for six weeks[18].

1999

9 March 1999. Mr. D attended his GP to request a letter to state that he has been registered with them since 24th February 1992[19].

1 April 1999. The Police cautioned Mr. D after he had been seen acting in a strange manner and was found to be in possession of a small amount of cannabis. When his car was searched the Police found 'rice flails" and so he was also cautioned with being in possession of an offensive weapon[20]. (A rice flail constitutes two pieces of wood each joined by a length of metal chain).

9 November 1999. Mr. D attended the GP surgery with his father "*to discuss his condition"*[21]*.*

2000

27 January 2000. Following the incident of 18 December 1998 Mr. D attended Wood Green Crown Court and pleaded guilty to Actual Bodily Harm (ABH), following which Mr. D was subject to a one year Combination Order consisting of a one year Probation Order and 40 hours of community service. He was also expected to attend the 'Break Free' project. The Pre-Sentence Report stated that Mr. D did not *"accept full culpability"* and at one time denied that he had run over the victim's foot, saying that the victim had stolen the mirror. The Probation Officer, completing the Pre-Sentence Report, recommended the Combination Order as this would enable Mr. D to work with a Probation Officer to explore the events of the offence and any underlying reasons for his aggressive behaviour. During Mr. D's initial interview he expressed the view that he had the right to kill people if they broke into his home or damaged his property. In addition Mr. D expressed little remorse for his victim and minimised the severity of the assault and the victim's injuries.

The sentencing Judge commented that
" had I dealt with this case earlier last year the proper sentence would have been three months imprisonment, however, time has moved on and I am faced with fact that you have served the equivalent of a six week prison sentence" [22]

3 February 2000. Mr. D attended his General Practice**,** complaining of abdominal pain. He was given a prescription and given advice about taking more fluids[23].

28 March 2000. Mr. D attended his General Practice complaining of a painful shoulder and was given a prescription for Diclofenac 50mgs. He was referred to have an x-ray of his left shoulder and cervical vertebrae[24].

First Admission

4 June 2000. At 4pm Mr. D attended the A&E department at the North Middlesex Hospital. He was complaining of headaches and a slow heartbeat. Mr. D was referred for a psychiatric opinion and admitted to Downhills Ward, St. Ann's Hospital for the first time. Mr. D felt that that there was something wrong with his blood. He

said that his *'blood was like water'* and that his *'body does not feel normal'* and *'I am dying'.* During the interview he confided that he felt that his skin was changing colour and he was hearing voices. An electrocardiograph (ECG) was completed and a letter sent to his GP[25].

On admission Mr. D was appropriately dressed, had good eye contact and fairly good rapport during the nursing assessment. The nurse gained the impression that he was preoccupied with vague hypochrondriasis and presented with somatic symptoms. During the medical assessment he said he had smoked cannabis for four years and had started chewing Somalian Grass (Khat) in 1999. He no longer smoked cigarettes. He now felt that his blood needed changing or he would die. He also complained of headaches, aches all over his body and that his bones felt like glass. He described his blood as being red and black and like lemon and water. He felt that he was dying slowly. He denied having any paranoid feelings but felt that he could no longer live with this 'sickness' and said he had had thoughts of killing himself but would not do so out of respect for his parents. Mr. D had worked for two years but was working no longer because of these symptoms. The medical notes stated that Mr. D was probably suffering from a psychotic illness precipitated by Khat. It was noted that Mr. D was distressed by his illness and that he had occasional thoughts of suicide. A routine blood and urine screen was ordered[26].

Later that evening Mr. D's sister telephoned the ward to say that her parents wanted to take Mr. D home. His illness was explained to them and that he needed to stay in hospital because he had a mental health problem. Mr. D agreed to stay in hospital as an informal patient. His parents visited Mr. D on the ward and still wanted to take him home. The duty doctor saw them and persuaded them to let Mr. D stay on the ward because he was agitated. After taking some medication Mr. D settled down and slept throughout the night[27]. Mr. D was given Droperidol 10mg and Lorazepam 2mg [28].

5 June 2000. Mr. D was allowed to go home on leave[29].

6 June 2000. Mr. D attended the ward review with his mother. Mr. D told the Locum Consultant, Dr. 3, that he

> " *had glass broken in his neck and arm. He heard and felt it. Maybe my blood doesn't go there* (he pointed to his head)
> *Inside me is dust and dried out"*

He also said that "*I cannot be happy because I always have my sickness on my mind I am in a very bad condition now"*

He did have suicidal thoughts but out of respect for his parents would not do anything to upset them. He denied he had a mental illness and refused medication[30].

Mr. D's mother was interviewed and she said that he was doing well but had some headaches and Mr. D complained about having pains in his shoulder and his back. She was told that various tests were required but she repeated that her son did not want to stay in hospital, as it was full of mentally ill patients. She told the doctor that she did not want her son to have any medication and wanted him to go to another hospital and have the tests carried out there. The doctor explained to her that Mr. D should stay in hospital so he could have some more tests such as a CT scan and an EEG as well as being observed before they decided on any future medication. These tests were ordered to ascertain whether or not Mr. D's symptoms had a physical cause. Mr. D was advised not to chew Khat. Mr. D's mother informed the doctor that she was going to Turkey to attend her father's funeral. A little later Mr. D left the ward[31].

7 June 2000. Mr. D failed to attend the ward round[32].

8 June 2000. A locum SHO saw Mr. D's parents without Mr. D present and also without a 'link worker' as one was not available. His parents admitted that their son was a 'little depressed' and still asking if his blood was all right. They denied that Mr. D had a mental illness. The parents' view was that it would be a good idea for Mr. D to be married as they felt that he would be happier and then he would not have any further problems. They also wanted Mr. D to have psychotherapy. The plan was to review Mr. D's care in a week's time with his parents and a 'link worker' present. A CT scan was booked for 7th July 2000[33].

13 June 2000. Mr. D was seen at the ward round. He did not want to sleep in the hospital, although it was explained that he needed to stay so that he could be helped. Mr. D was of the view that the only medication that would help him was steroids to 'pump up' his muscles. He said:

> "*I'm dried up*
> *Pain*
> *When I drink coca-cola my neck makes a noise"*
> *Dull and down*
> *Cannot sleep and can't breathe*
> *Everything has cut out"*[34]

He told the staff that he only came to the hospital so that he could have his blood changed and was adamant that he would not stay. He felt that he was going to die due to his illness. He was convinced that the Somalian Khat was responsible for his symptoms. Mr. D stated that he had never attempted self harm nor did he have plans to do so.
The plan was

1. *"to stay in hospital during the day and have leave*
2. *to have soluble olanzepine 5mg. at 5.30pm and then could go home"*[35]

Mr. D agreed to take the medication but left the ward and did not return as planned[36].

15 June 2000. Mr. D was discussed at the ward round in his absence as he had left the ward following the previous round two days earlier and had not returned.
The plan was to

1. *"discharge him*
2. *CMHN to be allocated and if concerns to be referred to Emergency Reception Centre (ERC)*
3. *Mr. D to collect medication*
4. *If family had concerns then to take Mr. D to ERC*
5. *EEG arranged for 20 June 2000. CT arranged 7 July 2000*
6. *Outpatient appointment on 19 July 2000 at 10am"*[37]

23 June 2000. The CPN wrote to Mr. D to inform him of her proposed home visit on the 29 June at 12 midday[38].

29 June 2000. The CPN visited Mr. D at home and saw both him and his parents. Mr. D appeared to be relaxed and quiet, although still concerned about his bodily functions and physical health. The CPN wrote:

"He appears to be of good health but believes that his skin is not his and is concerned about how it looked. Mood appears stable no signs of depression observed.

Psychotic symptoms, denies hearing voices and visual hallucinations"[39]

COMMENT
This last sentence does not appear to have been entered contemporaneously. This is fully analysed and discussed below in section 14.5

7 July 2000. Mr. D attended the North Middlesex Hospital for a CT scan. The scan showed that there was asymmetry in shape and size between the right and left ventricles. The right ventricle was slightly larger. It was felt that an MRI should be carried out to exclude any lesion.

13 July 2000. The CPN visited Mr. D's home address. He was not there and she told his parents that she would write to him and arrange another appointment.

"However sat and spoke to his parents to ascertain what were their concerns. Mother believes that he does not have a mental illness just needs new friends"[40]

COMMENT
This last sentence does not appear to have been entered contemporaneously

19 July 2000. The CPN telephoned Mr. D's home and was told that he was sleeping. She requested that Mr. D's sister wake him. Mr. D spoke to the CPN on the telephone and told her he was fine and that he did not want to see her anymore. He reassured her that he was no longer taking drugs but just wanted to live his life. She

told him that as he had an appointment to see the Consultant Psychiatrist, Dr. 2, she would telephone him again in three weeks time[41].

19 July 2000. The CPN wrote to Mr. D to inform him that she would see him at home on the 8 August at 10.30am[42].

19 July 2000. Mr. D was seen in the outpatients department. He was no longer taking the medication as he said it gave him headaches and made him feel worse. Mr. D complained that he felt *"disabled".* He could not breathe properly and that his chest and neck were "*pulling"* him. Mr. D was unable to work as he felt weak and was full of pain. He could hear noises in his chest, which he mimicked. Mr. D appeared mildly depressed with his sleep pattern being disturbed and feeling tired in the mornings. In a letter to the GP dated 24 July 2000 the following was stated:

"…..he denied deliberate self harm ideation, expressed no intent or plans but said he was dying anyway. He experienced persecutory delusions in that he believed evil was inside his body; possibly Satan and he believed this would kill him. He also wondered why he (Satan) chose him and not other people. Further he believed that Satan gave him signs, i.e. plucking at his eyebrows to bring it to his attention that people were looking at him. He denied any thought insertion or broadcasting. He experienced no visual or auditory hallucinations but did seem to experience tactile hallucinations with secondary delusional interpretations, i.e. if he felt a scratch on his face that meant somebody was bad and if he felt a tickle on his face it meant somebody was good. His insight remained poor; he did not believe he had an illness. He did however acknowledge that he would give it more time and if he did not get better he would consider coming back to hospital. My impression was that Mr. D was currently still quite unwell. He has depressive symptoms, such as biological features and also his thought content is of a depressive nature. He also suffers with paranoid delusions, likely a secondary feature of his depressive illness, but paranoid schizophrenia, still have to be considered as the main differential diagnosis. I have decided to start Mr. D on an anti-depressant and have given him two weeks supply of Cipramil 20mg which he will be taking in the mornings. I would be most grateful if you would re-prescribe these for him. I have arranged a follow-up appointment for in September 2000, at which stage we would give consideration to increasing the dose of his Cipramil, or the addition of another antipsychotic.

I have informed Mr. D of the service provided by our emergency reception centre and he has reassured me that he would attend there if his symptoms got worse."[43]

Second Admission

27 July 2000. Mr. D attended the Emergency Reception Centre and saw the duty doctor. Mr. D was complaining of

> "*Pain in my heart*
> *My insides do not work*
> *My neck may be broken*
> *My bones are paining*
> *My blood needs changing….it is empty*"

Mr. D said that his symptoms had worsened the night before and he felt that his heart was going to stop and he would die.

Mental health state examination

"Large rotund burly young man
Short hair, clean
Shaven
Holding himself as in pain
Notably no visual expression and hands and face to indicate pain
Coherent. Speaks limited English
Not suicidal- though wonders if he is dying
-Preoccupied by multiple complaints, including, pain in the neck, and noise like stones rubbing
-Pain in bones
-Breathlessness
-Slow heart
No obvious panic attacks
Nil psychotic and no hallucinations….

Plan

1. *agreed to informal admission*
2. *general observations on the ward*
3. *Olanzapine 5mg nocte*
4. *physical and treatment on ward*
5. *link worker*
6. *PRN paracetamol"*[44]

Mr. D was admitted for the second time. He appeared anxious and took his prescribed medication. At 1.25pm Mr. D went to buy a soft drink and when the next shift started he was not present on the ward and had not returned by the time the daily report was written[45].

1 August 2000. The Consultant Psychiatrist, Dr. 2, conducted the ward round. The

Early Intervention Team (this was in reality a duty CPN and not what we now understand by early intervention) was asked to visit Mr. D and attempt to bring him back to the ward. The CPN was asked to take his medication to him. An outpatient appointment was arranged for 18 August at 2pm. The ward team were anxious to contact the CPN leaving several messages for her. She did not respond. Mr. D was prescribed Paroxetine in his absence[46].

2 August 2000. The CPN went to the ward and collected Mr. D's medication and his outpatient appointment card[47].

3 August 2000. The Consultant Psychiatrist, Dr. 2, conducted the ward round. The CPN had not visited Mr. D and told the ward that she would visit later that day. It was agreed that if Mr. D did not attend the ward round and appeared to be settling, he would be discharged from the inpatient service and he would be given an outpatient appointment[48].

7 August 2000. A message was left for the CPN by the ward staff to *"Urgently"* contact the ward regarding feedback from her visit to Mr. D. The CPN visited Mr. D at his home[49].

8 August 2000. The ward staff spoke to the CPN who stated that Mr. D was not in when she visited so she put his medication and the Consultant's outpatient contact details through the letter-box. The CPN also stated that she intended to visit Mr. D at 10.00 am that day. From this point the CPN was regarded as Mr. D's Care Coordinator.

Later that day it appears that the Care Coordinator contacted the ward to say that Mr. D was settled and he was discharged in his absence[50].

The Care Coordinator made a home visit and spoke with Mr. D's mother, as Mr. D was not at home and she did know where he was. According to the hospital inpatient nursing notes, he was 'ok' and complying with his medication. The Care Coordinator telephoned Mr. D at home that afternoon but there was no reply. She wrote in the notes:

"Need to discuss with Consultant, as I am finding it difficult to complete a full assessment but so far no evidence of any psychotic symptoms and is not at risk of harming himself or others. Mr. D's parents were unhappy that he was spending long periods of time sleeping and staying out. It would appear that he is continuing to abuse drugs hence why he sleeps throughout the day and goes out in the evening. Discuss with Consultant best way forward. Possibly discharge with RMO agreement"[51]

17 August 2000. A hospital discharge letter was sent to Mr. D's GP. It included the following plan

1. *"Mr. D to continue taking his current medication-Paroxetine 20mg in the morning and Olanzapine 5mg at night*
2. *Ward staff have agreed to refer him to Early Intervention Team to visit and attempt to persuade Mr. D to return to the ward*
3. *If not agreeable to come to the hospital and found not to be sectionable, he should be referred to the Day Hospital*
4. *A MRI scan of his brain has been ordered*
5. *He has been given a 2 week supply of medication*
6. *An outpatient appointment has been made for 18 August 2000 at 2pm"*[52]

18 August 2000. Mr. D was reviewed in the Outpatient Clinic. He had been taking his medication and had made some progress. When asked how he was, Mr. D said "*the same*" and outlined his physical symptoms. The Consultant Psychiatrist wrote the following as described by Mr. D in his discharge letter to the GP

> *"….I cannot move my arm (which he then moved above his head) it turned out he meant at times without it paining him or his joints*
>
> *I am unable to breathe, I pointed out to him that he was indeed breathing, but he said, "well not deeply" and he attributes all of these symptoms to sticky things in Khat*
>
> *My bones are making noises, clicks in my knees*
>
> *A Turkish doctor said the bones are getting empty….*

My sleep is poor, *he described sleeping 11 hours a night for one night a week and the other nights 8-9 hours so it was unclear what he meant…..*

Psychiatric examination revealed a friendly, if bemused male with no evidence of thought disorder. He describes his moods as sad everyday…. He is not suicidal and apart from preoccupation with his bodily functions as described I could elicit no evidence of ideas of reference, paranoid ideation or first rank symptoms of schizophrenia. ……. I could elicit no evidence of psychosis.

My impression is that the patient's psychotic element to his illness has remitted, but he still has mild somatisation/hypochrondriasis, for which reason I have increased the Cipramil to 40mg daily and given him a month's prescription along with Olanzapine 5mg daily. He will be seen again in one month's time and if there is no improvement by then, I will try to encourage him to attend the day hospital. He has been sent an appointment for a MRI scan."[53]

30 August 2000. Mr. D attended for the MRI scan but the procedure had to be abandoned as he suffered from claustrophobia.

21 September 2000. Mr. D attended a private doctor, who in turn referred him to the Consultant Psychiatrist at St Ann's Hospital. The doctor described Mr. D as suffering from severe depression with psychotic features and dysmorphia. He thought he might well be suffering from mild schizophrenia. Mr. D was prescribed Melleril[54].

26 September 2000. Mr. D attended his General Practice complaining that he had suffered pain in his back, chest and all his joints for the past two months. He was unable to eat as he felt that food was *"stuck"* in his chest. On examination his chest was clear. He was referred for an ECG, a chest X-ray and blood tests[55].

28 September 2000. An appointment was sent to Mr. D to attend an Outpatient Clinic appointment on the 10 October 2000 at 3.45pm. On the same day a further letter was sent to Mr. D cancelling an appointment with the same Consultant but on the 29 November 2000 at 10.20 am[56].

2 October 2000. The Care Coordinator wrote in her notes

"*Discuss with Dr. 2 and informed him my opinion that client is not showing symptoms of psychosis. Only concerns are about aches and pains and condition of his skin. I will continue assessment then client will continue to be seen in outpatients"*[57]

3 October 2000. The Consultant, Dr. 2, who had seen Mr. D, wrote to his GP to inform him of Mr. D's condition. He also told the GP that Mr. D had seen a private doctor who, according to Mr. D, apparently told him that Cipramil (Citalopram) was no good and so he threw it into the dustbin. Mr. D complained that he had to pay for the interview and also the medication.

Mr. D felt that he was "*the same"* and as such all his problems were physical. Mr. D's mother was present. Mr. D had refused to go the day hospital as he felt that everyone who went there was "crazy". He was prescribed Prozac (Fluoxetine) 20mg daily as well as Thioridazine. Mr. D had applied for incapacity benefit but the Consultant did not think this was appropriate, as it would only reinforce his illness model. A further appointment was to be made for late November 2000[58].

10 October 2000. The Care Coordinator wrote to Mr. D informing him that she intended visiting on 20 October 2000[59]. No record of this meeting is made in the CMHT notes.

11 October 2000. Mr. D attended the outpatient clinic and his only complaint was that his bones creaked. The Consultant Psychiatrist, Dr. 2, wrote to Mr. D's GP and felt that it was a very difficult situation when both he and the private doctor were seeing Mr. D. Mr. D told him that he was suicidal and there was no evidence of hallucinations, paranoid ideation, first rank symptoms of schizophrenia or psychosis. He felt that Mr. D's insight was limited as he told him " *my problem is physical and my brain is dry"*

He also noted that the EEG (Electroencephalograph) had not been done and requested that another be arranged.

The Consultant, Dr. 2, also referred Mr. D to the Consultant Neurologist at the North Middlesex Hospital. He described him as having a multiplicity of physical symptomatology coupled with a depressive illness taking an atypical form. He enclosed a copy of the CT (brain) scan and explained that Mr. D did not have the MRI (brain) scan and why. He suggested that perhaps Mr. D should have Diazepam 5-10mg and a further attempt at completing the MRI scan[60].

24 October 2000. A private doctor wrote to the Consultant Psychiatrist, Dr. 2, thanking him for copying him into the GP's letter. He refuted that he told Mr. D to throw the Cipramil (Citalopram) in the dustbin. He explained that he started Mr. D on Melleril (Thioridazine) because it was so much cheaper to buy than Olanzepine, which he would have preferred but Mr. D could not afford the cost. This doctor also saw Mr. D's mother who would not accept his illness. He told her that Mr. D must take his medication. He asked that copies of Mr. D's medical notes be sent to him as he intended to continue seeing Mr. D[61].

25 October 2000. The Care Coordinator spoke to Mr. D's sister on the telephone and rearranged her appointment to visit him at Mr. D's request for 2 November 2000. She noted "*Turkish Link worker will be present because I have requested that Mr. D's family be there*"[62].

2 November 2000. The Care Coordinator visited Mr. D's home with an interpreter. Only Mr. D's mother was there. His mother did not think that Mr. D was mentally ill but that there was something wrong with his bones and skin because he complained of these things all the time. The Care Coordinator Notes stated:

"*Some educative work was completed concerning possible causes of constant substance abuse and how they can affect mental states. Symptoms were described and his mother agreed that Mr. D had experienced the same. His mother did feel that he had been depressed in the past but at present did not show any signs of depression but only concerns about body pain.*"[63]

24 November 2000. The Consultant Psychiatrist, Dr. 2, wrote to Mr. D's GP and was pleased to say that Mr. D seemed to be extremely well. Mr. D informed him that he

was taking his medication and although preoccupied with his breathing, it had improved since he had taken up sport. Mr. D was to continue taking Prozac (Fluoxetine) 20mg daily and would be seen in a further three months[64].

The Consultant, Dr. 2, wrote to the Consultant Neurologist again[65].

29 November 2000. The Care Coordinator made several telephone calls to Mr. D and spoke to his sister who said he was 'OK' and that he had no concerns except that he complained of neck pain and headache.

According to the notes, the Care Coordinator visited later that day, during which time she apparently completed a delusional rating scale, which was neither dated nor signed. Mr. D appeared to be preoccupied with physical functioning. Mr. D denied hearing voices inside or outside his head. He did not feel like harming himself or others and did not feel as though people were following him. Mr. D's mother made sure that he was compliant with his medication and that he took it regularly. Mr. D denied taking any drugs, as he knew they were not good for him. The Care Coordinator reported in her notes that she discussed possible early warning signs with Mr. D and his mother to ascertain when he might become unwell. Mr. D was described as *"verbally hostile and not wanting to listen".* He was told that he could be referred to the day hospital but he was not interested. The Care Coordinator informed the family that this would be her last visit[66].

COMMENT
These notes do not appear to have been entered contemporaneously

2001

3 January 2001. The Consultant Neurologist wrote to Mr. D's Consultant Psychiatrist, Dr. 2, apologising for the delay in the appointment for Mr. D's MRI (Brain) scan. The original letter failed to arrive. He reviewed the CT (Brain) scan and was uncertain about any abnormality but thought that it would be sensible to have the MRI examination[67].

26 January 2001. Mr. D completed the Combination Order[68].

7 February 2001. Mr. D did not attend outpatients for an appointment[69].

16 February 2001. The Care Coordinator made a home visit

"*Made attempt to visit Mr. D at his home after being informed he'd been admitted to Saint Ann's Hospital*".

Mr. D informed her that he had been chewing Khat, which he knew made him unwell. He was feeling better now and he only wanted to see the Consultant in the outpatient clinic and did not want her to visit him. He agreed to attend outpatient's appointment and the Care Coordinator informed Dr. 2 that Mr. D did not want her to continue visiting. Dr. 2 suggested that Mr. D should attend the day hospital for continuing support[70].

19 February 2001. The Care Coordinator wrote to Mr. D informing him that she would be on holiday from the 19 February until 26 February 2001[71].

28 February 2001. The Care Coordinator visited Mr. D at home and discharged him from her caseload, as he did not want her involvement. She wrote in the notes

"1. write to Dr S informing him client no longer wants my involvement
2. give client my contact number if he changes his mind
3. brief mental health assessment completed
4. Mr. D agreed to continue with outpatient appointments" [72]

2 March 2001. Mr. D's Consultant, Dr. 2, wrote to him, as he had not kept the appointment on the 20 February 2001 at 2.40pm.

10 March 2001. Mr. D did not attend outpatients for an appointment[73].

23 March 2001. Mr. D failed to keep his appointment on the 20 February 2001 and 10 March 2001. The Consultant, Dr. 2, wrote to Mr. D's GP and explained that as he had failed two appointments, unless he was re-referred he would receive no further

appointments. He reminded the GP that Mr. D was currently having investigations with the Consultant Neurologist[74].

Third Admission

20 May 2001. Mr. D was arrested for criminal damage to some head stones in Tottenham cemetery. The police helicopter was called out and video footage was taken. Mr. D thought the police helicopter was 'after' him. When Mr. D was arrested he was muttering incoherently and told the Police that *"God told him to do it"*
A police doctor, (forensic medical examiner-FME), saw Mr. D and advised that a MHA (1983) Assessment be carried out. He was found to be in need of detention.
Mr. D admitted to chewing Khat again and said that it had made him unwell in the past. He had stopped taking his medication possibly two to six months earlier.

Mr. D was admitted to St Ann's Hospital on section (2) MHA 1983 at 7 pm. On admission he was loud and hyperactive and pre-occupied with the police 'going after him'. He had stopped taking his medication because he said that it made him feel worse.

On examination he was mildly agitated with pressured speech and feeling sad about what had happened. The SHO on duty wrote the following plan

> *" Haloperidol prn. Team to review medication in the morning*
> *blood forms.*
> *drug screen*
> *routine obs.*
> *team to follow up MRI scan"*[75]

21 May 2001. Mr. D remained agitated and argumentative, refusing to take any medication and demanding to leave the ward. He complained of not being able to breathe and was reassured by spending time in the garden in the fresh air[76].

22 May 2001. Mr. D's mother received a letter from the Trust as his 'nearest relative'. The letter stated that Mr. D may be of harm to himself or and others[77].

24 May 2001. Mr. D was feeling more relaxed and 'mentally improving'. He was allowed to go the canteen and walk in the hospital grounds with an escort[78].

25 May 2001. Mr. D attended the ward round and although feeling better he complained of side effects from the drugs. Mr. D also was reported as believing that helicopters were following him around. He also complained of asthma and was told to see his GP when he was discharged to obtain an inhaler[79].

29 May 2001. Mr. D was seen at the ward round accompanied by his mother and an interpreter. Mr. D refused to take any medication including depot injections as he believed it was not good for him. His mother would not give consent for Mr. D to have his medication by injection.

Mr. D was discharged from the MHA section and went on leave. He was 'bailed' to attend the police station on the 16 July at 11am. His mother wanted to take Mr. D to Turkey but this was refused as this would breech his bail conditions[80].

31 May 2001. Mr. D attended the ward with his mother but left without seeing a doctor at the ward round. Later that day his father and sister collected his medication[81].

2 June 2001. Mr. D attended the ward round. The plan was for Mr. D to attend the outpatient clinic, continue with Risperidone which was newly prescribed on the 31 May and to see his Care Coordinator[82].

5 June 2001. A CPA meeting was conducted with Mr. D and his mother being present. The CPN, as the nominated Care Co-Coordinator, was not there. No risk behaviours were identified.
His care plan was as follows:

1. *"to continue with present medication*
2. *to see Dr. 2 in the outpatient clinic 10th July 2001 at 2.40pm*
3. *CMHN (CPN) to continue with support and advice*
4. *medication explained to patient*

5. *drugs given for two weeks and then to attend GP for further medication"*

10 July 2001. Mr. D did not attend his outpatient appointment.

17 July 2001. Mr. D's Consultant Psychiatrist, Dr. 2, informed the Consultant Neurologist that Mr. D had failed to keep three appointments[83].

2 August 2001. The Consultant Neurologist wrote back to Mr. D's Consultant Psychiatrist, Dr. 2, to inform him that the MRI scan could not be completed because Mr. D was claustrophobic[84].

24 September 2001. Mr. D attended the clinic at the North Middlesex Hospital and saw the Consultant Neurologist. This Consultant was of the opinion that there was no organic cause for Mr. D's symptoms. Mr. D declined to have another MRI scan and so the Consultant recommended some blood tests[85].

25 September 2001. Mr. D attended the Outpatient Clinic as somehow he was given another appointment although he had not attended on three previous occasions. Mr. D was feeling *'better'* and had spent two months on holiday in Turkey. Dr.2's impression was that Mr. D was clinically stable and should continue with the medication Lustral (Sertraline) 50mg daily, which had been prescribed for him whilst in Turkey. Dr. 2 reminded Mr. D that he should keep his appointments with the Neurologist and have the MRI scan. Dr. 2 wrote to Mr. D's GP and the Consultant Neurologist[86].

8 October 2001. Mr. D presented himself at the Outpatient Clinic. As Dr. 2 could not see him he was referred to the Emergency Reception Centre (ERC). Mr. D returned to see the Dr. 2 on the morning of the 9 October 2001 with a catalogue of physical problems. He told the doctor

"my foot is white. I cannot breathe at times, my chest is like superglue, my blood is sticky…. I feel it in my arms, my hands …my heart is very slow"

The Consultant thought that Mr. D was suffering from psychotic depression but encouraged him to see his GP for a physical examination to exclude any organic pathology[87].

10 October 2001. The Consultant (Dr. 2) wrote to Mr. D's GP informing him of his recent contact with Mr. D. He increased the Lustral to 100mg daily and prescribed Risperidone 0.5-1mg at night. Mr. D was given a further appointment for December 2001.

Fourth Admission

5 November 2001. Mr. D was admitted to St Ann's Hospital at 3am on a section 4 of the Mental Health Act (1983). The police took Mr. D to the ERC after his family had alerted them to the fact that Mr. D wanted to cut his wrists. Mr. D believed that he was the Son of God, his family were very scared. Mr. D would not accept that he needed to be treated in hospital and required rapid tranquilisation, seclusion and restraint.

During examination Mr. D was verbally aggressive and very intimidating, shouting and gesticulating as well as banging the wall. He had poor insight despite the three previous hospital admissions and did not see the need for this admission. His parents were interviewed who said that Mr. D's behaviour had changed and from the night before had threatened to end it all by slashing his wrists.

The admitting doctor diagnosed relapse of schizophrenia due to non-compliance with medication and depression. His plan following discussion with the Specialist Registrar was:

1. *"attempt to explain the need for hospital admission*
2. *contact with ASW*
3. *admit under MHA 1983 section 4*
4. *Haloperidol 10mg and Lorazepam 2mg immediately*
5. *nurse in seclusion under constant vision – level 3 observation because of threats of hanging himself*

6. *review level of observation and mental state after seclusion*
7. *PRN Haloperidol 10mg and Lorazepam 2mg*
8. *team to review in the morning*
9. *routine investigations when patient more settled and amenable."*

After one hour Mr. D was reported to have settled and was asleep. Four hours later he was still asleep. It was agreed that when Mr. D woke up he was to be escorted back to the main ward.

At 9am. Mr. D was more settled. He said he only threatened self-harm as he did not want to be admitted to hospital. Mr. D was diagnosed with paranoid schizophrenia and the notes state that he was not controlled by Risperidone[88].

6 November 2001. The Inpatient Consultant, Dr. 4, contacted Mr. D's family and spoke to his sister. The family wanted Mr. D to come home only if he agreed to take his medication and so they suggested he had depot medication as they had concerns about Mr. D's compliance. The written plan stated

"*CPN (CPN/Care Coordinator mentioned by name as Nurse 3) to follow up in the community as soon as possible this gentleman <u>can</u> be managed in Community*[89]

It was noted that his Care Coordinator had not visited Mr. D "for a while". The Medical Records state that the plan is for the Care Coordinator (specifically named) to follow Mr. D up in the community "ASAP". No CPA papers appear to have been initiated or completed. The Care Coordinator did not follow Mr. D up at a later date[90].

Mr. D was discharged home with two week's medication. The family were noted to be extremely reluctant to take him home.

7th November 2001. Mr. D was referred to the day hospital. In the letter of referral, the doctor wrote

" ……he came into hospital briefly on Section 4 due to ideas of wanting to cut his wrists. He was discharged 2 days later to the care of his family as he was not sectionable and did not want to stay and agreed to take medications. The latter is

questionable however, due to past non-compliance. The team feels he will be appropriate for day hospital care due to the need for monitoring and support"[91]

The Care Coordinator was clearly identified in this correspondence.

13 November 2001. In the discharge summary the SHO wrote

"…….the patient was nursed in seclusion for four hours and went back to the ward. He was reviewed by the team the following day where he agreed to take medications, denied having suicidal ideations and said that his ideas of cutting himself was just threats and that he didn't want to act upon them he just wanted attention and refused to stay in hospital. The CPN was contacted and she was to arrange an urgent follow up in the community by the Consultant, Dr. 2, and herself as soon as possible in order to monitor his mental state… they [the family] reluctantly agreed to accept him at home on this agreement though they did have concerns about his past non-compliance and threats to himself."[92]

Comment
No follow up visit was made by the Care Coordinator, neither was a visit made by the Consultant, Dr. 2.

22 November 2001. Mr. D was seen at the ERC at 12 midday. His father took him there because he was complaining of side effects from Risperidone. His medication was changed to Olanzepine 5mg [93].

30 November 2001. Mr. D saw his GP because he was having an adverse reaction to Risperidone. The GP told him if he was unable to tolerate the drug he should stop it and he referred Mr. D to the Consultant, Dr. 2, requesting that he saw him *'urgently*[94]*'.*

7 December 2001. Mr. D attended his GP practice, complaining that he was unable to tolerate Risperidone as he was suffering all the reactions he had read about in the patient information leaflet.

10 December 2001. Mr. D was seen in the Outpatient Clinic. Mr. D had previously been seen at the ERC and was advised to stop taking Risperidone prescribed Olanzapine 5mg after which he settled well. The Consultant, Dr. 2, felt he was settled "my impression is that he is now stable on Olanzapine 5mgs and has been advised to think about going for employment in the next few weeks". Agreed to see him in February 2002[95].

2002

20 February 2002. Mr. D attended the Outpatient Clinic and saw the Consultant. He was described as making excellent progress and taking Olanzapine 5mg daily. Mr. D was asymptomatic and had no stressors. There was no evidence of hallucinations, paranoid ideation or first rank symptoms of schizophrenia. The Consultant gave him details of a day centre and in his letter (dated 8 March 2002) to the GP requested that the GP also encouraged him to attend[96].

8 May 2002. Mr. D attended the Outpatient Clinic and saw the Consultant. His only concern was that his muscles and bones appeared to "*stretch and have pressure".* Mr. D had seen a Harley Street specialist and had some investigations were carried out. He was due to be seen again in outpatients in September 2002[97].

18 September 2002. Mr. D was reviewed in the Outpatient Clinic. He had had a 'good' three month holiday in Turkey but was not working because of the 'physical pains' he was experiencing; he gave a description of how "shoulder pains cause him to have pressure on his brain". He was clinically stable on Olanzapine and not exhibiting any symptoms. The Consultant, Dr. 2, therefore, discharged Mr. D back to the GP for ongoing care on the understanding that should the GP have concerns he would be re-referred. Dr. 2 said

"Psychiatric examination revealed a friendly, relaxed male with no biological symptoms of depression; he was not suicidal, there was no aggressivity present... my impression is that Mr. D is now clinically stable...I am referring him back to your

care on the understanding that if you have worries about the patient in the future, he may be re-referred back to my clinic"[98].

1 October 2002. Mr. D's family collected a prescription for 28 tablets of Olanzapine 5mg.from the General Practice[99].

2 October 2002. Mr. D attended the General Practice with a minor psychical condition[100].

14 November 2002 and 12 December 2002. Mr. D's family collected a prescription for 28 tablets of Olanzapine 5mg from the General Practice[101].

2003

28 January 2003. The Care Coordinator wrote to Mr. D, inviting him to keep an appointment at the Tynemouth Road Mental Health Centre. Mr. D did not keep this appointment and there was no 'follow up' appointment.

Mr. D's father told us that he saw the Care Coordinator at the supermarket a couple of days later and she said she would visit Mr. D at home, but in the event she did not. There is no copy of this letter in the CMHT clinical records. The Care Coordinator said she had no recollection of this letter. A copy of the letter was given to the Investigation Team by the family of Mr. D.[102]

3 March 2003, 27 March 2003 and 9 May 2003. Mr. D's family collected a prescription for 28 tablets of Olanzapine 5mg from the General Practice[103].

13 June 2003. Mr. D attended the General Practice complaining of pains in his legs. The GP arranged some investigations and gave him a prescription for Olanzapine 5mg with three other items[104].

27 June 2003. Mr. D was given a prescription for Olanzapine 5mg and received 84 tablets as he was going on holiday for 3 months[105].

3 July 2003. One of the GPs completed an Incapacity for Work Form for Mr. D, stating "*paranoid schizophrenia*" as his diagnosis[106].

30 December 2003. Mr. D's family collected a prescription for 28 tablets of Olanzapine 5mg.from the General Practice.

2004

10th February 2004

Mr. D's Disability Benefit Form was completed by his GP[107].

29 March 2004, 29 April 2004 and 11 June 2004. Mr. D's family collected a prescription for 28 tablets of Olanzapine 5mg.from the General Practice[108].

17 June 2004. A prescription for 84 tablets of Olanzapine 5mg was prepared. This was never collected from the surgery.

Events in 2004 leading up to the Incident of the 23 December 2004

15 October 2004. Mr. D's mental health began to deteriorate. He became anxious and suspicious of his family. He was irritable and aggressive when upset about anything. His sleeping pattern changed in that he would get up in the night and wander about. His mother bought him a computer to give him something to do as he no longer went out. He was unable to use it properly despite being reasonably computer literate in the past. On one occasion he became very angry with his sister because she did not respond as quickly as he wished when he wanted her help. She wanted to watch the television; Mr. D switched it off, frightening her with his aggressive behaviour. She went upstairs and locked herself in her bedroom, putting a sofa up against the door. Mr. D continued kicking the door and eventually broke into the room having knocked the door out of its frame. He said he was the "*leader"* and talked about God despite not being religious. After about one hour he calmed down. His family were concerned enough to seek help[109].

15 October 2004. Mr. D's mother and his sister went to the Community Mental Health Team office at Tynemouth Road. One of the team members, a social worker and the duty worker that day, met with them and they told him that they were concerned about Mr. D's mental health and his recent behaviour in that he was very quiet and would not speak to the family. The duty worker checked Mr. D's records and found out that he had been discharged in 2002. The duty worker apparently tried to contact Mr. D's GP but the surgery was closed. He advised Mr. D's relatives to go to the GP when the surgery reopened later that day and gave the relatives his contact details inviting them to make contact if they had any further concerns. The duty worker was not alerted to any serious concerns during this visit[110].

Approximately Eight Weeks Prior to the Incident. Mr. D's father went to the Kate Marsden Unit and spoke to the receptionist. Following their conversation, Mr. D's father was told to go his GP[111].

25 October 2004. Mr. D's family collected a prescription for 84 tablets of Olanzapine 5mg, enough for three and half months, from the General Practice[112].

2 November 2004. Mr. D had an appointment with the GP but he did not attend[113].

Approximately Six Weeks Prior to the Incident

Mr. D's father informed the Investigation Team that he went to St. Ann's Hospital asking for Dr, S. He had no success[114].

Approximately Four Weeks Prior to the Incident. Mr. D's father visited Tynemouth Road MH Centre and requested to see the Care Coordinator who had previously visited them at home. They were told that she was on holiday, returning to work the following week[115].

Approximately Three weeks Before the Incident. Mr. D's father visited Tynemouth Road Mental Health Centre again and explained that his son was unwell, aggressive and needed to see someone. He told the reception staff that Mr. D was liable to harm himself or another person and that the family were 'unable to cope'. He asked for the Care Coordinator again, and was told that she was still on leave [116].

Later on the same day Mr. D's father went back to Tynemouth Road Mental Health Centre with his daughter because Mr. D was aggressive. He was again told to visit his GP[117].

Comment
This was Mr. D's father's fifth attempt to seek help for his son. He told members of the Investigation Team that at this point he felt let down by everyone and did not know what to do next.

30 November 2004. Mr. D's parents went to seek help from the GP as Mr. D would not go himself. According to the GP notes his parents asked for a letter for re-housing. The Clinical Record states

> *"Seen the parents – came on behalf of him – does not want to see me. Parents want a letter for rehousing +*
>
> *paranoid schizophrenia. Seen before Dr X to make an appointment with him".*[118]

This GP visited by the parents on the 30 November had not seen Mr. D before. He gave Mr. D's parents a note to give to the receptionist to arrange a home visit with a GP who had seen Mr. D previously. This GP gave Mr. D's parents a written instruction for the receptionist because he realised that the family had difficulties understanding English[119].

COMMENT
Mr. D's parents were supposed to give this 'post-it' note to the receptionist. They did not do this. As a result no home visit was organised and so did not happen. Mr. D's parents still had the note when we met them as part of this Investigation. When we interviewed the GP, he explained that he wrote the note for the receptionist to arrange a home visit. Although Mr. D's father understands some English, it was perhaps not sufficient for him to understand exactly what was being asked of him. The family left the surgery frustrated. This was the last time

they tried to obtain help for their son

13. Timeline and Identification of the Critical Issues

RCA Second Stage

Timeline

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

Critical Issues Arising from the Timeline

On examining the Timeline the Investigation Team identified 23 critical junctures directly arising from the care and treatment of Mr. D. When these junctures where reviewed it was found that they fell into six main categories. They are as follows:

1. clinical management of Mr. D: diagnosis, medication and treatment;
2. risk assessment and care planning;
3. Care Programme Approach (CPA);
4. Community Mental Health Team involvement;
5. quality of clinical documentation and communication;
6. Primary Care mental health provision.

Critical Issues arising from the Review of other Data

The Investigation Team also found other critical issues not immediately apparent from reviewing the chronology of Mr. D's involvement with mental health services. These are set out as follows:

1. service user engagement and involvement;
2. carer assessment and support;
3. cultural diversity and language;
4. clinical leadership and supervision;
5. organisation and management of mental health services;

These critical issues are the areas that the Investigation Team identified as requiring further exploration. It must be noted that although some areas have been identified as critical issues, critical issues in themselves do not always have a direct causal bearing on a critical incident. In other words an investigation will sometimes identify areas of practice that require examination and improvement, but these on their own may not have contributed to the events of 23 December 2004.

14. Further Exploration and Root Causes

14.1. 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 good practice;
2. areas of practice that fell short of both national and local policy expectation;
3. key casual factors.

14.2. Critical Issue Number 1. Clinical Management of Mr. D: Diagnosis, Medication and Treatment

Description of Events

This next section is very detailed. At the risk of repetition the Investigation Team felt that it was necessary to detail Mr. D's inpatient and outpatient history here in order to be able to isolate the key features of his care and treatment that required examination.

In total Mr. D had four inpatient admissions to St. Ann's Hospital. On the 4 June 2000 Mr. D was admitted for the first time following a referral from North Middlesex A&E. He presented with somatic symptoms. On admission to St. Ann's Mr. D was prescribed Droperidol 10mg and Lorazepam 2 mg. He gave the impression of having a psychotic illness. He was also distressed and suicidal[120]. On the 15 June Mr. D was discharged after having spent a total of two nights on the ward. Mr. D was discharged in his absence on Olanzepine 5mg.

On the 19 July 2000 Mr. D was seen in Outpatients by Dr. 1 where he claimed that Satan was giving him signs. It was noted that Mr. D had poor insight. Dr. 1 felt that

Mr. D had a depressive illness with paranoid delusion and that paranoid schizophrenia should also considered. His medication was changed to Citalopram 20 mg[121].

On the 27 July 2000 Mr. D was admitted as an informal patient following a self referral to North Middlesex A&E. It was deemed that he was psychotic and possibly suicidal. He was prescribed Olanzepine, but no medication is recorded as having been administered for this stay. The night nursing record noted that Mr. D was missing[122].

The next day on the 28 July 2000 Mr. D presented at the Whittington Hospital A&E, the doctor there telephoned the ward at St. Ann's to say that he was there. In Mr. D's absence, the Ward Manager partially completed a risk assessment for him. On the 1 August 2000 Mr. D had still not returned to the ward. On this date a ward round was held at which Mr. D was not present. It was decided that a home visit was required from Mr. D's CPN and that she would ascertain whether Mr. D was sectionable, or if not, would agree to return to the ward. The ward made four attempts to contact the CPN, leaving three messages for her[123].

On the 2 August 2000 the ward staff telephoned the CPN and spoke to her. She came onto the ward to collect Mr. D's medication. On the 3 August 2000 it was noted that the CPN had still not seen Mr. D. A decision was made on the 4 August 2000 to discharge Mr. D[124].

Comment
The decision to discharge Mr. D should not have been made until the home visit had taken place and the assessment made

On the 7 August 2000 an urgent message was left for the CPN requesting her to urgently call the ward and give them feedback regarding Mr. D's wellbeing. On the 8 August the ward spoke to the CPN again ascertaining that she still had not been able to see Mr. D but that she had posted his medication and Out Patient's appointment card through his letterbox. The ward was told that the CPN was planning to visit Mr.

D later that day. Mr. D was then formally discharged in his absence[125]. From this date the CPN was regarded formally as Mr. D's Care Coordinator.

Mr. D was seen in the Outpatient Clinic on the 18 August 2000 by Dr. 2 where it was noted that the psychotic element of his illness appeared to be remitted but that the somatic element remained. At this point Mr. D's Citalopam was increased to 40 mg[126].

On the 21 September 2000 a private doctor, who was consulted by Mr. D on three previous occasions, wrote to Dr. 2, Mr. D's consultant, stating that he believed Mr. D was suffering from severe depression and psychotic features. The private doctor also considered that Mr. D might be suffering from a mild schizophrenia and dysmorphia. He started Mr. D on Melleril and sought Dr. 2's advice. In a letter from Dr. 2 to Mr. D's GP he stated that he disagreed with the diagnosis and treatment instigated by the private doctor[127].

Dr. 2 saw Mr. D in Outpatients on the 10 October 2000; he noted that Mr. D was feeling better. Mr. D told Dr. 2 that the private doctor had prescribed Kemedrin (Procyclidine) 5 mg[128].

The private Doctor wrote to Dr. 2 again on the 24 October 2000 stating that the Olanzapine Mr. D was taking was making him tired. The private Doctor requested copies of Mr. D's medical records as he was planning on maintaining his contact with Mr. D[129]. The Investigation Team did not feel that the input from this private doctor required further exploration as it was clear that the medication changes made only occurred for a short period, some two to three weeks, and that four years prior to the events of the 23 December 2004. There is no evidence that this doctor continued to treat Mr. D.

On the 21 November 2000 Dr. 2 saw Mr. D in Outpatients. Mr. D continued to improve and appeared to be compliant with his medication[130].

On the 27 February 2001 and the 20 March 2001 Mr. D did not attend his Outpatient Clinic appointment. Dr. 2 made the decision to discharge Mr. D back to the care of his GP[131].

On the 20 May 2001 Mr. D was admitted to St. Ann's Hospital under Section (2) of the Mental Health Act (1983) for criminal damage and agitated behaviour. The Police had apprehended him as he had been found smashing gravestones in a local cemetery. It was noted during Mr. D's admission that he had been arrested two months previously for an unspecified offence, but had been released. On admission Mr. D required restraint and he was speech and thought disordered. He had delusional ideas and was found not to have been compliant with his medication for four months. His notes recorded a possible diagnosis of schizo-affective disorder, drug induced psychosis and hypomania. Mr. D was written up for Haloperidol PRN. In the section application it was noted that Mr. D's CPA key worker was cited as being Ms. X Her name did not appear again in any other part of Mr. D's clinical record. Ms. X was in fact the duty worker for that day and subsequently played no further part in care and treatment of Mr. D[132].

It was noted at the time that Mr. D presented with many somatic symptoms and that he continued to be paranoid and thought disordered. His medication was reviewed; Mr. D took this with encouragement and stayed on the ward. Over the next four days Mr. D stayed on the ward. There were concerns about his medication compliance. At the ward round on the 29 May 2001 an interpreter was present. Dr. 4 suggested that Mr. D should have a depot injection instead of oral medication. Mr. D's mother, who was at the round ward, refused this on his behalf. Mr. D was given a week's leave[133].

The next day on the 30 May 2001 Mr. D presented at A&E with chest pains and depression. Mr. D attended the ward on the 31 May 2001 with his mother but left before being seen in the ward round. At this stage Mr. D's medication was reviewed. He was contacted at home to say that his medication had been changed to Haloperidol 5 mg *nocte,* Risperidone 1 mg *nocte,* and procylidine 5mg BD[134].

On the 2 June 2001 Mr. D was diagnosed as having schizophrenia. During the ward round Mr. D, who was present, was discharged. He was discharged on Risperidone 2 mg for 3/7 increasing to 3mg 4/7 and then 6 mg daily. There was an expectation that the Care Coordinator would follow up Mr. D's care and treatment in the community[135].
On the 27 June Mr. D did not attend an Outpatient Clinic appointment. On the 25 September 2001 after being on holiday in Turkey Mr. D attended an Outpatient appointment with Dr. 2. Mr. D said that he had not been well with possible side effects from the Risperidone. His medication was written up to continue with Lustral 50mg[136].

On the 8 October 2001 Mr. D self-referred at the Outpatient Clinic. He was seen the next day by Dr. 2. Mr. D presented with somatic symptoms and anxiety. Dr. 2 increased the Lustral to 100 mg daily[137].

On the 5 November 2001 Mr. D was admitted to St. Ann's Hospital under police escort on Section 4 of the Mental Health Act (1983). The police had been called to the family home of Mr. D as his family were very afraid believing that Mr. D was going to harm himself. Mr. D did not accept that he needed to be in hospital and required rapid tranquilisation, seclusion and restraint. The diagnosis was that of relapsed schizophrenia and depression. It was noted that Mr. D's illness was not controlled on Risperidone. He was nursed on 1:1 observation[138].

On the 6 November 2001 at the ward round the decision was made to discharge Mr. D once his section had expired. It was noted that Mr. D's Care Coordinator had not seen him for some time. It was not felt necessary to detain Mr. D. No CPA papers were completed[139].

On the 13 November 2001 a discharge summary was sent and the Care Coordinator was contacted and told to arrange urgent follow up in the community. The family reluctantly agreed to take Mr. D home[140].

On the 22 November Mr. D had a reaction to his medication which was treated on the 1 December 2001. Mr. D was seen at Outpatient Clinic on the 10 December

2001, the 20 February 2002, the 8 May 2002 and the 18 September 2002 whereupon he was discharged by Dr. 2 back to care of his GP[141].

Issues Raised and Analysis by the Independent Investigation Team

During Mr. D's contact with the mental health services in Haringey a pattern emerges. The pattern is typified by an overall lack of decision making and follow up procedures. Decisions were made to admit Mr. D on four occasions, twice under a section of the Mental Health Act (1983), but no progress regarding Mr. D's long term condition appears to have been made. The Investigation Team found several issues related to the above sequence of events. They are encapsulated as follows:

1. diagnosis;
2. medication;
3. failure to utilise the Mental Health Act effectively;
4. failure to engage with Mr. D;
5. somatic presentation;
6. lack of a contingency plan as Mr. D was known not to be compliant with his medication;
7. poor documented communication between the Care Coordinator, the ward staff and the Consultant psychiatrist.

Diagnosis

From Mr. D's first contact with mental health services a general diagnosis of 'psychosis' was made. At the time of Mr. D's first admission his psychosis was thought to have been possibly induced by Khat.

It is the view of the Investigation Team that the label of 'psychotic illness' was appropriate at the stage when Mr. D first presented. It is not always possible to give a more certain or specific diagnosis of what may appear as an undifferentiated psychotic state. At the time of Mr. D's first admission a more certain diagnosis of say, schizophrenia or mania would not necessarily have been appropriate, especially in the context of his possible drug misuse.

The uncertainty regarding the specificity of the diagnosis is reflected in the diagnosis made by Dr. 1, and reflected in his letter following Mr. D's outpatient appointment on 19 July 2000, when he clearly notes the presence of delusions and considers the possibility of both a depressive illness with psychotic symptoms and paranoid schizophrenia[142].

On Mr. D's subsequent admissions to hospital there seemed to have been little doubt that Mr. D was thought to have a psychotic illness, although the definitive diagnosis of schizophrenia or an affective disorder was never settled upon (for example, see admission in May 2001[143]) until the final admission in November 2001 when a diagnosis of schizophrenia was indisputably made. Subsequent independent opinions appear to confirm this diagnosis. Despite having made this diagnosis, Mr. D's non compliance with medication, his lack of insight and his family's limited understanding, no coherent care plan was put in place and neither was he made the subject of enhanced CPA. It is the opinion of the Investigation Team that Mr. D ought to have been considered for enhanced CPA at this stage as he had recently been sectioned, brought to hospital under police escort and had a clinical presentation that required this measure be taken.

A key issue that the Investigation Team considered was that of somatic presentation. It is difficult to understand the exact significance of Mr D's complaints of somatic symptoms. At times these appear to have been of a delusional nature and part of his psychotic illness. At other times he appears to complain of medically unexplained symptoms in the absence of psychosis, this later type of presentation appears to be consistent with general evidence about somatic presentation:

"Cultural contexts are important to the assessment of mental health. Ethnicity, i.e., belonging to a particular cultural group is thought to account for differences in the presentation of psychopathological symptoms and in the utilization of community mental health services across cultures the presentation of medically unexplained physical symptoms, is a major cause of hidden psychiatric morbidity in primary care settings[144]"

Somatic presentation is a topic far too complex to do justice to in the body of this report. However international research has shown that refugee and immigrant populations do have a significantly high rate of somatic presentation particularly when suffering from depression.

In Mr D's case it is possible that some of his somatic symptoms that occurred in the absence of psychosis may have related to dysphoria and arousal that he experienced when recovering from his acute psychotic states. Whilst these were not ignored by the clinicians treating him, they were probably not understood by them. Whilst it is difficult to know how much this may have disadvantaged Mr D's management, it did affect his consulting behaviour as he consulted several other doctors outside the mental health services which may have lead to changes in prescribing which were unnecessary.

Medication

Throughout Mr. D's contact with mental health services Mr. D was given medication appropriate for the treatment of a psychotic disorder, including schizophrenia. During his first admission in June 2000 Mr. D was treated with Olanzepine, an antipsychotic drug, and was given this when he left hospital. By the time of his outpatient appointment on 19 July 2000 he had stopped taking Olanzepine and he was prescribed Citalopram, an antidepressant, by the Locum Consultant, Dr. 3. The Investigation Team considered this to be appropriate for the hypothesised diagnosis made at that time of depression with delusions. However it was not clear why an antipsychotic medication was not continued as this would have been appropriate.

During Mr. D's second admission he was again treated with Olanzepine (as appropriate) and an antidepressant, Paroxetine. Mr. D continued to be prescribed these medications as an outpatient (for example when seen in outpatients by Dr. 2 on 18 August 2000[145]). During Mr. D's third admission in May 2001, which appears to have been precipitated by his non-adherence to medication, he was again appropriately given Olanzepine. Mr. D was also prescribed Haloperidol and Lorazepam during this admission, these two drugs being commonly given to reduce arousal and psychosis in an acute phase.

The Haloperidol and Lorazepam were not given to Mr. D on his discharge from hospital and his medication was changed to Risperidone, an antipsychotic drug. This medication change was made in Mr. D's absence from the ward. He was finally discharged on an increasing regime of Risperidone 2mg increasing to 3mg and then to 6 mg.
However this dose regime would not usually be recommended practice for someone who was known to have poor adherence to oral medication, especially when the dose was to be increased to 6mg as at that dose the risk of extra-pyramidal side effects (rigidity, abnormal movements and tremors) increase.

These side effects are well known to reduce adherence on the part of the service user if they occur. Mr. D did seem to experience these side effects, as recorded in the outpatient clinic on 25 September 2001[146].

During Mr. D's third admission the use of a depot antipsychotic medication was considered. This was appropriate in the context of a service user with poor adherence to oral medication; however the depot injection was not prescribed possibly owing to Mr. D's mother not wishing for it to be given[147]. The Investigation Team could not understand how her view was allowed to override a clinical decision made in the best interests of the service user by a doctor.

During Mr. D's final admission in November 2001 he was again treated with Risperidone and given this when he was discharged from hospital. He experienced extra-pyramidal side effects as an outpatient and was changed to Olanzepine. He seemed to tolerate the Olanzepine and appeared to be adherent to it when he was discharged from mental health services back to the care of his General Practitioner in September 2002[148].

In general it is the view of the Investigation Team that the use of antipsychotic medication in Mr. D's case seems to have been appropriate and was within acceptable practice. The main drug used was Olanzepine, a newer atypical antipsychotic approach which is widely used in clinical practice and has a low risk of extra-pyramidal side effects which are not liked or tolerated by service users. Mr. D's

adherence to medication was often poor and several factors may have affected this. They are as follows:

1. All four of Mr. D's admissions to hospital were short and this made a thorough assessment of his condition and response to treatment difficult. This particularly applies to his admission in May 2001 when he was placed on Section 2 of the Mental Health Act (1983) and this was rescinded before the 28 day period. It was during this admission that depot medication was considered and he was given Risperidone shortly before his discharge from hospital. There was no reasoned argument as to why Mr. D was discharged before the Section was due to run out, after all the main reason for using this section was to observe, monitor and commence a care plan which required input from both Mr. D and his family.

2. The inadequate follow-up and engagement by the Community Mental Health Team (CMHT) and lack of adequate supervision of his medication adherence (see section below on CMHT inputs)

3. The visits to a private General Practitioner led to a short term disruption in Mr. D's NHS prescribed medication regime which may have led to clinical changes in, and confusion for, Mr. D. Mr. D's NHS Consultant should have actively followed this up as invited to do so by the private doctor concerned

4. The discharge of Mr. D from mental health services after four admissions in a person with known schizophrenia who had engaged in aggressive public acts (one in response to psychotic symptoms) who was never adequately engaged with the CMHT and who had no clear crisis or contingency plans in place

Failure to utilise the Mental Health Act effectively

On two occasions Mr. D was admitted under a section of the Mental Health Act. It is the view of the Investigation Team that the Mental Health Act could have been used to better effect than it in fact was.

Mr. D's clinical team did not take advantage of the opportunity to observe and assess Mr. D that was offered to it. Mr. D's last two admissions gave the team an opportunity to stabilise him and to understand him better. This is considered to be a key causal factor in the care and treatment of Mr. D leading to the subsequent deterioration of his mental health in 2004.

The fourth admission should have been managed differently. There was a 72 hour detention order in place. A section 3 (MHA 1983) would have been justified at this stage, particularly as Mr. D's family were afraid of him and felt unable to take him home. Mr. D was not engaged with any member of the clinical team, was still complaining of the same symptoms and was becoming more violent. Treating Mr. D in the community no longer appeared to be an ideal option. There was an opportunity to intervene and this was not taken.

Failure to Engage with Mr. D

The failure to engage with Mr. D is a hallmark of the care and treatment that he received. The Investigation Team considers this to be a significant factor that runs throughout all of the other critical issues and casual factors identified and analysed. During Mr. D's contact with mental health services in Haringey no concerted effort was made to develop an enduring therapeutic relationship with either him or his family.

Mr. D only spent short periods of time on the ward during his admissions; this made it difficult for engagement of any kind to take place especially during his first and fourth admissions. However there appears to have been no real effort made to get to know him on his second and third admissions despite the fact that he spent more time on the ward. For example, Mr. D is described as laying on his bed, pleasant and manageable, and happy to walk outside on his own[149]. No real attempt appears to have been made by the nursing staff at this stage to understand the dynamic of Mr. D's mental illness, his social and cultural situation and his ongoing needs.

This pattern of non-engagement is constant throughout Mr. D's inpatient, outpatient and community-based care and treatment. This is compounded by the fact, that for most of this time, Mr. D and his family were often reluctant to engage with mental

health services. Failure to engage ensured that Mr. D's condition was never fully understood, treated or monitored appropriately.

It is a fact that for Mr. D's first two CPA planning meetings the sessions occurred in his absence. Mr. D was present during the CPA planning meeting held towards the end of his third admission. However, although Mr. D's signature can clearly be read on the paperwork, it is unclear how well either he or his family understood the plans that were being put in place to ensure his future mental wellbeing. A great deal of emphasis was placed on the Care Coordinator support that was being proposed, and for Mr. D and his family to trigger additional support if they felt it was needed[150].

The Investigation Team concluded that it is never good practice to place the chief responsibility for engagement with services onto the service user and their carer's, if they have any, whilst they are still coming to terms with their diagnosis. It is very common for people with mental health problems to have varying levels of insight into their condition. In the case of Mr. D it was clear that he had no acceptance of, or insight into, his illness. This was coupled with a history of poor compliance. Mr. D's family often covered up for their son and played down his condition. This is not uncommon with families when coming to terms with the fact that someone they love has been diagnosed with a life changing illness. Basically Mr. D had little or no insight into his condition, and his parents could not accept that their son was mentally ill. This did not form the best basis for engagement with services.

Summary View of the Independent Investigation Team

The Investigation Team did not find any key causal factors stemming from the diagnosis and medication regime that Mr. D was subject to, but the Team was concerned about the apparent lax attitude to monitoring his medication especially at times when new drugs were introduced.

However the Investigation Team did feel that the failure to use the Mental Health Act (1983) effectively when taken in combination with the lack of engagement with Mr. D were key causal factors which contributed to the breakdown of Mr. D's mental health in 2004. The reasons are summarised as follows:

1. significant history of non-compliance with medication;

2. significant history of acts of violence and aggression when unwell;

3. Mr. D's lack of insight into and non-acceptance of his condition coupled with the failure of mental health services to address this throughout his contact with them;

4. Mr. D's new diagnosis of schizophrenia at the end of his fourth admission and his subsequent discharge with no crisis or contingency plans drawn up;

5. Mr. D's rapid discharge following his fourth admission meant that no meaningful dialogue occurred with Mr. D and his family as to what his new diagnosis would mean for him personally. The symptoms and management of his mental illness were not discussed with either Mr. D or his family.

The Investigation Team felt that Mr. D's care was severely compromised by the lack of consistent medical management throughout the period of his care and treatment at Barnet, Enfield and Haringey Mental Health Trust. For this the Consultant Medical Team must take a great deal of responsibility. It was not possible for the Investigation Team to locate Mr. D's key psychiatrists in order to invite them for interview although every effort was made to do so. Because of this it was not possible to interview them and the Investigation Team were not able to make a detailed critique of the medical interventions taken. However the Investigation Team would like to state, from the evidence made available to them, that the standard of medical care, treatment and management fell below those indicated for a service user with the diagnosis, risk and symptoms that Mr. D presented with.

- ***Key Causal Factor Number 1. Failure to use the Mental Health Act effectively.***
- ***Key Causal Factor Number 2. Failure to engage with Mr. D and his family.***
- ***Key Causal Factor Number 3. Failure to manage the ongoing care, risk and treatment needs of Mr. D. This had a direct bearing on the***

breakdown of the mental health of Mr. D in 2004 and the delay in marshalling responsive services that would have been able to help and support him.

14.3. Critical Issue Number 2. Risk Assessment and Care Planning

Description of Events

It was obvious to the Investigation Team that Mr. D presented with significant risk factors. This view was partially garnered from the fact that Mr. D had been admitted under police custody on two occasions when he had been both violent and aggressive requiring a period of restraint and seclusion on his last admission.

The Investigation Team were also aware of Mr. D's forensic history, particularly the events of 8 December 1998 which had led to Mr. D being held on remand at Pentonville Prison for a period of 6 six weeks and a conviction of Actual Bodily Harm (ABH) in January 2000 resulting in a year-long Combination Order in January 2000[151]. It remains unclear to the Investigation Team whether or not the mental health team were aware of this previous and very relevant conviction. It is especially concerning because Mr. D was still subject to the Probation Combination Order during the time of his first two admissions.

Equally unclear to the Investigation Team is why Mr. D was not formally charged with carrying an offensive weapon in April 1999 when he was apprehended and cautioned by the police[152]. At this stage Mr. D had been remanded for ABH and was awaiting his court appearance.

Risk assessments were completed by the inpatient team on the 29 July 2000, the 20 May 2001, the 26 May 2001 and the 6 November 2001. The Investigation Team acknowledge that risk assessment procedures across London in 2000 and 2001 were not robust processes, however in this case risk behaviours were identified in the clinical notes but do not appear to have formed part of the assessment and management of the care and treatment package offered to Mr. D.

Issues Raised and Analysed by the Independent Investigation Team

On reviewing the clinical record Mr. D's risk behaviours were identified as being:

1. lack of insight;
2. non engagement;
3. non compliance to drug regime;
4. history of drug misuse;
5. unclear diagnosis;
6. suicidal thoughts;
7. aggression;
8. threatening and violent behaviour.

At the point of Mr. D's third admission under Section 2 (MHA 1983) on the 20 May 2001 a pattern of escalating risk behaviour is clearly identifiable from the inpatient medical and nursing notes. This history however was not taken into account during Mr. D's fourth admission only a few months later.

The care planning process that Mr. D was subject to was considered by the Investigation Team to be quite basic and not related to the distinct problems that he presented with, in particular; non compliance, violence, aggression and drug misuse. There is no evidence that either Mr. D or his family were either formally or informally involved with this aspect of his treatment and care whilst subject to inpatient services.

Summary View of the Independent Investigation Team

Mr. D's third admission was the opportunity for the inpatient clinical team to have recognised a distinct pattern of risk behaviours. Mr. D's risk assessments were not always coherent or complete. They definitely did not appear to be part of a dynamic process designed to form the framework under which a management plan could be put into place. This ensured that no crisis plan or contingency plan was adequately prepared and this contributed ultimately to the fact that when Mr. D's mental health broke down in 2004 there was no safety net in place to manage his care, support his family and protect the public. The Investigation Team found the poor quality of risk assessment to be a direct causal factor in the subsequent breakdown of Mr. D's mental health.

- ***Key Causal Factor Number 4. Lack of adequate risk assessment that formed part of a dynamic care and management plan process.***

14.4. Critical Issue Number 3. Care Programme Approach (CPA)

Description of Events

Mr. D was the subject of three formal CPA meetings between 15 June 2000 and June 2001 that were held at, or around, the point of discharge for his first three admissions[153]. No CPA meeting was held at the point of his fourth discharge on 6 November 2001.

There appears to have been no involvement with the designated Care Coordinator or other CMHT representative at each CPA meeting organised by the ward, and no further CPA meetings were documented, arranged or held by the named Care Coordinator at any other time as would normally be expected.

The inpatient medical records did record a CPA meeting being held on the 29 May 2001 at which both Mr. D and his mother were present, although this meeting was not transcribed onto the correct CPA format and was therefore not communicated to anyone[154].

By the time Mr. D had been discharged for the third time on 6 November 2001 the CPA documentation had been changed. By this time the format incorporated risk assessment and crisis/contingency planning with the adoption of enhanced and standard levels. The documentation indicates that the levels of CPA, e.g. the level of risk and need, attributed to Mr. D was increasing at each discharge as he was rated level 1 on 15 June 2000, level 2 on 8 August 2000 and finally enhanced care on the 15 June 2001[155].

The CPA documents for the meetings held on the 15 June and 8 August 2000 were present in both the CMHT file and the General Practice records; the CPA record for the meeting held on the 5 June 2001 was present in the General Practice records but were absent from the CMHT files; there are no records beyond the medical notes for the meeting held on the 13 November 2001. Mr. D's Care Coordinator stated that

she had no knowledge of any CPA's for Mr. D following his discharge from her caseload on the 28 February 2001. The Care Coordinator also claims not to have been sent any further CPA documentation[156]. In Mr. D's case it was usual practice to hold CPA meetings in the absence of the patient and his family with changes to medication often being made at the point of discharge.

The Investigation Team found that the CPA documentation for Mr D was often incomplete and the paperwork that was present did not elaborate on details of need, presentation, or risk that had indeed been recorded elsewhere in the medical and nursing inpatient notes. This meant that the CPA documentation did not reflect the individual and particular needs of Mr. D.

The only CPA documentation held within Mr. D's clinical records were confined to the inpatient multidisciplinary team usually comprised of the Consultant Psychiatrist and other members of the medical team, the Ward Manager, a staff nurse and an occupational therapist. This practice was not what was regarded as best practice for the time by the clinical staff that the Investigation Team interviewed. These witnesses held the view that:

1. " A CPA should not take place unless the Care Coordinator is there"[157]

2. "There was the expectation that the CPA's [meetings] were organised so that Care Coordinators were there. This did not always happen"[158]

The Care Programme Approach has four main elements as defined in *Building Bridges: A Guide to the Arrangement for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People*, DoH (1995)[159]. They are as follows:

1. **Assessment to involve:** systematic arrangements for assessing the health and social needs of people accepted by specialist mental health services.

2. **A Care Plan to involve:** the formulation of a plan of care which addresses the identified health and social care needs.

3. **A Key Worker (now Care Coordinator):** to keep close touch with the patient and to monitor care.

4. **Regular Review:** to provide ongoing assessment and if need be, agreed changes to the care plan

Issues Raised and Analysed by the Independent Investigation Team

The CPA process in operation at Barnet, Enfield and Haringey at the time Mr. D received his care and treatment was reflective of a traditional medical model in that an assessment and care plan was drawn up relating to the allocation of a Community Psychiatric Nurse and Outpatient follow up. There was no reference to social, financial or cultural issues or to the potential needs of the family. The CPA assessments for Mr. D lacked any form of individual analysis suggesting the notion that the process was merely a paper exercise that was systems driven.

This was further compounded and evidenced through the inconsistencies and contradictions in approach as borne out at the time of Mr. D's second discharge. On the 1 August 2000 it was agreed at the ward round, which doubled as the CPA meeting, that Mr. D required assessing under the Mental Health Act, and yet it was also stated that if Mr. D did not wish to return to the ward he should be discharged[160]. It was also noted by the Investigation Team that the discharge date for Mr. D was inconsistently recorded across the inpatient, CMHT and primary care record. The date on the copy of the CMHT file reads the 1 August 2000 and the copy in the primary care record reads 8 August 2000. The inpatient copy appears to have the date altered from the 1 August to that of the 8 August 2000 possibly demonstrating a degree of indecision and inability to make decisions about the care and treatment of Mr. D.

There is no documented discussion about clinical need or level of risk in either the nursing or medical notes. As a consequence the allocation and grading of CPA seems to have been an arbitrary decision process possibly made by the person completing the paperwork as there is no documented discussion about clinical need or level of risk in either the nursing or medical notes, nor is there any reference to eligibility criteria operational within the CMHT. In the case of Mr. D the CMHT appear

to have accepted the ward's decision about Mr. D's CPA level without any further input from themselves. Likewise the decision made by the Care Coordinator in February 2001 to discharge Mr. D from her caseload was made without any documented discussion or CPA meeting held with any other healthcare professional currently then engaged with Mr. D's care and treatment[161].

During the course of the Investigation the Team were able to access the CPA Policy for the Trust dated 1996 and a later version dated 2003. It was not possible to access the Operational Policy for the CMHT for 2001/March 2002 as this document was not archived by the Trust and no longer exists. A document however was available to the Investigation Team regarding CMHT Operational Policy dated from April 2002.

These documents explain how CPA referrals were made during the period that Mr. D was an inpatient. The process of referral to the CMHT was verified by witness interviews. On referral a form and the completed CPA documentation would be sent to the CMHT by both post and fax. This would then be formally allocated to the designated Care Coordinator, or allocated to a new Care Coordinator if the patient was a new referral. If a patient had been previously discharged then the Team Manager would make the decision as to whom the case would be allocated. The Investigation Team were told that is was 'unusual' for any CPA paperwork to go missing between the referral from the ward team and the allocation at the CMHT[162].

The CPA allocation communication system appears to have been well established and robust. The Investigation Team received no explanation as to why the CPA papers for Mr. D's third admission were absent from the CMHT folder and why no one from the CMHT appears to have acted as Mr. D's Care Coordinator, despite the clear expectation from the Medical records from the ward that the designated Care Coordinator would be following Mr. D up after his discharge[163].

Manager 2, a CMH Team Manager during the period that Mr. D received his care and treatment, was interviewed by the Investigation Team. She stated that there were some poor practices at that time whereby the ward staff would often put a CPN's name down as the Care Coordinator if there had been previous contact with a

patient[164]. However this was not cited as an explanation as to why no CPA follow up occurred after Mr. D's third and fourth discharges.

Summary View of the Independent Investigation Team

It is the view of the Independent Investigation Team that the CPA process employed by the Barnet, Enfield and Haringey Trust was flawed in many ways during the period that Mr. D received his care and treatment from the Trust. This is summarised as follows:

1. **Communication**: processes were poor. This was illustrated by inadequate communication channels and processes between inpatient, outpatient and CMH teams. It would appear that communication and discussion did not take place in formally arranged CPA meetings. Instead conversations were purported to have been conducted over the telephone and these conversations were often not recorded in the patient clinical records. Because of this assumptions were made regarding the support and monitoring that Mr. D was receiving in the community, assumptions that were not based on fact and were often misleading.

2. **CPA as a systematic process:** there was no evidence to suggest that CPA had been adopted as a process within the patient file for Mr. D in any shape or form by the community-based Care Coordinator and that it was little more than a paper exercise for the ward-based team.

3. **Assessment and care planning:** the CPA did not form an assessment of Mr. D's need and did not constitute a care plan. In short the CPA practice fell short of both national and local policy expectation.

4. **Family and carer input:** there is no evidence to suggest that Mr. D or his family had any input into the CPA process or understood how it would serve to address the needs of Mr. D.

5. **Record keeping:** the standard of record keeping utilised at this time was poor and well below what would be considered as acceptable by healthcare professional bodies. The enhanced CPA documents were missing from the

CMHT file and that this must be seen in the light of other record keeping anomalies detailed in section 13.4 below.

The Independent Investigation Team believe that the failure to operate a coherent CPA procedure was a key causal factor in the breakdown of Mr. D's mental health in 2004 in that he was not assessed and monitored in a manner that was timely and appropriate. No process was in place to predict and prevent Mr. D's relapse thereby ensuring that an appropriate treatment response could be instituted.

- ***Key Causal Factor Number 5. Non compliance with a coherent CPA process. The lack of which prevented the ongoing assessment, monitoring and treatment of Mr. D in the community.***

14.5. Critical Issue Number 4. Community Mental Health Team Involvement

This section has two distinct themes that are inextricably woven. They are:

1. clinical practice (part a)

and

2. clinical records (part b)

The Investigation Panel was initially focused on:

- the Care Coordinator; recollection of events;
- the level of contact the Care Coordinator had with Mr. D;
- the use of interpretation services;
- the assessment process;
- the use of CPA;
- supervision.

Description of Events

Clinical Practice (part a)

The first CMHT referral regarding Mr. D was received on the 16 June 2000[165]. His case was allocated to a CPN who was his named Care Coordinator, for an assessment at his home with a view to completing a full needs assessment and plan of care to meet any identified needs. At this stage Mr. D had been placed on level 1 CPA reflecting his first contact with mental health services.

At this time the Care Coordinator was an experienced community nurse having worked with the Home Treatment Team for five years working with individuals and their families who were experiencing first onset psychosis through psycho-social interventions. It was reported by the Care Coordinator at her interview with the Investigation Team that she had completed training in psycho-social interventions[166].

During the interview process the Investigation Team were told by witnesses that the CMHT from which Mr. D received his care and treatment had a social worker manager and a nurse manager who worked differently in accordance with their particular professional responsibilities and duties. The witnesses interviewed recognised that the CMHT at the time Mr. D was receiving his care and treatment was not a properly integrated mental health and social work team, and that both nurses and social workers worked within traditionally accepted roles. It was noted that the sickness levels of the staff were generally good and were considered to be within acceptable ranges[167].

At the time of Mr. D's first contact with mental health services case load numbers within the CMHT were around 35 - 40 for a whole time equivalent nurse and 25 for a whole time equivalent social worker. This is higher than the Department of Health Mental Health Policy Implementation Guide would recommend[168]. However it was explained to the Investigation Team during the interview of Manager 2 that "*some of the patients had been on case loads for a very long time*" and that a significant percentage of these patients did not require regular follow ups. Apparently it was the preferred practice of Dr. 2, Mr. D's Consultant Psychiatrist, that every patient once admitted who had a long term mental health problem, should "have a nurse for life"[169].

The Care Coordinator was interviewed twice by the Investigation Team, for the first time on the 22 February 2008, and for the second time on the 25 April 2008. At the time of the first interview the Investigation Team had been working from a set of photocopied notes as the original notes had not been available from the Trust in time to ensure that all Team members had had the opportunity to view them prior to the first day of interviewing. At this first interview the Care Coordinator was given the original notes in order to refresh her memory. After the interview the Investigation Team scrutinised the original CMHT file and noted significant discrepancies and concerns around dates and entries that warranted recalling the Care Coordinator back for a further interview.

At the first interview, the Care Coordinator when questioned by the Investigation Team could recall the physical attributes of Mr. D and his mother very clearly. She was able to inform the Team that Mr. D was fluent in English, not requiring an interpreter, and that his mother's English was very limited. At interview the Care Coordinator was able to recollect that " *the first thing that comes to mind was his [Mr. D's] preoccupation with his physical health and well being and that this always seemed to be a common theme that came up in relation to any long conversation with him*"[170]. However the Care Coordinator was very vague about her interventions in the case and could recall very few details even with the aid of the case notes that had been provided for her.

The Care Coordinator was asked by the Investigation Team how she found out about the incidents of 23 December 2004, and said that she had an immediate recollection of the name and the fact that she had worked with him as she had "*a feeling of extreme terror and concern for his family, thinking what have I done wrong*?" which the Team recognised as a natural reaction of concern after a serious incident rather than an admission of having done anything wrong[171].

It is unclear from the CMHT case notes exactly how many times the Care Coordinator visited Mr. D at his home. On initial reading it appears that she visited Mr. D on four occasions, usually with his mother present. *The Care Coordinator was unable to determine from viewing her own clinical notes how many visits she had in fact made to Mr. D. The Investigation Team did not think that four visits were*

sufficient in the light of the expectations of the inpatient Consultant Psychiatrist and the plan of care as set out for both of Mr. D's first two discharges. Neither the Care Coordinator nor the Investigation Team could establish how many times she met with Mr. D.

There were two recorded visits in the CMHT notes when the Care Coordinator was accompanied by an interpreter, on the 2 November 2000 and the 29 November 2000, as it was recognised that "*the message wasn't getting conveyed at its best*". On other occasions the Care Coordinator said that she spoke to Mr. D's mother in order to obtain "*feedback*" about Mr. D's condition. The Care Coordinator explained to the panel that she had to "*speak much slower, take your time, confirm maybe repeat, and sometimes use simpler words to ensure the message is being conveyed*"[172]. The Investigation Team members who subsequently met Mr. D's mother found that in their experience her command of the English language was too poor for any exchange with the Care Coordinator to have been meaningful if conducted in the absence of an interpreter.

The Care Coordinator made her initial visit to Mr. D on the 29 June 2000 two weeks after Mr. D's first discharge. The next face-to-face contact that the Care Coordinator had with Mr. D was on the 2 November 2000 following his second admission and discharge. It is appreciated that the Care Coordinator had attempted other visits but that Mr. D had not been at home. However the Care Coordinator had been charged with conducting a full needs and risk assessment. This was not done, and neither was her difficulty in doing so reported back to Mr. D's Consultant Psychiatrist. An assessment finally appears to have been completed seven months after it was first requested, but was of poor quality. It is the view of the Investigation Team that this should have been conducted within 4-6 weeks of Mr. D's first discharge with any difficulties reported to Mr. D's Responsible Medical Officer without delay.

According to the CMHT file an attempt was made to visit Mr. D on the 8 August 2000[173], four days after his second discharge, however he was not seen. The Care Coordinator's conclusion, even though she had not seen Mr. D was that "*there was no evidence of psychotic symptoms or risk of harm to self or others*" and that "*it would appear that he is continuing to abuse drugs as his parents are unhappy that he spends long periods of time out of the house or sleeping*[174]". The Investigation

Team felt that it was not helpful to conclude that Mr. D's behaviour was attributed to his drug taking and that depression and psychosis were overlooked. The Investigation Team also felt that the Care Coordinator's conclusion about the lack of psychotic symptoms was premature as she had only met him once, and that was four weeks prior to his second admission.

Two months later in October 2000 there was an entry in the CMHT file recording a telephone conversation that the Care Coordinator had had with Dr. 2, Mr. D's Consultant. The Care Coordinator repeated the opinion that Mr. D was "*not showing symptoms of psychosis, concerned only with aches, pains and his skin*" although her only visit to him had been in June[175].

On the 2 November 2000 a further contact was made with Mr. D and an initial assessment form was completed.

On the 29 November 2000 a delusional scale was completed (although this document was not actually dated). This scale indicated that Mr. D had a preoccupation with his physical functioning, however little significance was placed on his somatic symptoms. The initial plan was to also complete a Becks Depression Inventory, this was not done. An interpreter was present at this visit and relapse indicators were identified with Mr. D and his mother.

The Care Coordinator informed the family that this would be her last visit. The Care Coordinator stated in a written statement to the Investigation Team that fortnightly meetings took place between her and Mr. D's Consultant. However there is no documented record of these meetings ever having taken place in Mr. D's clinical record. The Investigation Team could find no evidence of prior consultation, discussion or liaison with either Mr. D's Consultant, Dr. 2, or his General Practitioner. There was no evidence to suggest that written or telephone communication subsequently took place to inform either of them of the decision made by the Care Coordinator as could be expected from the 1996 Trust CPA Policy. As far as the Care Coordinator was concerned the case was closed although she did go on to visit Mr. D on two further occasions early in 2001. The Care Coordinator did not remember any further communication with the inpatient team regarding her future

role regarding the care and treatment of this patient[176]. This despite subsequent recorded communications in the medical notes between inpatient clinicians and the Care Coordinator following Mr. D's third and fourth discharges.

Issues Raised and Analysed by the Independent Investigation Team

The Investigation Team were concerned by several key issues in the medical notes, the inpatient nursing notes and the CMHT notes regarding the quality of care that Mr. D received from community services, and in particular his Care Coordinator. There were also key discrepancies between the Care Coordinator's recollections and those of Mr. D's mother and father. These concerns were as follows:

1. Why were the instructions and discharge plans for Mr. D not actioned by the Care Coordinator?

2. Why did the Care Coordinator discharge Mr. D from her case load without prior apparent consultation with other colleagues?

3. Why did the Care Coordinator have no further recollection of Mr. D and his last two admissions and discharges when the medical inpatient records clearly document telephone conversations with the Care Coordinator regarding Mr. D and her future role in his care?

4. Why did the Care Coordinator not make the urgent domiciliary visits that had been requested of her on 1 August 2000 and the 13 November 2001?

5. Why did the Care Coordinator not comply with the CPA Policy and communicate with both Mr. D's Consultant Psychiatrist, Dr. 2, and General Practitioner regarding her difficulties in engaging with Mr. D?

6. Why did Mr. D's mother and father have a written communication from the Care Coordinator two years after she said she had discharged Mr. D, and why was this communication not placed within the CMHT file?

7. Why were the Care Coordinator's clinical records incomplete and confusing, particularly with regard to date changes and apparent record amendments (please see below)?

The Investigation Team does not think that the Care Coordinator made domiciliary visits to Mr. D that were either timely or sufficient enough in nature to, a) build up a relationship with him and, b) to be able to provide a professional and robust assessment of his risks and needs. The visits that were made fell far short of the expectations of the inpatient clinical team and Mr. D's Inpatient and Outpatient Consultant Psychiatrist. However due to the lack of communication between the inpatient, outpatient and CMHT teams it appears that no one else was aware of the lack of contact and progress being made by the Care Coordinator.

The Investigation Team believe that the initial assessment for Mr. D should have been conducted within an interval of one month, not the seven that it finally took. The assessment should also have been more rigorous and complete and communicated back to Mr. D's Consultant.

The Care Coordinator's decision to discharge Mr. D appears to have been taken without prior consultation with either Mr. D's Consultant Psychiatrist, Dr. 2, or General Practitioner. The Care Coordinator had not completed her assigned programme with Mr. D and she gave no rationale for her action in the CMHT file. The Investigation Team could not understand why the Care Coordinator finally decided to discharge Mr. D once it appeared that he had decided to engage with her, albeit reluctantly.

Comment
If contact had been continued at this point a therapeutic relationship could have been developed

The Care Coordinator stated in both her interviews that she had no recollection of any contact with, or communication regarding, Mr. D after February 2001. This recollection runs counter to the evidence to be found in the inpatient medical records where on several occasions telephone conversations with the Care Coordinator have been recorded regarding Mr. D.

It also runs counter to the recollections of Mr. D's parents. When Mr. D's parents were interviewed they produced a letter written on Trust headed paper from the Care Coordinator dated the 28 January 2003. The purpose of this communication was to arrange a visit for Mr. D to meet with the Care Coordinator. Mr. D's parents recalled meeting the Care Coordinator at a supermarket car park shortly after the letter was received; they had a conversation with the Care Coordinator asking her to visit Mr. D at home as they did not believe that he would keep his appointment at the clinic. Apparently she agreed to this, but no further communication was made. There is no trace of this letter in the CMHT file.

The Investigation Team also could not discover why the Care Coordinator despite being requested to visit Mr. D urgently over the telephone did not do so. The Care Coordinator had no recollection of these phone messages and stated that the CPA documentation following Mr. D's third and fourth discharges was never seen by her, despite the third set being sent to and received by Mr. D's General Practitioner.

During the course of the Investigation significant concerns were raised regarding the quality of the CMHT clinical records. This will be explored directly below.

Summary View of the Independent Investigation Team

It is the view of the Investigation Team that there was a significant systems failure in that a disjointed tripartite system was operating whereby inpatient services, outpatient services and community mental health teams operated separately. At the time that Mr. D was receiving his care different Consultants led the inpatient and outpatient services thereby ensuring that there was little continuity of care. This was compounded by poor communication systems and a Care Coordinator who appeared to have been performing to a standard well below that expected from someone of her experience and seniority.

It is counter to both national and local best practice policy to discharge a patient without a formal CPA meeting. This meeting, and any subsequent decisions made in it, should have been followed up with letters to the General Practitioner and to the service user and a full record of the discussion should have been made in the patient clinical record. This is clearly set out in the Trust CPA Policy for 1996. The Care

Coordinator was of the opinion that Mr. D remained in contact with the CMHT after she had discharged him as he was still being seen by Dr. 2 in the Outpatient Clinic. However Mr. D had been effectively discharged from CPA without any formal processes having been conducted or recorded and the Investigation Team noted that as the Outpatient and CMH Teams operated as separate entities Mr. D had in effect been discharged from the CMHT.

The Investigation Team concluded that the assessment conducted by the Care Coordinator was untimely, of a poor quality, lacking in analysis and having no adequate care plan to meet Mr. D's needs. Mr. D did not receive the care and treatment that he required.

- ***Key Causal Factor Number 6. Failure to provide adequate Care Coordination in the Community leading to a lack of assessment, monitoring and case management. This had a direct bearing on the breakdown of the mental health of Mr. D in 2004 and the delay in marshalling responsive services that would have been able to help and support him.***

Clinical Records (part b)

When the Investigation Team saw the original CMHT file for the first time concerns were raised regarding the contemporaneous nature of the clinical records. The photocopied version did not lend itself to a thorough visual examination in the same way as the original did. This led to the Investigation Team calling the Care Coordinator, the author of the record, back for a second interview. The Investigation Team saw that additional entries appeared to have been inserted between entries and that the date '2004' inexplicably appeared in three separate places, two of which had been clearly overwritten. When asked specific questions at her second interview the Care Coordinator confirmed the following:

1. that the clinical records shown to her appeared to have had amendments inserted between entries;

2. that all of the entries were made in her handwriting.

Subsequent to the interview the Care Coordinator prepared a statement as an addendum to her second interview transcription. It read as follows:

"My view is either the entries were made at the same time as the 'original' entries but made with a different pen, or that during the time I was working with Mr. D entries could have been made following subsequent contacts"

"I have carefully looked at the content of the entries in question and I find it difficult to understand any reason for these entries to have been made later in order to change the sequence of events. Rather the entries appear to form a continuation of the assessment process"

"Regarding the care plan and date of 2004. I believe that this is a straightforward error"[177]

The Care Coordinator denied falsifying the clinical record, although this was not directly posed to her as an accusation by the Investigation Team. The Care Coordinator could not recall why the notes were prepared in such an unorthodox format and apologised to the Investigation Team for not being able to remember any more clearly.

The Investigation Team mapped out the contacts and the interventions made by the Care Coordinator, both with and without apparent amendments, to ascertain whether or not the apparent amendments altered the view that could be taken when assessing the quality of care and treatment that Mr. D received.

Description of Events

The Investigation Team would like to warn the reader that the following account will appear confusing and not logical in places, this is because the actual records are confusing and not logical. The contacts and interventions made by the Care Coordinator are described below. The sections that appear to have been amended are added in bold typeface, as are all record keeping anomalies. All entries have been taken from the original CMHT file.

29 June 2000. A home visit was made by the Care Coordinator, Mr. D and his parents were present. The Care Coordinator noted that an interpreter would be needed for future visits. She wrote that Mr. D appeared to be stable in mood. **Apparently amended notes added " *[No] psychotic symptoms, denies hearing voices and visual hallucinations*"**

13 July 2000. A home visit was made; Mr. D was not at home the Care Coordinator wrote that she would write to him. **Apparently amended notes add "however sat and spoke to parents to ascertain what their concerns were. Mother believes that he doesn't have mental illness"**

19 July 2000. **(The date for this entry has been overwritten it is not clear whether the date is the 11, 15 or 19).** The Care Coordinator telephoned Mr. D at home. She spoke to Mr. D's sister who told her that Mr. D was asleep. His sister told the Care Coordinator that he was fine. The Care Coordinator told Mr. D's sister that she would telephone in three weeks time.

(From medical inpatient notes) 2 August 2000. Following Mr. D's second admission and discharge, ward nursing records stated that the Care Coordinator was telephoned and informed of the discharge plan for Mr. D. **This is not recorded in the CMHT file**

(From medical inpatient notes) 3 August 2000. The notes stated *"not yet seen by CPN who will visit this pm*". **This visit, or its unsuccessful outcome, is not recorded in the CMHT file**

8 August 2000. The Care Coordinator visited Mr. D at home. Mr. D's mother said he was not in. The Care Coordinator wrote in the notes that she later telephoned the family home but that there was no reply. She wrote that it was proving difficult to make an assessment. She also wrote that at that time there was no evidence of psychotic symptoms or risk to self or others; his parents were unhappy that he spent long periods of time out or sleeping. It would appear that he was continuing to abuse

drugs. The Care Coordinator felt that Mr. D should possibly be discharged with RMO agreement.

Comment
The Investigation team do not understand how the Care Coordinator could make this kind of professional judgement without having met with Mr. D.

8 August 2000 the ward nursing team were trying to contact the Care Coordinator urgently to obtain feedback from her domiciliary visit to Mr. D. The ward staff managed to contact the Care Coordinator on the fourth attempt and were told by her that she had put Mr. D's TTOs (his prescribed medication from hospital) and his outpatient appointment through his letterbox. The ward contacted the Care Coordinator later the same day where she reported that Mr. D was *"ok and complying with medication".*

Comment
It is unclear how the Care Coordinator ascertained this information.

2 October 2000 the Care Coordinator wrote in the CMHT file that she had discussed Mr. D with Dr. 2. She stated that "*my opinion is that Mr. D is not showing symptoms of psychosis; concerned only with aches and pains and his skin*". Her plan was to continue to assess Mr. D.

Comment
It is unclear how the Care Coordinator reached her opinion regarding Mr. D as she does not appear to have seen him since the 29 June 2000.

10 October 2000 the Care Coordinator wrote to Mr. D arranging a home visit with him on the 20 October 2000. **No visit is recorded in the CMHT file**

25 October 2000 the Care Coordinator telephoned Mr. D confirming that she would be visiting later on that day. Mr. D said he was too tired and another appointment was made for the 2 November 2000 with an interpreter.

2 November 2000, the care Coordinator made a home visit to Mr. D with an interpreter. Mr. D and his mother were present. Mr. D's mother did not believe that Mr. D had a mental illness.

2 November 2000. An evaluation form was filled in. **The date on this form was overwritten from 2/11/04 to 2/11/00. The Care Coordinator writes that Mr. D complains of physical problems only, appears to have no psychotic features at present, mood appears to be flat, no present risk noted, little insight, will continue to see client on the 25 November 2000, appears to have no psychotic features at present and will continue to see client on 25 November 2000 (the next meeting was in fact on the 29 November 2000).** The Care Coordinator stated that she would discuss Mr. D's discharge with his RMO. There is no record of this ever having been done.

3 November 2000 an assessment form was signed and dated by the Care Coordinator. Her plan was to complete the mental health assessment, ascertain the client's needs and to offer education to the family.

December 2000, the date for the day is indecipherable **(the date has been overwritten to read 29 November 2000).** The Care Coordinator wrote that she had made several attempts to contact Mr. D by telephone. "*Family informed me that he is often sleeping and unwilling to get out of bed; sister informs that he is ok except that he complains of neck pain".*

The appointment that took place on this day is noted as having been rearranged for 1pm instead of 10am. **A different pen appears to have been used from the one used to make the above statements regarding the telephone call. Apparently amended notes go on to add: Care Coordinator visited with an interpreter and conducted a delusional rating scale (the date of completion is absent). Mr. D's mother said that Mr. D was compliant with his medication. Mr. D denied hearing voices inside or outside his head, does not feel like harming himself or other people and does not feel as though people are following him, denies taking drugs, discussed early warning signs.**

Comment
These symptoms are cited from Mr. D's third admission in May 2001. They had not previously been noted by Mr. D's clinical team and were not concerns that had been identified as early as November/December 2000, the dates that these notes were made. These amended notes were not signed for at the end of the entry as would normally be expected.

29 November 2000 **(date has been overwritten on this entry from 29/11/04 to 29/11/00). These notes appear to have been amended and state that the Care Coordinator discussed early warning signs with Mr. D and his mother and that this would be her last visit. It is recorded that Mr. D was spending time with friends taking drugs and that Mr. D felt that he was well at present. Mr. D and his mother were informed that they could go to St. Ann's Hospital or visit the GP or the CMHT if he wanted to be seen again. The Care Coordinator explained that Mr. D would continue to be followed up by Dr. 2 in outpatients. The notes state, *"Last visit no further involvement".***

Comment
The Investigation team are of the opinion that the weight of evidence available suggests that the whole of this entry is likely to have been added at a later date.

16 February 2001 the Care Coordinator made a home visit after being informed that Mr. D had been admitted to hospital. *"informed Dr. 2 that client does not wish to be supported by CMHT but will keep outpatient appointments. Dr. 2 suggested that the client attend the day hospital for support".*

Comment
Neither the Investigation Team nor the Care Coordinator know where this referral came from as Mr. D had not been admitted at this stage; the recommendation for Mr. D to attend the day hospital was made following his fourth admission.

19 February 2001. The Care Coordinator wrote to Mr. D to inform him that she was going to be on Annual Leave between the 19 – 26 February 2001

28 February 2001. The Care Coordinator visited Mr. D at his home. The Care Coordinator wrote:

" Mr. D explained that he feels alright and still does not want my involvement

Plan

1) Write letter to Dr S informing him that client no longer wants my involvement

2) Give client my contact number should he change his mind

3) Brief mental health assessment completed

4) Agreed to continue to see Dr. 2 in out patients"

(Additional entry adds)

Assessment

Mr. D denied hearing voices appeared cooperative to answer questions regarding his mental state.

Denied hearing voices, appeared clean well dressed and calm in manner

Answered all questions in an appropriate manner; stated that he is not taking drugs and does not want help regarding this

Mr. D stated that he was not admitted to hospital

Plan

1. Inform RMO of involvement. RMO to continue to see client in outpatients

no further involvement, until requested by client or referral to team. Client agreed to all above"

Comment
None of the above was actioned, nor is there any evidence that this was communicated to Dr. 2. The basic mental health assessment was inadequate and does not cover the basic assessment expected of a registered nurse

There is no mention in the CMHT file of the Care Coordinator's telephone contact with inpatient services regarding Mr. D's third admission and discharge.

13 November 2001 the inpatient Medical notes records that *"Care Coordinator (actually named in the notes as the individual in question) contacted and is to arrange urgent follow up in the community*". **No record of this was made in Mr. D's community file and no follow up action was recorded. All CPA documentation for Mr. D's third and fourth discharge is missing from the CMHT record.**

28 January 2003 letter was sent to Mr. D from the Care Coordinator. There is no record of this in the CMHT file. Mr. D's parents showed members of the Investigation Team the copy that they had retained.
29 November 2004 the Care Coordinator signed off a care plan evaluation for Mr. D and can give no explanation for the date, claiming it was a mistake and that it was contemporaneously made in either 2000 or 2001. The original care plan had been commenced in June 2000.

Following the events of 23 December 2004 the Metropolitan Police requested the medical notes. The Care Coordinator was asked to collect the CMHT file ready for its collection by the police. The CMHT file being required in preparation for their investigation.

Issues Raised and Analysed by the Independent Investigation Team
Neither the Investigation Team nor the Care Coordinator could find a logical explanation for the anomalies present in Mr. D's CMHT clinical records. Four serious areas of concern were noted:

1. dates have been overwritten;

2. entries have been apparently added to and inserted;

3. entries in the CMHT file are inconsistent with those made in the inpatient medical and nursing records;

4. documents are missing.

There is clear evidence that dates have been changed in the CMHT file. At interview the Care Coordinator agreed that dates had been altered. The Care Coordinator's

manager for the period of 2000-2001 also agreed during interview that the notes appear to have been amended.

Clinical records are kept on pink sheets of paper. In the CMHT file there are two pages of clinical records and in date order these are referred to as sides 1, 2, 3 and 4 respectively. Sides 1 and 2 are the same sheet as are 3 and 4; both sides of the paper are written on. Entries have been made as set out in the table below

Table Three

Sheet Number	**Date of entries**
Sheet No. 1	29 June 2000 - 2 October 2000
Sheet No. 2	25 October 2000 - December 2000
Sheet No. 3	29 November 2000/04
Sheet No. 4	16 February 2001 & 28 February 2001

Pages 1 and 2 are different shades of pink which may be coincidence or a further indication that notes have been added. At the top of side 3 the date has been altered from 2004 to 2000 and the additional notes added as a continuation of the initial entry. There is also a large gap in the notes at this point with the entries for February 2001 being on side 4. If the notes had been contemporaneous there should not have been such a large gap in the records.

On side 1 there are three entries all of which appear to have had additional notes inserted. The same pen appears to have been used for all the apparent additional entries, there are no spaces in between the entries, and the signatures of the Care Coordinator are out of line with the entries. At the second interview these discrepancies were pointed out to the Care Coordinator who did not contest that the notes appeared to have been amended.

The Investigation Team became aware that some clinical interventions and contacts were not represented in the CMHT records although they were recorded in other

clinical files, the CPA documentation for Mr. D's third discharge being the most important omission. The Investigation Team noted that the Care Coordinator was aware of Mr. D's 'verbal hostility and paranoia' all features of his third admission from her apparently amended notes. The Team were told by other witnesses that missing letters and documentation was a rare occurrence within the Trust at the time.

Summary View of the Independent Investigation Team

The Investigation Team formulated three hypotheses to explain the events set out above.

1. The Care Coordinator conducted her visits strictly in accordance with the entries in the CMHT clinical record. The notes were not strictly speaking contemporaneously made, but were made soon after her contacts with Mr. D. **Her care and treatment of Mr. D fell below the standard expected of a Care Coordinator as outlined in the Trust CPA policy**

2. The Care Coordinator did conduct her visits in accordance with the entries made in the CMHT clinical record, but were amended at a later date from memory, possibly in 2004 before the Metropolitan Police arrived to collect them. **Her care and treatment of Mr. D fell below the standard expected of a Care Coordinator as outlined in the trust CPA policy**

3. The Care Coordinator did not conduct her visits and contacts as set out in the CMHT clinical record and she fabricated her entries at a later date, possibly in 2004 before the Metropolitan Police arrived to collect them. **Her care and treatment of Mr. D fell below the standard expected of a Care Coordinator as outlined in the trust CPA policy**

The Investigation Team are aware of the seriousness of the allegations posed by the above three hypotheses. During the course of the Investigation it was not possible to ascertain any supporting mitigating circumstances as the Care Coordinator could not remember the details of her clinical input in sufficient depth.

The Investigation Team came to the conclusion that the apparently amended notes read in an entirely different manner to the same notes without the alterations having been made. The apparently amended notes, whilst not affecting the view of the quality of care that Mr. D received from the Care Coordinator, would lead the reader to think that Mr. D received a more robust assessment and treatment package than the one he did in fact actually receive.

"*Quality of record keeping is also a reflection of the standard of professional practice. Good record keeping is the mark of a skilled and safe practitioner, whilst careless or incomplete record keeping highlights wider problems with the individuals practice*" (NMC 2002)[178]. The Investigation Team found that the practice and record keeping of the Care Coordinator fell below the expected standard of a registered nurse.

The Investigation Team found practice of a dubious nature during the course of this Investigation. It is the recommendation of the Investigation Team that further investigation into the practice of the Care Coordinator should be conducted to:

- ascertain any mitigating factors that were not available to the Investigation Team;
- audit the Care Coordinator's past case load to ensure that the appropriate care responses have been made with her other clients.

The Investigation Team recommends that appropriate action be taken in accordance with the Trust's internal policies and national guidance once all due enquiries have been completed. A full recommendation is made in the relevant section below.

14.6. Critical Issue Number 5. Quality of Clinical Documentation and Communication

Description of Events

Throughout the period of time that Mr. D received his care and treatment from Barnet, Enfield and Haringey Mental Health Trust the Investigation Team noted that there were distinct issues with regard to communication and clinical documentation.

The quality of Mr. D's Inpatient, Outpatient and Community Mental Health Team care was compromised by a lack of communication. The Investigation Team has drawn this conclusion from the sequence of events described within Mr. D's clinical records.

Inpatient and Outpatient mental health services were headed up by different Consultant Psychiatrists. This was not such an issue for Mr. D's first admissions as Dr. 2 who had been the Inpatient Consultant became Mr. D's Outpatient Consultant, ensuring some initial continuity. However as Mr. D's contact with services progressed, communication between inpatient and outpatient facilities appear to have been non-existent. There is no record in the medical notes of any communication ever having taken place between the Outpatient Consultant, Dr. 2, and the Care Coordinator. There are largely unsubstantiated intentions recorded in the CMHT notes that the Care Coordinator planned to communicate with the Outpatient Consultant. The extent to which this actually occurred is not clear.

The Investigation Team noted that CPA documentation for Mr. D's third discharge, whilst present in the medical records and the GP records is not present in the CMHT records. The Investigation Team also noted that the CPA documentation following Mr. D's fourth discharge is entirely absent from the clinical record.

Issues Raised and Analysed by the Independent Investigation Team

From the events recorded in the chronology above it is clear that the failure to engage with Mr. D was partly exacerbated by the failure of the mental health teams within the Trust to communicate appropriately. The purpose of CPA planning as set out in the Enfield and Haringey Health Agency Joint Care Programme Approach Policy (1996) was to:

- **ensure that no one who is vulnerable slips through the safety net of care;**
- assess an individual's health and social care needs;
- develop an appropriate and agreed plan;
- identify a Care Coordinator;
- ensure regular monitoring and review.[179]

It is a reasonable assumption to make, based on the evidence available to the Investigation Team that in the absence of the CPA documentation, communication and the ensuing care would be compromised.

As has been explained above in section 13.4. the Investigation Team found serious flaws in the implementation of both national and local CPA policy expectation. Concerns regarding communication are raised further with regard to CPA when the Team considered the process employed to discharge Mr. D from both the Care Coordinator's caseload and from the CPA process.

On two separate occasions, 29 November 2000 and 28 February 2001 the Care Coordinator decided that no further visits would be made to Mr. D, in effect discharging him from the CMHT caseload and the CPA. The Trust CPA policy states that

"Patients receiving the Care Programme Approach will have their plans reviewed at least every six months, more frequently if that is necessary. They may be discharged from Care Programme Approach only when they no longer need specialist services; they refuse to co-operate with the Care Plan and are not considered, ***when the situation is reviewed by the multi-disciplinary team****, to be at risk*[180]*"*

It is clear that no discussion or reasonable level of communication took place prior to the decision made to discharge Mr. D from the CMHT. This lack of communication appears to the Investigation Team to have led to the belief on the part of both Inpatient and Outpatient Teams that Mr. D may have been in receipt of more care and monitoring that he in fact was.

The Trust CPA policy at the time also stated

"If patients refuse aftercare every effort must be made to keep in contact by community services. The patient's General Practitioner and /or carer must be informed. Contact should be made by visiting the patient at home or by attendance at the Outpatient Clinic, or if the patient refuses, by maintaining contact via the General Practitioner[181]*"*

Communication between the Outpatient Consultant and Mr. D's General Practice appears to have been good. However there is no record of any communication ever having taken place between the CMHT and the General Practice. Mr. D's non compliance with his aftercare was not communicated to his General Practitioner as instructed in local policy documentation.

The Investigation Team found the CMHT clinical records content to be poor. There was little evidence of care planning, monitoring and review. The only care plan in the folder bears the date of 29 November 2004 and was signed by the Care Coordinator[182]. The Investigation Team found this entry to be of concern as it had previously been told by the Care Coordinator that her contact with Mr. D ended late in early 2001[183]. The Care Coordinator put the nature of this date entry down to being an error[184]. The Investigation Team found that many entries in Mr. D's clinical records failed to meet professional good practice standards in that:

- dates were often missing from assessment forms;
- signatures were illegible;
- mistakes were routinely crossed out with additions superimposed on top rendering the entire entry illegible;
- terms such as, Key Worker, Named Nurse, Care Coordinator, CMHN and CPN were often interchangeably used with little or no explanation or understanding on admission and CPA documentation;
- care plans were missing or incomplete;
- risk and needs assessments were absent or incomplete;
- CPA documentation and letters appear to be missing from several clinical files, e.g. the CPA documentation following Mr. D's third discharge appears in the General Practice records and the Inpatient record, but not in the CMHT record;
- CPA documentation following Mr. D's fourth discharge is incomplete.

It was noted by the Investigation Team that most of the errors and issues regarding documentation occurred on the part of nursing staff. Whilst current and more modern guidance is available from the Nursing and Midwifery Council (NMC), the Investigation Team used the old guidance from The United Kingdom Central Council

for Nursing and Midwifery (UKCC) *Guidelines for Records and Record Keeping* (1998, revised 2002) which was in force during the period that Mr. D received his care from the Trust. This guidance stated that:

"Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.....The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual's practice[185]*"*

The UKCC guidance goes on to state that patient and client records should:

- *be written as soon as possible after an event has occurred;*
- *be written clearly in a manner that cannot be erased;*
- *be written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly;*
- *be accurately dated, timed and signed, with the signature printed alongside the first entry;*
- *be readable on any photocopies;*
- *be consecutive.*[186]

Poor communication also took place between the Metropolitan Police and the Barnet, Enfield and Haringey Mental Trust regarding Mr. D's forensic history and criminal record, especially with regard to his previous convictions for actual bodily harm and criminal damage. It was unfortunate that few witnesses could actually remember Mr. D and were not able to give an explanation as to why this aspect of Mr. D's behaviour and history was not explored further and managed more appropriately.

Summary View of the Independent Investigation Team

After analysing the evidence available, the Investigation Team concluded that communication between the Trust Inpatient, Outpatient and CMHT services could have been both more effective and efficient. This failing, when coupled with poor record keeping, was a contributory factor that ensured Mr. D was able to *"slip through the safety net of care*[187]*"*.

At the time Mr. D received his care and treatment the Trust had a set of clear local procedures that adequately set out its obligations in implementing national policy expectations and best practice. The witnesses interviewed by the Investigation Team described local practice as complying with set policy and procedure. No mitigating circumstances or service issues were put forward to explain the issues regarding poor communication and clinical record keeping.

- ***Key Causal Factor Number 7. Poor communication and clinical record keeping practice contributed to Mr. D "slipping through the safety net of care".***

14.7. Critical Issue Number 6. Primary Care Mental Health Provision

Description of Events

Mr. D was registered with a General Practice in Haringey in 1990. Between 1990 and 2004 Mr. D made several visits regarding his concerns with his physical symptoms. This is charted in the Chronology above.

The Practice was a four partner general medical practice operating from two sites which are about ten minutes walking distance apart. The practice provided a general medical service to around 9,500 patients and had the usual administrative staff support including a practice manager, office clerks and receptionists. The practice was situated on the main high street and had an open list. The General Practitioners reported to the Investigation Team that there was a high incidence of mental health needs amongst their practice population[188].

The Practice started the process of computerisation in the mid 1990's. Initially this was for patient registration and was followed by computerisation of prescriptions and

subsequently for clinical record keeping. In common with many practices at the time undergoing computerisation manual records were maintained alongside computer records during this phase of development. Between 2000 and 2004 repeat prescriptions were issued electronically but clinical records were still hand written.

The Practice operated a mixed appointment system with a certain number of appointments available to be booked in advance combined with ‘on the day’ emergency appointments. At the time Mr. D was receiving his care and treatment from the practice the appointments were 5 minutes in length. In morning surgeries the doctors would see between 20 to 23 patients and in evening surgeries between 12 to 15 patients. Home visits were carried out as requested and required.

The Practice operated a ‘duty doctor’ system. This role would be shared on a daily basis between two doctors. One would read all of the hospital letters and clinical communications from hospital colleagues received each day by the practice, the other would sign off all repeat prescriptions.
When interviewed the General Practitioners described a repeat practice system which dealt with written requests for repeat prescriptions within 48 hours. In exceptional circumstances repeat prescriptions could be issued more quickly than this.

The Doctors described their usual practice at the time for arranging clinical reviews of patients on repeat prescriptions. Their policy was to authorise repeat prescriptions for 3 months of treatment before asking patients to attend for a clinical review with a doctor. This was their policy for all classes of medication. Patients were informed of the need for clinical review as part of the prescription printout and backed up by advice from the receptionists involved in the repeat prescription system.

As was nationally commonplace at the time, there were no other procedures in place to encourage patients to attend for clinical review and there was no monitoring of compliance with attendance for medication reviews. The doctors had considered the issue of patients continuing to request repeat medication whilst not attending for clinical review. They took the view that it was more appropriate to continue to issue repeat prescriptions than to discontinue medication, if patients failed to attend for

clinical review but were otherwise apparently compliant with treatment. This was because they considered the clinical risks to be heightened if patients were denied access to their medication. Mr. D's prescriptions were regularly collected by his family members, which the doctors took to be a sign that Mr. D was compliant.
The General Practitioners reported a generally good working relationship with secondary care mental health colleagues and they described a clear understanding of access routes to specialist mental health opinion.

The primary care records show a good level of written communication between specialist mental health doctors and the practice. The General Practitioners were confident in the decision making, judgement and opinion of their specialist colleagues. They did however express concern that the Trust's reorganisation of community psychiatric nursing services reduced the practice level of contacts with specialist services in 2003. This, they believed, left them in a more vulnerable position when dealing with the patients on their list who had long term enduring mental health conditions[189].

In 2001 when Mr. D had presented at the Practice with side effects from his medication the attending doctor responded immediately and appropriately by making an urgent referral to Mr. D's Outpatient Psychiatrist.

Following Mr. D's discharge from psychiatric outpatient follow up in September 2002 he was seen by the practice on one occasion in June 2003 with physical symptoms. Requests for repeat prescriptions were made and repeat prescriptions were issued throughout the remainder of 2003 and 2004.

An Incapacity for Work Form was completed in 2003 and a Disability Benefit form was completed in 2004. Both of these forms were completed from information held in the medical records.

On the 30 November 2004 Mr. D's parents went to the General Practice. It remains unclear what occurred during the consultation. The doctor who saw Mr. D's parents maintains that they came seeking help and support to obtain re-housing for their

son[190]. Mr. D's parents claim that they visited the surgery because they were afraid of their son and were worried about his mental health condition[191].

Whatever was discussed at that meeting the General Practitioner felt that it was appropriate to arrange a home visit to assess Mr. D. He wrote a note on a post-it - pad instructing the receptionist to arrange a home visit with a view to assess Mr. D for re-housing, he did this because he knew the family had difficulty in speaking and understanding English and he felt that a written instruction would make things easier for them. This post-it-note was given to Mr. D's parents, for whatever reason it remained in their possession and no home visit was arranged.

Issues Raised and Analysed by the Independent Investigation Team

Events of the 30 November 2004 (part a)

It is always difficult when accounts of the same event differ so greatly as do those relating to the 30 November 2004. The Investigation Team found no reason to doubt the account given by the General Practitioner, GP. 1 who met with Mr. D's parents on that day. There are several reasons for this.

The General Practitioner concerned had a variety of options at his disposal to manage the deteriorating mental health of patients on his list. The two options open to most practitioners in his position if faced with a patient with deteriorating mental health would be to:

1. arrange for a practice colleague to visit;

2. arrange for secondary care input.

The notes made by the Practitioner following the visit from Mr. D's parents read as follows and does not indicate that he believed Mr. D to be an individual with a potentially deteriorating mental health problem

> *"Seen the parents – came on behalf of him – does not want to see me. Parents want a letter for re- housing +*

paranoid schizophrenia. Seen before GP 2 to make an appointment with him[192]"

There is no indication in these contemporaneously made notes that the General Practitioner had any immediate concerns regarding the health and wellbeing of Mr. D. He understood from Mr. D's parents that he would not attend the practice to seek housing for himself. The General Practitioner understood that GP 2 had met with Mr. D before and set plans in place to arrange a home visit.

The option selected by the General Practitioner shows no indication that he had been alerted to any possible suggestion of aggression or violence on the part of Mr. D. It is most definitely not usual practice for any healthcare professional to advise a lone colleague to visit a potentially violent and aggressive patient in their home environment. The Investigation Team conclude that for whatever reason the doctor who met with Mr. D's parents that day was **not** alerted to any significant risk that Mr. D may have posed. We know that the General Practice did make routine urgent referrals to secondary care and were alert to the indicators for doing so.

This being the case, based on the evidence available to the Investigation Team, the conclusion was that the doctor acted appropriately on the 30 November 2004. It is not possible to understand why Mr. D's parents did not manage to arrange a home visit with the receptionist. It is clear that the request note for a home visit remained in their possession. This will be discussed further below.

Repeat Prescribing (part b)

It is the view of the Investigation Team that most General Practitioners working across the country at the time would have continued to prescribe medication even if a patient failed to attend the practice for a review. This is obviously not good practice. However it is a dilemma that primary care practitioners face on a regular basis when patients are referred back to their GP from secondary care services. This is of course made more problematic when patients are not being monitored in outpatient facilities and are also not being managed via CPA. Primary care practitioners are often expected to succeed in engaging with service users even when specialist mental health services have failed to do so.

The Internal Investigation set out the chronology of Mr. D's repeat prescription history very well. It stated that:

"During 2002 Mr. D had been receiving his prescribed medication on a fairly regular basis from his GP. Each prescription was for 28 days, except in the summer when he received 90 days' supply as he was going to Turkey for three months. However, by the end of 2002 the GP records indicate that Mr. D was picking up a repeat prescription for Olanzapine in an increasingly erratic manner. Between 2002 and June2003, the intervals between prescriptions were 8 weeks, 7 weeks, 6 weeks, and 5 weeks. On June 2003 a prescription was issued for 12 weeks, to cover a period of holiday in Turkey. This would only have lasted until the end of September 2003 and yet Mr. D did not pick up a repeat prescription until the end of December 2003. 13 weeks later in March he received another prescription for 4 weeks, and another, 4 weeks later. Between April 2004 and December of that year, only one further prescription was issued. The entry in the GP notes is undated, but is believed to be 11 June 2004. This prescription was not collected from the surgery.[193]"

The Investigation Team conclude that not reviewing patients at least every six months is poor practice. However it is an enduring problem for most General Practitioners when considering how to engage with mental health service users, who do not wish to, who are informal and who are not obligated to comply. If a General Practitioner is unaware of an appropriate risk history or clinical management plan from secondary care services a clear way forward is not always easy to find.

At the time Mr. D was receiving his care and treatment Haringey had no Assertive Outreach Team in place. However, even if such a team had been place it was unlikely that Mr. D would have been a recipient as secondary care services did not appear to have judged Mr. D as requiring any further input.

Communication (part c)

Mr. D's parents do not understand or speak English well. This fact was understood by the General Practitioner who met with them on the 30 November 2004. It is

possible that language and communication difficulties had a part to play resulting in the confusion that obviously occurred within the consulting room leading to two differing accounts of the same meeting on the part of both the doctor and Mr. D's parents.

The Investigation Team know that GP 1 wrote a note for Mr. D's parents to give to the receptionist so that a home visit could be made. It is difficult to understand a scenario where a General Practice receptionist would wilfully ignore a doctor's written instruction. We know as a fact that the written communication existed as it was presented to the Investigation Team by Mr. D's parents. We can therefore surmise that the General Practitioner was prepared to arrange a home visit and was prepared to support Mr. D's family in their request.

The Investigation Team know as a fact that the written instruction remains in the possession of Mr. D's family. The Team were unable to ascertain exactly what could have occurred to prevent the visit being arranged. It is possible that despite the best efforts of the General Practitioner the family did not present the note to the receptionist thereby ensuring the home visit never occurred.

Summary View of the Independent Investigation Team

It must be remembered that the doctor meeting with Mr. D's parents on the 30 November 2004 acted without the benefit of hindsight. It is the conclusion of the Investigation Team that when confronted with the request made by Mr. D's family he did in fact act appropriately. When seen within the context of the General Practice's proven track record there was no reason why Mr. D would not have been referred to secondary care services if the perceived risk that the doctor was presented with was high.

Secondary care services failed to engage with and manage Mr. D's mental illness. The letter sent by Mr. D's Outpatient Consultant on the 18 September 2002 prior to his discharge back to his General Practitioner gave no indication that Mr. D posed any kind of risk to either himself or to others, or that he posed any kind of clinical management problem. He stated that:

"Psychiatric examination revealed a friendly, relaxed male with no biological symptoms of depression; he was not suicidal, there was no aggressivity present... my impression is that Mr. D is now clinically stable...I am referring him back to your care on the understanding that if you have worries about the patient in the future, he may be re-referred back to my clinic[194]*"*

The Investigation Team cannot state with certainty that a visit from a clinician at this stage could have prevented the events that occurred on the 24 December 2004. If a visit had taken place there would have been no guarantee that Mr. D would have been at home, or that he would have been exhibiting any florid symptoms. However it is possible that if Mr. D had been seen at this stage an appropriate referral could have been made to secondary services. The fact that he was not seen by a member of the primary care team cannot be taken as a direct and final causal effect regarding the outcomes of the 24 December 2004.

However the Investigation Team does acknowledge that Mr. D's lack of compliance with his medication was a major contributing factor to the breakdown in his mental wellbeing. The Investigation Team believe that this lack of compliance has to be considered as shared responsibility throughout Mr. D 's period of care and treatment with both secondary and primary care services. If primary care services had been better alerted via their own systems then an appropriate referral could have been made. However without Mr. D's cooperation it is doubtful how successful this intervention would have been until Mr. D's health had actually broken down.

Key Causal Factor Number 8. Poor review and performance management of repeat prescription protocols and care pathways within the General Practice and Haringey Teaching Primary Care Trust.

14.8. Critical Issue Number 7. Carer Assessment and Support

Description of Events

Mr. D's parents did not have a carer assessment conducted at any stage during Mr. D's care and treatment with Barnet, Enfield and Haringey Mental Health Trust. Mr. D's mother came onto the ward at St. Ann's Hospital on several occasions during Mr. D's admissions. However no relationship appears to have been built up with her, possibly exacerbated by communication and language difficulties.

Although both ward and Care Coordinator utilised a translator on several occasions opportunities were missed to assess and plan care for both Mr. D and his family in a holistic manner.

Issues Raised and Analysed by the Independent Investigation Team

Mr. D's family found it difficult to both accept and manage his mental illness. When Mr. D's parents were interviewed by members of the Investigation Team they were able to describe how difficult their son's behaviour was to understand and also how difficult they found it to function as a family unit when he was at his most unwell[195].

On the 2 November 2000 the Care Coordinator visited Mr. D at his home. He was not there, but the Care Coordinator was able to talk to his mother and provide some educative input[196]. This action fulfilled section 7.9 of the Trust's CPA Policy (1996)[197]. However this single action alone did not satisfy the full expectation of the policy.

The Policy clearly stated that regular contact should have been maintained with carers in order to ensure that support was offered. This was considered to be especially relevant when a service user was non-compliant with planned aftercare, as was the case with Mr. D[198].

During the course of both the Internal and Independent Investigations it became apparent to both Teams that Mr. D's family were subject to many assaults and acts of violence perpetrated by him[199]. The Independent Investigation Team were able to access a comprehensive range of documentation from Broadmoor Hospital which gave further accounts of Mr. D's aggression and acts of violence within the family home.

Summary View of the Independent Investigation Team

Mr. D's family had not wanted to make these difficulties known to mental health services at the time as they were reluctant to make things more difficult for their son and did not want to involve the police. If mental health services had worked better with this family then Mr. D's deteriorating condition and increasing propensity for violence could have been understood and managed. If a carer assessment had been undertaken the opportunity for developing a rapport and relationship with the family would have been created. A crisis plan could have been developed and coping strategies discussed with, and employed for, Mr. D's parents.

Key Causal Factor Number 9. The absence of a carer assessment contributed to the isolation of Mr. D's family. This meant that when the family entered a crisis situation with Mr. D they had no established relationship with a healthcare worker who could support them.

14.9. Critical Issue Number 8. Cultural diversity and Translation Services

Description of Events

The Investigation Team had to ascertain whether or not the care and treatment that Mr. D and his family received was culturally appropriate, and if it was not whether it contributed to the outcome of the events of 23 December 2004.

A great deal has been said throughout this report regarding the significance of the language and communication difficulties that Mr. D's parents experienced when trying to access care and treatment for him. However cultural diversity issues run far more deeply than language and communication issues alone.

The arena of cultural diversity is huge. There is no one single convenient definition of 'culture' *per se*. It can be characterised by behaviours and attitudes that can be determined by upbringing and by personal choice. We also have to consider here the issue of 'race', which is sometimes characterised by physical appearance, and determined by genetic ancestry. Also relevant is 'ethnicity', characterised by a sense of belonging and group identity, and determined by social pressure and psychological need[200].

Mr. D's family originally came from Afsin in East Turkey. Whilst Mr. D's family nationality is Turkish, they identify ethnically as Kurdish. They left Turkey to come to the UK in June 1989 due to a deteriorating political situation and as Kurds, a minority group there, felt oppressed and more at risk. There has been a long history of discrimination and oppression of Kurds in Turkey and certain other countries. The family were subsequently granted asylum here and sought to settle in an already established Kurdish community in North London. Other extended members of the family also live in the United Kingdom. After periods in a homeless hostel and temporary accommodation they were permanently re-housed at their current address.

It was understood by the Investigation Team that Mr. D's mother and father speak a particular dialect of Turkish in their own home as well as using a more mainstream version of Turkish when conversing with a translator who has worked with them for some time. English, spoken or written, is not the family's first language. Mr. D's father can understand spoken English to a limited extent but prefers to speak Turkish. Mr. D's mother has an extremely limited knowledge of English, to the extent that she has used a simple sign language to get her point across, for example pointing and gesticulating, when communicating with the Investigation Team. Both parents required a translator for communicating in English.

The Investigation Team concluded that there were two main issues regarding cultural diversity that were relevant to the quality of the care and treatment that Mr. D and his family received. They are as follows:

- no adequate use of translation services;

- cultural issues regarding mental health and stigmatisation.

Issues Raised and Analysed by the Independent Investigation Team

The use of translation services was sporadic. It was possible that the family were not able to fully understand all of the information that they were being given. Mr. D had no insight into his mental illness, and although his understanding of the English was

considered to be of an acceptable standard, would not necessarily have discussed his condition with his parents or shared with them the information that he was given by mental health services. The failure to provide adequate translation services to the family of Mr. D contributed to their confusion, isolation and initial rejection of the diagnosis that their son was given. By the time the family had accepted that Mr. D was mentally ill, and required specialist help, contact with services had been lost.

Mr. D's family found it difficult to accept his diagnosis from the outset, only realising the depth of its severity and implications when it had progressed beyond their control. The family stated to members of the Investigation Team their wishes for their son, for him to be able to live a normal life and to be able to marry and have children. It was clear that mental illness bore a stigma which they felt would negatively impact on Mr. D's future[201].

Mental illness is still viewed with both fear and suspicion by members of the general public in many countries of the world. In Turkey people with mental illness have few rights under legislation and treatments are often harsh and open to human rights abuses[202]. Mental illness is not viewed as positively in Turkey as it is within the United Kingdom. It is therefore entirely understandable that Mr. D's family not only found it difficult to accept the notion of his mental illness, but also his care and treatment regime.

Summary View of the Independent Investigation Team

As has been explored above, engagement with both Mr. D and his family was minimal. If a supportive and therapeutic relationship had been established then both communication and cultural issues could have been raised and understood. This could in turn have led to appropriate education and care solutions that were appropriate and sensitive to the concerns and cultural needs of the service user and his carers. It is difficult to understand why services in Haringey were not more geared to the cultural requirements of its Turkish community as this community has formed a significant proportion of its population for the past forty years.

The Internal Investigation report summed this issue up very well

"It is therefore incumbent upon all agencies involved in providing access to sensitive, appropriate and effective mental health services that all relevant staff are fully aware of the need to create a climate of trust and respect within which such difficult issues can be raised. This entails listening to what is not said as well as what is; it means providing appropriate language support and not using accidental interpreters; it means helping people through the system and not turning them away if they have not used the most appropriate entry point[203]*"*

Key Causal Factor Number 10. A service was offered to Mr. D and his family between 2000 and 2004 that was not culturally sensitive. This played a direct role in the breakdown of Mr. D's health and compounded the failure to provide timely interventions when both he and family required it.

14.10. Critical Issue Number 9. Organisation, Management and Supervision of Mental Health Services

Description of Events

During the course of this investigation the Team utilised the National Patient Safety Agency (NPSA) decision tree. The decision tree is a useful tool that helps investigations to analyse events and evidence in an objective way that does not automatically seek to place blame. This tool can be used to place the known events and facts into a simple methodology that facilitates an understanding of *why* certain actions or omissions took place. The decision tree methodology highlighted three main kinds of failure regarding the care and treatment of Mr. D. They are as follows:

1. individual professional failure to respond appropriately to the care requirements of Mr. D and his family;
2. leadership and management failure to monitor and supervise the clinical inputs that Mr. D received;
3. systems failures that ensured services were developed and delivered in such a way as to exacerbate poor communication and professional isolation.

It is important to note here that the Investigation Team was analysing events with the full benefit of hindsight. With the benefit of hindsight it is a relatively simple task to

understand the cause and effect of both individual professional, and management actions, with a degree of clarity not available to the people concerned at the time. It is a fact of life that often decisions made are sometimes the wrong ones. This does not mean that a decision was necessarily unreasonable or unprofessional. Only that the outcome turned out not to be what was envisaged or desired. Neither individuals nor systems should be singled out for blame when actions carefully considered and in adherence to both national and local policy fail to achieve what was intended.
That being said it is clear that some clinical actions and decisions appear to have been made regarding the care and treatment of Mr. D without evidence of all due care and attention having been taken. These actions and decisions also represent a clear departure from both national and local policy guidelines.

Issues Raised and Analysed by the Independent Investigation Team
There are three key areas where clinical leadership, management and service configuration appear to have failed with particular effect. They are:

- management of the ERC;
- clinical supervision and leadership within the CMHT;
- communication and seamless working between internal secondary care services.

It is essential for service users and their carers to have a contingency plan when they have been discharged from specialist mental health services. GP's know how to refer patients back into the system but families are quite often left to fend for themselves. Mr. D's parents attempted to seek help from the secondary care service which proved to be unresponsive. Their visits to St Ann's Hospital and Tynemouth Road in late 2004 came to nothing because no-one took on the responsibility for taking action. At St Ann's hospital an Emergency Reception Clinic had been put in place with a duty junior doctor and a nurse. It had been part of Mr. D's third CPA contingency plan to access the ERC if his mental health broke down[204]. This service was described to the Investigation Team as having been a *"battleground and an absolute nightmare"* because it was chaotic, always busy and a very difficult place to work[205]. It was a service set up as essentially an A&E for mental health concerns. It was an open door for people in the community to seek immediate help. As a

consequence each day was a bit of unknown quantity. The patients who attended could be very disturbed, presenting with anything from acute suicidal ideation to a psychosis. If anyone could not speak English, an interpreter could by contacted by telephone, but in the case of Mr. D's family this service was not utilised and the family was sent away.

It is the role of Clinical Team Leaders and Community Mental Health Team (CMHT) Managers to provide both clinical leadership and management to the CMHT. Clinical leadership and service management have a distinct role in ensuring that all practitioners receive the supervision, support and performance management necessary to ensure that a safe service is delivered. In the particular case of Mr. D there is evidence that the Care Coordinator providing his care and treatment was being neither adequately supervised or performance managed. It is clear that this individual's standard of care fell short of what could reasonably be expected or required. The failure to deploy the 1996 CPA policy was seen as a significant root cause in the breakdown of Mr. D's health. If the Care Coordinator had been supervised and performance managed appropriately preventative action could have been taken.

Service configuration and design between 2000 and 2003 appeared to the Investigation Team to be fragmented and compartmentalised. This ensured a lack of continuity of care between inpatient, outpatient, community and primary care services. The changes that occurred to specialist mental health services in 2003 (the withdrawal of CPNs from General Practice) brought about a dislocation of communication and service provision previously available to the General Practitioners in Haringey and this exacerbated the management problem of chronically ill mental service users in the area.

Summary View of the Independent Investigation Team

It has been difficult for the Investigation Team to understand exactly what it was like to work in Haringey between 2000 and 2004. This is due to the distance of time between the events being investigated and the present day and the resulting lack of organisational memory. The Investigation Team found it difficult to locate individuals who could remember Mr. D and his family. It was therefore impossible to understand

why certain actions and omissions took place as they did in his case. It was also difficult for witnesses to explain how the service was run in 2000 with the distance of eight years between the events that comprised Mr. D's care and treatment and this investigation.

However, that being said, it is clear that whilst adequate clinical policies and procedures appear to have been in place, disjointed leadership and management systems appeared to have been in operation. Whilst this does not remove the personal accountability of practitioners for their actions or omissions it serves to explain how poor standards of practice can 'slip below the radar' and go undetected.

Key Causal Factor Number 11. Poor supervision and performance management practices ensured poor standards of care went undetected. This was exacerbated by dislocated service design that did not encourage seamless working between internal departments and external agencies.

15. Findings

The National Service Framework for Mental Health was published in 1999[206]. It set out a group of standards by which services would be measured and described how each service could achieve these standards. The essence of any mental health service is co-operation, integration and co-ordination with the knowledge that

everyone understands the role they are playing. In the case of Mr. D professionals appeared to be working in 'silos'. There was little if any discussion between all of the key players regarding Mr. D's care and treatment and no cohesive organisational processes were in place to facilitate this occurring.

The Investigation Team recognised that between 2000 and 2004 many national initiatives were in an embryonic stage of local implementation. The Investigation Team also recognised that the secondary care services in question were subject to both reconfiguration and reorganisation, factors that can destabilise clinical delivery. That being said the consistent critical factors that have been identified by this investigation are:

1. the clinical management of Mr. D: diagnosis, medication and treatment;
2. risk assessment and care planning;
3. Care Programme Approach (CPA);
4. Community Mental Health Team involvement;
5. secondary and primary care interface;
6. quality of clinical documentation and communication;
7. service user engagement and involvement;
8. carer assessment and support;
9. cultural diversity and language;
10. clinical leadership and supervision;
11. organisation and management of mental health services.

Key Causal Factor Number 1. Failure to use the Mental Health Act effectively.

On two occasions Mr. D was admitted under a section of the Mental Health Act. It is the view of the Investigation Team that the Mental Health Act could have been used to better effect that it in fact was.

Mr. D's clinical team did not take advantage of the opportunity to observe and assess Mr. D that was offered to it. Mr. D's last two admissions gave the team an

opportunity to stabilise him and to understand him better. This is considered to be a key causal factor in the care and treatment of Mr. D leading to the subsequent deterioration of his mental health in 2004.

The fourth admission should have been managed differently. There was a 72 hour detention order in place. A section 3 (MHA 1983) would have been justified at this stage, particularly as Mr. D's family were afraid of him and felt unable to take him home. Treating Mr. D in the community no longer appeared to be a sensible option. There was an opportunity to intervene and this was not taken.

Key Causal Factor Number 2. Failure to engage with Mr. D and his family

The failure to engage with Mr. D is a hallmark of the care and treatment that he received. The Investigation Team considers this to be a significant factor that runs throughout all of the other critical issues and casual factors identified and analysed. During Mr. D's contact with mental health services in Haringey no concerted effort was made to develop an enduring therapeutic relationship with either him or his family.

A great deal of emphasis was placed on the Care Coordinator support that was being proposed, and for Mr. D and his family to trigger additional support if they felt it was needed. The Investigation Team concluded that it is never good practice to place the chief responsibility for engagement with services onto the service user and their carers whilst they are still coming to terms with their diagnosis. It is very common for people with mental health problems to have varying levels of insight into their condition. In the case of Mr. D it was clear that he had no acceptance of or insight into his illness. This was coupled with a history of poor compliance. Mr. D's family often covered up for him and played down his condition. This is not uncommon with families when coming to terms with the fact that someone they love has been diagnosed with a life changing illness. Basically Mr. D had little or no insight into his condition, and his parents found it difficult to accept that their son was mentally ill. This did not form the best basis for engagement with services.

Key Causal Factor Number 3. Failure to manage the ongoing care, risk and treatment needs of Mr. D. This had a direct bearing on the breakdown of the

mental health of Mr. D in 2004 and the delay in marshalling responsive services that would have been able to help and support him.

The Investigation Team felt that Mr. D's care was severely compromised by the lack of consistent medical management throughout the period of his care and treatment at Barnet Enfield and Haringey Mental Health Trust. For this the Consultant Medical Team must take a great deal of responsibility. It was not possible for the Investigation Team to locate Mr. D's key psychiatrists in order to invite them for interview although every effort was made to do so. Because of this it was not possible to interview them and the Investigation Team were not able to make a detailed critique of the medical interventions taken. However the Investigation Team would like to state, from the evidence made available to them, that the standard of medical care, treatment and management fell below those indicated for a service user with the diagnosis, risk and symptoms that Mr. D presented with.

Key Causal Factor Number 4. Lack of adequate risk assessment that formed part of a dynamic care and management plan process.

Mr. D's third admission was the opportunity for the inpatient clinical team to have recognised a distinct pattern of risk behaviours. Mr. D's risk assessments were not always coherent or complete. They definitely did not appear to be part of a dynamic process designed to form the framework under which a management plan could be put into place. This ensured that no crisis plan or contingency plan was adequately prepared and this contributed ultimately to the fact that when Mr. D's mental health broke down in 2004 there was no safety net in place to manage his care. The Investigation Team found the poor quality of risk assessment to be a direct causal factor in the subsequent breakdown of Mr. D's mental health.

Key Causal Factor Number 5. Failure to provide a coherent CPA process which was able to provide ongoing assessment, monitoring and treatment of Mr. D in the community.

It is the view of the Independent Investigation Team that the CPA process employed by the Barnet, Enfield and Haringey Trust was flawed in many ways during the period that Mr. D received his care and treatment from the Trust. This is summarised as follows:

1. **Communication**: processes were poor. This was illustrated by inadequate communication channels and processes between inpatient, outpatient and CMH teams. It would appear that communication and discussion did not take place in formally arranged CPA meetings. Instead conversations were purported to have been conducted over the telephone and these conversations were often not recorded in the patient clinical records. Because of this assumptions were made regarding the support and monitoring that Mr. D was receiving in the Community, assumptions that were not based on fact and were often misleading.

2. **CPA as a systematic process:** there was no evidence to suggest that CPA had been adopted as a process within the Patient File for Mr. D in any shape or form by the community-based Care Coordinator and that it was little more than a paper exercise for the ward-based team.

3. **Assessment and care planning:** the CPA did not form an assessment of Mr. D's need and did not constitute a care plan. In short the CPA practice fell short of both national and local policy expectation.

4. **Family and carer input:** there is no evidence to suggest that Mr. D or his family had any input into the CPA process or understood how it would serve to address the needs of Mr. D.

5. **Record keeping:** the standard of record keeping utilised at this time was poor and well below what would be considered as acceptable by healthcare professional bodies. It is the Investigation Team's belief that the enhanced CPA documents may have been removed from the CMHT file and that this must be seen in the light of other record keeping anomalies detailed in section 13.4 below.

The Independent Investigation Team believe that the failure to operate a coherent CPA procedure was a key causal factor in the breakdown of Mr. D's mental health in 2004 in that he was not assessed and monitored in a manner that was timely and appropriate. No process was in place to predict and prevent Mr. D's relapse thereby ensuring that an appropriate treatment response could be instituted.

In other words the GP did not know that the Care Coordinator was unable to engage with Mr. D. There was some doubt about the level of communication between the ward-based staff and the Care Coordinator. The Care Coordinator never attended a meeting and does not seem to have informed anyone that she had discharged Mr. D from her caseload. Of particular concern is the poor communication between the Care Coordinator and Mr. D's Outpatient Consultant.

Key Causal Factor Number 6. Failure to provide adequate Care Coordination in the Community leading to a lack of assessment, monitoring and case management. This had a direct bearing on the breakdown of the mental health of Mr. D in 2004 and the delay in marshalling responsive services that would have been able to help and support him

It is the view of the Investigation Team that there was a significant systems failure in that a disjointed tripartite system was operating whereby inpatient services, outpatient services and community mental health teams operated separately. At the time that Mr. D was receiving his care different Consultants led the inpatient and outpatient services thereby ensuring that there was little continuity of care. This was compounded by poor communication systems and a Care Coordinator who appears to have been performing to a standard well below that expected from someone of her experience and seniority.

It is poor practice to discharge a patient without a formal CPA meeting. This meeting, and any subsequent decisions made in it, should have been followed up with letters to the General Practitioner and to the service user and a full record of the discussion should have been made in the patient's clinical record.

The Investigation Team concluded that the assessment conducted by the Care Coordinator was untimely, of a poor quality, lacking in analysis and in the construction of an adequate care plan to meet Mr. D's needs. Mr. D did not receive the care and treatment that he required.

Key Causal Factor Number 7. Poor communication and clinical record keeping practice contributed to Mr. D "slipping through the safety net of care".

Throughout the period of time that Mr. D received his care and treatment from Barnet, Enfield and Haringey Mental Health Trust the Investigation Team noted that there were distinct issues with regard to communication and clinical documentation.

The Investigation team found that many entries in Mr. D's clinical records failed to meet professional good practice standards in that:

- dates were often missing from assessment forms;
- signatures were illegible;
- mistakes were routinely crossed out with additions superimposed on top rendering the entire entry illegible;
- terms such as, Key Worker, Named Nurse, Care Coordinator, CMHN and CPN were often interchangeably used with little or no explanation or understanding on admission and CPA documentation;
- care plans were missing or incomplete;
- risk and needs assessments were absent or incomplete;
- CPA documentation and letters appear to be missing from several clinical files, e.g. the CPA documentation following Mr. D's third discharge appears in the General Practice records and the Inpatient record, but not in the CMHT record;
- CPA documentation following Mr. D's fourth discharge is incomplete.

Key Causal Factor Number 8. Poor review and performance management of repeat prescription protocols and care pathways within Haringey Teaching Primary Care Trust.

There was an absence within the health system of clear and workable protocols and care pathways to ensure that service users with enduring mental health problems were managed appropriately once discharged back into primary care contexts. The situation as it stood between 2000 and 2004 has to be regarded as the responsibility of both commissioners and service providers.

Key Causal Factor Number 9. The absence of a carer assessment contributed to the isolation of Mr. D's family. This meant that when the family entered a crisis situation with Mr. D they had no established relationship with a healthcare worker who could support them.

Mr. D's parents did not have a carer assessment conducted at any stage during Mr. D's care and treatment with Barnet, Enfield and Haringey Mental Health Trust. Mr. D's mother came onto the ward at St. Ann's Hospital on several occasions during Mr. D's admissions. However no relationship appears to have been built up with her, possibly exacerbated by communication and language difficulties.

Although both ward and Care Coordinator utilised a translator on several occasions opportunities were missed to assess and plan care for both Mr. D and his family in a holistic manner.

Key Causal Factor Number 10. A culturally insensitive service was offered to Mr. D and his family between 2000 and 2004. This played a direct role in the breakdown of Mr. D's health and compounded the failure to provide timely interventions when both he and his family required it.

The use of translation services was sporadic. It was possible that the family were not able to fully understand all of the information that they were being given. Mr. D had no insight into his mental illness, and although his understanding of English was considered to be of an acceptable standard, would not necessarily have discussed his condition with his parents or shared with them the information that he was given by mental health services. The failure to provide adequate translation services to the family of Mr. D contributed to their confusion, isolation and ultimate rejection of the diagnosis that their son was given. By the time the family had accepted that Mr. D was mentally ill, and required specialist help, contact with services had been lost.

As has been explored above, engagement with both Mr. D and his family was minimal. If a supportive and therapeutic relationship had been established then both communication and cultural issues could have been raised and understood. This could in turn have led to appropriate education and care solutions that were appropriate and sensitive to the concerns and cultural needs of the service user and his carers. It is difficult to understand why services in Haringey were not more

geared to the cultural requirements of its Turkish community as this community has formed a significant proportion of its population for the past forty years.

The Internal Investigation report summed this issue up very well

"It is therefore incumbent upon all agencies involved in providing access to sensitive. Appropriate and effective mental health services that all relevant staff are fully aware of the need to create a climate of trust and respect within which such difficult issues can be raised. This entails listening to what is not said as well as what is; it means providing appropriate language support and not using accidental interpreters; it means helping people through the system and not turning them away if they have not used the most appropriate entry point[207]*"*

Key Causal Factor Number 11. Poor supervision and performance management practices ensured poor standards of care went undetected. This was exacerbated by dislocated service design that did not encourage seamless working between internal departments and external agencies.

Barnet, Enfield and Haringey Mental Health Trust had a range of adequate policies and procedures in place between 2000 and 2004. However the organisation suffered from a lack of clinical leadership and sound performance management procedures. Services appear to have been provided and monitored in silos allowing variations in standards of good practice to go undetected and unchallenged. This was probably exacerbated by organisational change and reconfiguration.

16. Barnet, Enfield and Haringey MHT and Haringey TPCT Response to the Incident and the Internal Investigation

Management and Investigation of the Incident

On the 24 December 2004 a 24 Hour Notification Report was filled in by the Assistant Director of Community Services for Haringey. The incident was graded as a level 1 incident and the details of the 'Gold' meetings held at Edmonton Police

Station were set out. All of the appropriate Trust and Primary Care Trust personnel were notified[208].

The 24 Hour Investigation Report set out the following initial issues of concern:

1. *"the appropriateness of the transfer of care from the Mental Health Trust to Primary Care;*
2. *the details of the transfer of care from the Mental Health Trust to Primary Care; the care plan/medication follow up etc.;*
3. *GP treatment and follow up of mental health patients in the community;*
4. *the handling of repeat prescribing;*
5. *the follow up of DNA patients in General Practices".*[209]

The 24 Hour Investigation Report noted that the senior partner at the General Practice at which Mr. D was registered had been advised to contact the Medical Protection Agency and Local Medical Committee for advice[210].

Between the 23 December 2004 and the beginning of January 2005 the Metropolitan Police collected both the Mental Health Trust and the Primary Care Trust held records. It appears from documents held in the Internal Investigation archive that Barnet, Enfield and Haringey found it difficult to retrieve the nursing notes, as they appeared to have not been sent to medical records after Mr. D's last discharge from the CMHT. However a fax was sent to a Detective Constable on the murder inquiry on the 31 December 2004 stating that the relevant nursing sheets had been faxed to him and that the original notes were held with the secretary of the Assistant Director of Community Services for Haringey.

An Expert Reference Group was held at the Haringey Teaching Primary Care Trust on the 26 January 2005. This group set out the Terms of Reference for the Internal Serious Untoward Incident Investigation. It was decided that the Internal Investigation would be led by the Haringey Teaching Primary Care Trust and that the Lead Investigating Officer would be Helen Hally (Director of Nursing and Services for Adults and Older People, Haringey Teaching Primary Care Trust) supported by Bernadette Hennigan (Director of Nursing, Barnet, Enfield and Haringey Mental

Health Trust)[211]. Initially it was hoped to have the Investigation completed by the end of March 2005.

The action notes from this meeting set the scope for the Investigation as follows:

- *"In the light of Mr. D's mental health history, could a reoccurrence of a psychiatric episode have been anticipated?*
- *Was there any pattern to his previous episodes that might have helped to predict the manifestation of any future episode?*
- *Were all reasonable steps taken to reduce the likelihood and impact of any potential recurrence by:*
  - *GP*
  - *Psychiatrist*
  - *CMHT*
  - *Other*
- *Context:*
  - *Service structures*
  - *Capacity*
  - *Protocols and procedures*
  - *Demographics*
  - *Language*
  - *Other"*[212]

At this meeting the action notes state that there were police reservations about either of the Trusts contacting the victims or the survivors. This reservation was to become more of an issue as the Investigation started to progress.
The Metropolitan Police placed restrictions on the scope of the Internal Investigation. Between February and June 2005 the Serious Untoward Incident Review was only able to conduct a desk-based investigation into the Care and Treatment provided by the Mental Health Trust. Due to the perceived police restrictions placed on the investigation only two interviews were conducted, and those of a *preliminary* nature. The witnesses interviewed were the Care Coordinator, and a Duty Social worker who had met Mr. D's family when they came for assistance to Tynemouth Road shortly before the events of 23 December 2004.

A preliminary report and interim action plan was produced and taken to the Mental Health Trust Board and to a Board-Level Committee of Haringey Teaching Primary Care Trust in June 2005[213] In March 2006 the Chief Executives of both Haringey Teaching Primary Care Trust, and Barnet, Enfield and Haringey Mental Health Trust, and the Director of Social Services at the London Borough of Haringey were asked to identify senior level respondents to address the activities set against each area of the action plan. This comprised Part 1 of the internal investigation.

In April 2006 the internal investigation began a second phase and interviews were conducted with the General Practitioners who had been involved in Mr. D's care and treatment. A report was prepared in June 2006. This comprised Part 2 of the internal investigation.

Part 3 of the internal investigation was also produced in June 2006. Part 3 reviewed the findings from parts 1 and 2 and brought everything together in the form of issues, recommendations and action planning. Part 3 also recorded all of the initial progress that had been made to-date against the original interim action plan from Part 1 of the process.

The Primary Care Trust took the lead for the investigation which was unusual as the incident involved a mentally ill patient known to one of their provider Trusts. The Investigation Team was concerned to learn that middle managers and staff were not aware of all of the findings and recommendations of the internal investigation until the Trust informed them that this Independent Investigation was going to take place. It is more usual for the organisation, in which the incident occurs, to conduct their own investigation with the primary aim of learning lessons quickly and making sure that their services are appropriate and safe for service users.

Support of Both the Victim's Family and Survivors' of the Attack

When the Independent Investigation Team interviewed the family of Mr. EM and the survivors of the events of the 23 December 2004 one thing became apparent. The initial support that they received came solely from the Family Liaison Officers posted by the Metropolitan Police. Both Health Trusts maintained that this was at the

insistence of the Metropolitan Police who did not want potential witnesses to the criminal proceedings being compromised in any way by the internal healthcare-led investigation.

A Memorandum of Understanding was published in November 2006 in order to investigate serious untoward incidents that involve the Police, the Health Service and the Health and safety Executive. In 2004 there was no such memorandum or understanding between the Police and the Health Service. The 2006 guidance provides clarity around topics such as preserving and protecting evidence, communication and instigating an incident coordination group. In any future event the Trusts will be able to utilise this guidance[214].

Because of the restrictions placed upon them by the Metropolitan Police, the Health Trusts also felt unable to build up any degree of relationship with Mr. EM's family and with the survivors of the incident. Because of this, information flows were slow and many of the witnesses that we spoke to were frustrated at not knowing the results of the internal investigation and the slow progress that was being made to bring it to a conclusion. The victim's family and the survivors often felt that they had to push constantly for information and that this was often too little and too late.

The Independent Investigation Team noted that families and individuals were only sent letters in the autumn of 2007 regarding the provision of any counselling and support that they might require. Three years after the incident this cannot be seen as an appropriate or timely response.

National Guidance from the National Patient Safety Agency (NPSA) in *Being Open* (2005) states that good communication channels must be maintained with both the families of perpetrators and victims of serious untoward incidents. Although this guidance came out several months after the incident, it was in place nationally during the Trust's internal investigation processes. This guidance is a basic tenant of good practice.

Support of Staff

The General Practitioners with whom Mr. D was registered were advised at an early stage that they should seek advice from both the Medical Protection Agency and Local Medical Committee. The Haringey Teaching Primary Care Trust Investigation Report stated

"Dr. Y sounded calm but upset and shocked. She said that the press had been in the waiting room[215]*"*

The Primary Care Trust offered support to the Practice from their Director of Communications. The General Practitioner was asked by the Police to hand over Mr. D's clinical records. The General Practitioner expressed concern to the Primary Care Trust regarding this as they did not have the patient's consent. The Primary Care Trust advised the Practice that the notes should be surrendered. The Practice complied with this instruction. ***It must be noted that the original notes were taken by the Police and they have not been able to be accessed or located since***[216]***.***

The Independent Investigation Team asked all Mental Health Trust employees how they learnt about the events of the 23 December 2004. The response varied considerably. It was clear that no formal Trust briefing was sent out to the clinicians who had provided Mr. D with his care and treatment. None of the witnesses that we spoke to could recall being sent the entire report on its completion. Even senior members of staff were only sent the parts of the report that contained recommendations that had been designated for them to action. None of the witnesses that the Investigation Team spoke to were invited to any kind of event to examine the lessons to be learnt. None of the witnesses that we spoke to attended any kind of debriefing meeting.

Remedial Action and Progress against the Action Plan

The Independent Investigation Team found that the Internal Investigation Report provided a sound synopsis of most of the salient issues regarding the care and treatment of Mr. D. The Independent Team acknowledge the difficulties that confronted the original investigation in that it was not able to secure all of the documentation available to the Independent Team and was unable to interview sufficient witnesses to ensure all aspects of Mr. D's care and treatment were considered.

The action plan that was produced by the internal investigation listed the following areas that required action and review. The key actions from the Mr. D Interim Action Plan Version 3, 27 May 2006 are listed below:

Primary Care

1. strengthen primary care performance and monitoring mechanisms;
2. review management of care by GP in context of repeat prescribing pattern/evidence of variable compliance with medication;
3. review prescribing patterns;
4. develop education and training programmes to support improved practice in primary care;
5. review record keeping;
6. review communication between secondary and primary care;
7. review working with families as part of the therapeutic approach.

Specialist Mental Health Services

1. review Mr. D diagnosis, admission and discharge;
2. review CPA in that there was an absence of evidence that CPA was used in an appropriate and effective manner;
3. review risk assessment in that there was an absence of formal and thorough risk assessment;
4. review CMHT operational policies to include duty system referrals;
5. review the interface between inpatient and community services;
6. review working with families as part of the therapeutic approach;
7. review record keeping and inaccurate records.[217]

Good progress appears to have been made shortly after the internal investigation with regard to the updating of clinical policies and procedures such as the:

- Community Mental Health Team Operational Policy 2006
- CMHT management review 'Modernising CMHTs' March 2006
- Did Not Attend Protocols
- CPA Policy 2005 and 2007

And audits such as the

- Health Record Keeping Report, August 2006
- CPA Case Notes Audit Report, October 2005
- In-patient Case Notes Audit Report December 2005

Barnet, Enfield and Haringey Mental Health Trust are currently working to an action plan specifically addressing black and minority ethnic issues. This action plan forms part of a dynamic, continuous quality improvement process. The Trust was able to demonstrate a huge culture and service shift between the events of 2000-2004 and the present day. The following achievements are listed as follows:

Managing Diversity:

1. **Ensuring mental health services are responsive to the needs of BME communities.** A detailed research project has taken place to ascertain the cultural needs of the Turkish/Kurdish community. Scoping around refugee communities has taken place in order to better understand how mental health services need to respond to their needs. Work has been conducted to develop tools and assessment methodologies that are culturally appropriate for BME communities. Detailed audit processes are being used to follow up discharge and CPA processes.

2. **Building capacity to deliver culturally sensitive services.** The Trust has been able to ensure that BME communities have an active role in the training of healthcare professionals, and has also been able to link with the voluntary sector to work in partnership in both community and strategic contexts.

3. **Reducing inequalities in mental health care.** The Trust now provides a more balanced range of therapies that are culturally appropriate and effective for its population. The Trust has ensured that BME service users have improved access to trained advocates. This has helped to improve access to services and has helped to remove the stigma and associated fear that many BME communities feel with regard to mental health services.

4. **Promote recovery and wellbeing.** The Trust has endeavoured to provide more choice to service users. The aim is to provide a more assertive and responsive suite of services. This work is ongoing and the Trust hopes to have this completed by October 2008.

5. **Tackling Stigma and promoting mental health.** BME communities now have an active role in the training of healthcare professionals and the development of mental health policy. The Trust is attempting to work positively with BME communities to ensure that mental illness is understood and accepted and that communities understand how to access services and keep themselves well.

The Mental Health Trust is monitoring the services provided to its BME communities in a coherent manner. More work is planned between the time of writing this report and throughout 2009. Future work will focus on the cultural competency of healthcare workers and further community outreach work.

When the Investigation Team interviewed Haringey Teaching Primary Care Trust they were told that the Joint Strategic Implementation Group (JSIG) continued the action plan implementation work. The actions taken from the Internal Investigation Report have been set into a new format with comprehensive actions and performance management and monitoring systems in place. A great deal of work has been completed. The action plan is colour coded in a traffic light system. Most of the colours are coded green which means that the actions have been completed. The achievements accomplished up until July 2008 are listed as follows:

1. **Engaging with families and carers**. This action is colour rated green. The current percentage of carers with carer assessments was rated as being 72.68. It was noted that 100% of General Practices in Haringey have a carers register. Continuous training is in place and monitoring takes place on a two-monthly basis.

2. **Using language services in providing clinical care.** This action is colour rated green. HTPCT has recently completed the commissioning process of tendering for a new language service. Service level agreements are still to be

agreed, no data was available for General Practice uptake of language services. Cultural diversity is being including in induction training and mandatory training for all staff in HTPCT and Barnet, Enfield and Haringey Mental Health Trust (BEHMHT). Review and monitoring processes have yet to be put into place. The JSIG recognise that this work is ongoing and that it will require regular monitoring and review.

3. **Dignity and respect.** This action is rated green. Assurance mechanisms are in place but no quantifiable data was available to the Investigation Team as to how this is being implemented in practice. It was noted that work was still required to ensure that all General Practices were aware of standards and procedures in this area. *The Independent Investigation Team believe that more work is required to achieve local aspirations in this area.*

4. **Risk management in secondary care.** This action is colour rated green. Audits are currently being done to ascertain the quality of risk assessment. Risk management training is being currently reviewed and the plan is that it is now mandatory for all clinical staff. Audit data from BEHMHT demonstrates a steady improvement year on year with regard to the presence of risk assessment forms in individual clinical records. However there has been a decrease in content quality noted, this is now subject to a detailed improvement plan. *The Independent Investigation Team believe that work on risk assessment requires more input and regular review must be maintained.*

5. **Meeting training needs identified by serious incident procedures.** This action is colour rated green. Single agency training events only are available at the present time; the plan is to broaden this out into interagency events. *The Independent Investigation Team believe that more work is required to achieve local aspirations in this area.*

6. **Systematic follow-up processes in primary care.** This action is colour rated green. HTPCT are implementing processes to ensure that GPs have systems in place to monitor vulnerable patients with ongoing mental health problems, encompassing repeat prescribing and non compliant patient alerts. *Processes still require embedding and monitoring.*

7. **Implementation of CPA policy.** This action is colour rated green. Audits are being conducted annually in BEHMHT. A new CPA trainer is now in post. No figures were forthcoming as to how many BEHMHT staff have attended training or the outcome of the annual audit. *The Independent Investigation Team believe that more work is required to achieve local aspirations in this area.*

8. **Discharge from secondary care processes.** This action is colour rated both amber and green. BEHMHT and HTPCT are in the process of developing a discharge protocol. This protocol will be implemented and audited. *Processes still require embedding and monitoring.*

9. **Inpatient Care.** This action is colour rated green. The plan states that BEHMHT will undertake an assessment of the current functioning of inpatient wards at St. Ann's Hospital. The inpatient environment has been refurbished. The Healthcare Commission review in 2007 described the services as 'fair'. *Processes still require embedding and monitoring.*

10. **CMHTs.** This action is colour rated amber. A major reorganisation of the Barnet, Enfield and Haringey CMHT's took place on the 1 October 2007. What the outcomes have been from this reorganisation are not clear as they have not been quantified or assessed as yet. *Processes still require embedding and monitoring.*
11. **Duty services.** This action is still colour rated amber. A reorganisation has introduced radical change. How this has impacted on services is not yet clear.

12. **Internal communication in secondary care.** This action is colour rated green. This action is described as being superseded by the reorganisation in community services. *Processes still require embedding and monitoring.*

13. **Communication between primary and secondary care services.** This action is colour rated both amber and green. The action plan states that standards are in place and that work is ongoing to align General Practices with Complex Care Teams. Work is currently in progress to develop and

implement new protocols. *The Independent Investigation Team believe that more work is required to achieve local aspirations in this area.*

14. **Health records.** This action is colour rated both amber and green. There is an ongoing system of audit being conducted. The plan describes an urgent need for integrated health records to be implemented and the plan describes this occurring at the current time.[218] *Processes still require embedding and monitoring.*

The Independent Investigation Team would like to acknowledge the sound and comprehensive work that has been undertaken since the events of 23 December 2004. The Investigation Team appreciates the ethos of the Haringey Joint Strategic Implementation Group in fostering a continuous quality planning methodology.

There has been a significant improvement in the organisation and management of services in both HTPCT and BEHMHT since Mr. D received his care and treatment. What happened then, between 2000-2004, and what is happening now, reflects not only the passage of time of some eight years but the journey that local services have undertaken. The Independent Investigation Team recognises that further work will be required in the light of both constantly changing national health policy and procedure and local service reprovision. There are some outstanding issues that both Trusts need to consider from the internal investigation report, these will be outlined below in the recommendations section together with the specific recommendations from the Independent Investigation process.

17. Notable Practice

The Investigation Team would like to acknowledge all of the hard work that has gone into creating a comprehensive series of action plans following the internal investigation report.

The JSIG has achieved a whole systems process of both implementing and monitoring significant service transformation. It is encouraging to see how such major change can be brought about when sound project management and partnership working are brought together.

Barnet, Enfield and Haringey have achieved significant progress with regard to addressing BME issues in their locality. Both Trusts have demonstrated how organisations can learn from serious untoward incidents and attempt to meet the challenges in a proactive manner.

The Investigation Team understands that both Trusts acknowledge more work needs to be done and that there is no room for complacency. However the work achieved by both Trusts can be seen as an exemplar process that other London Trusts may be able to learn and benefit from.

18. Lessons Learned

A long interval has occurred between the time that Mr. D first entered mental health services in 2000 and the completion of this report in 2008. The Independent Investigation Team have recognised that a great deal of work has taken place since the events of December 2004, and the subsequent publication of the Haringey TPCT Internal Investigation Report, to ensure that lessons have been learned and that measures have been put in place to prevent such occurrences happening again.

Both the Haringey Training Primary Care Trust and the Barnet, Enfield and Haringey Mental Health Trust are operating within reorganised services and to new and revised policies and procedures.

The Independent Investigation Team would like to add that they believe that both Haringey Teaching Primary Care Trust and Barnet, Enfield and Haringey Mental Health Trust have worked diligently to not only learn lessons but to improve the services offered to their local populations.

The key and transferable lessons learned from this Independent Investigation can be simply listed as follows:

1. The Care Programme Approach forms a central part of the care and treatment of people with a mental illness. The Care Programme Approach creates an essential safety net, without which, service users such as Mr. D can find themselves isolated and a danger to both themselves and others.

2. Risk assessment is a dynamic tool that needs to consider all aspects of an individual's past and present condition. Risk assessment is not an isolated activity; it needs to feed into all aspects of care planning and clinical treatment and intervention.

3. Engagement with service users and carers is crucial. Engagement takes time, patience and skill on the part of the clinician. Rapport, and the building of a therapeutic relationship, must be considered as being of the utmost importance.

4. Policies, procedures and protocols are developed and implemented by Trusts to ensure the safe and effective delivery of clinical services. Routine non adherence to both national guidelines and local policies by healthcare workers leave services and service users vulnerable. Audit is an essential tool in ensuring that Trust Boards are assured that Trust-wide systems are not only in place, but being implemented satisfactorily.

5. Clinical record keeping is not an ‘optional extra’ it is a central requirement for any registered health and social care professional. Good record keeping is the hallmark of good clinical practice. An Investigation such as this demonstrates the old adage, ‘if it was not recorded then it did not happen’. Poor clinical record keeping can prevent good contemporaneous communication and prevent planned care and treatment from taking place in an effective and timely manner.

6. Clinical and caseload supervision is an important part of clinical service delivery. It is there to provide a very real and solid assurance that clinicians are practising safely and appropriately and within their areas of competence.

7. Learning organisations can learn lessons from serious untoward incidents. These lessons can be transformed into dynamic service delivery plans that develop and improve services ensuring that the likelihood of such incidents occurring again is reduced.

19. Recommendations

The Internal Investigation, despite the limitations imposed upon it, delivered a robust synopsis of the care and treatment received by Mr. D. As a result both Haringey Teaching Primary Care Trust and Barnet, Enfield and Haringey Mental Health Trust were able to develop sound recommendations and implement a robust action plan.

The Independent Investigation Team endorses both the recommendations and the action plan from the internal investigation as it recognises its continued relevance

and validity. The Independent Investigation Team have a few further recommendations to add, they are as follows:

1. **That the JSIG forms a time-limited operational implementation group to ensure that all outstanding actions on the plan are brought to a conclusion within a six month period of the publication of this report.**

2. **That Barnet, Enfield and Haringey Mental Health Trust ensures that the learning which has taken place jointly with the Haringey Teaching Primary Care Trust as a result of both the Internal and Independent Investigations into the care and treatment of Mr. D is shared throughout the whole organisation and with other health and social care partners.**

3. **That the CPA Policy is reviewed against the most recent Clinical Audit and Effectiveness Report regarding the overall quality of CPA documentation, and that the Barnet, Enfield and Haringey Mental Health Trust ensures that individual practitioners are monitored via supervision and personal development plans to assure the Trust Board that they are practising to an effective standard. The Investigation Team understand that the Trust has prepared new CPA processes in readiness for the new national requirements in October 2008.**

4. **That Barnet, Enfield and Haringey Mental Health Trust audit the quality of service delivery of the newly reconfigured CMHTs in the light of the findings of the Independent Investigation Report.**

5. **That Haringey Teaching Primary Care Trust and Barnet, Enfield and Haringey Mental Health Trust review their Serious Untoward Incident Policy in the light of the findings of this report to ensure that the spirit of the National Patient Safety Agency guidance *Being Open* is fully met.**

6. **That Barnet, Enfield and Haringey Mental Health Trust review its clinical supervision strategy and makes explicit how it forms part of the professional regulatory framework within the organisation.**

7. **That Barnet, Enfield and Haringey MHT take the findings of fact from this Report to further investigate the quality of care and treatment given to Mr. D by the Care Coordinator. This should include consideration of any support that the said Care Coordinator should have received in order to ascertain whether there were any systems failures that prevented the individual from practicing in accordance with both national and local policy and procedure. The Trust should also review all of the Care Coordinator's previous caseload to assure the Trust Board that there are no other cases that require urgent remedial action to be taken. The Trust will be expected to act in accordance with its internal policies and procedures in determining any further actions that need to be taken.**

8. **In light of the fact that the Care Coordinator has not contested the evidence that suggests amendments were made to Mr. D's clinical records, that Barnet, Enfield and Haringey Mental Health Trust act in accordance with both national and local policy and procedure with regards to this matter.**

Glossary of Terms

ASW	Approved Social Worker. A person who is qualified to assess people for detention under the Mental Health Act (1983)
Care Coordinator	Qualified mental health practitioner who coordinates a person's care
Cervical Vertebrae	These are part of the spine that are found in the neck

Cipramil	an antidepressant drug used to treat depression associated with mood disorders
Citalopram	An anti-depressant drug
CPA - Care Programme Approach	National systematic process to ensure assessment and care planning occur in a timely and user centred manner
CPN - CMHN	Community Psychiatric Nurse, or Community Mental Health Nurse
CT Scan - Computerised Tomography	A way of taking images of the body, and the brain
ECG - Electrocardiogram Graph	Method of checking the electrical activity of the heart
EEG - Electroencephalogram Graph	The EEG records brainwave patterns from the continuous tiny electrical signals coming from the brain
ERC - Emergency Reception Centre	A place where mental health service users can go for emergency help. This was a 24 hour walk-in service
Haloperidol	Haloperidol is a major tranquilizer used to treat psychoses
Hypochondrias	A condition when a person always thinks there's something wrong with them physically and that they always think they're ill or are in danger of becoming ill.
Kemedrin (procylidine)	A drug to counteract the side effects of psychiatric medication
Link Worker	Translators
Lorazepam	a sedative and anti anxiety agent
Lustral	An antidepressant drug
Melleril (Thioridazine)	a tranquilizer with antipsychotic and sedative effects
MRI - Magnetic Resonance Imaging	Magnetic Resonance Imaging uses a

	strong magnetic field and radio waves to produce detailed pictures of the inside of the body.
Neurologist	Brain and nerve specialist
Observations	A way of assessing a person in order to assess their mental state
Olanzepine	A psychotropic drug used orally and intramuscularly in the treatment of schizophrenia, bipolar disorder, and acute psychosis
Somatic presentation	A mental disorder characterised by the constant presentation of a complicated medical history and of physical symptoms
Ventricles	Fluid filled spaces in the brain

Notes

1. Department of Health Guidance EL (94)27, LASSL(94) 27
2. Investigation Archive File 1. Broadmoor Clinical Notes. P. 26
3. Investigation Archive File 1. Broadmoor Clinical Notes. P. 27
4. Investigation Archive File 1. Broadmoor Clinical Notes. P. 27
5. Investigation Archive File 1. Broadmoor Clinical Notes. P. 27
6. Investigation Archive File 1. Broadmoor Clinical Notes. P. 27
7. Investigation Archive File 1. Broadmoor Clinical Notes. P. 27

8. Investigation Archive File 1. Broadmoor Clinical records
9. Investigation Archive File 1. Broadmoor Clinical records
10. Investigation Archive File 1. Broadmoor Clinical Notes. P. 142
11. Investigation Archive File 1. Broadmoor Clinical Notes. P. 142b
12. Investigation Archive File 1. Broadmoor Clinical Notes. P. 142b
13. Investigation Archive File 1. Broadmoor Clinical Notes. P. 143
14. Investigation Archive File 1. Broadmoor Clinical Notes. P.143
15. Investigation Archive File 2. GP Clinical Records. P. 5
16. Investigation Archive File 2. GP Clinical Records. P. 97
17. Investigation Archive. Mr. & Mrs. D's Interview Transcription. P. 3
18. Investigation Archive File 1. Broadmoor Clinical Records. P.143b
19. Investigation Archive File 2. GP Clinical Records. P. 7
20. Investigation Archive File 1. Broadmoor Clinical records. P. 3 of PNC printout
21. Investigation Archive File 2. GP Clinical records. P. 7
22. Investigation Archive File 1. Broadmoor Clinical records. PP. 60-61
23. Investigation Archive File 2. GP Clinical records. P. 7
24. Investigation Archive File 2. GP Clinical records. P. 8
25. Investigation Archive File 3. BEH Medical Records. P. 370
26. Investigation Archive File 3. BEH Medical Records. PP. 206-207 & P. 375
27. Investigation Archive File 3. BEH Medical Records. P. 354
28. Investigation Archive File 4. BEH Medical Records. P.114
29. Investigation Archive File 3. BEH Medical Records. P. 354
30. Investigation Archive File 3. BEH Medical Records. P. 377
31. Investigation Archive File 3. BEH Medical Records. P. 378
32. Investigation Archive File 3. BEH Medical Records. P. 355
33. Investigation Archive File 3. BEH Medical Records. P.381
34. Investigation Archive File 3. BEH Medical Records. P. 382
35. Investigation Archive File 3. BEH Medical Records. P. 383
36. Investigation Archive File 3. BEH Medical Records. P. 357
37. Investigation Archive File 3. BEH Medical Records. P. 384
38. Investigation Archive File 3. BEH Medical Records. P. 196
39. Investigation Archive File 3. BEH Medical Records. P. 177
40. Investigation Archive File 3. BEH Medical Records. P. 177

41. **Original CMHT Clinical Records**
42. Investigation Archive File 3. BEH Medical Records. P. 197
43. Investigation Archive File 3. BEH Medical Records. P.321
44. Investigation Archive File 3. BEH Medical Records. PP. 386-389
45. Investigation Archive File 3. BEH Medical Records. P. 357
46. Investigation Archive File 3. BEH Medical Records. P. 389 & 351
47. Investigation Archive File 3. BEH Medical Records. P. 350
48. Investigation Archive File 3. BEH Medical Records. P. 390
49. Investigation Archive File 3. BEH Medical Records. P. 350
50. Investigation Archive File 3. BEH Medical Records. P. 350
51. Investigation Archive File 3. BEH Medical Records. P.177
52. Investigation Archive File 3. BEH Medical Records. P. 319
53. Investigation Archive File 2. GP Clinical Records. P. 98
54. Investigation Archive File 3. BEH Medical Records. P. 313
55. Investigation Archive File 2. GP Clinical Records. P. 92
56. Investigation Archive File 3. BEH Medical Records. PP. 314-315
57. Investigation Archive File 3. BEH Medical Records. P. 177
58. Investigation Archive File 3. BEH Medical Records. P. 311
59. Investigation Archive File 3. BEH Medical Records. P. 198
60. Investigation Archive File 3. BEH Medical Records. PP. 308-310
61. Investigation Archive File 3. BEH Medical Records. PP. 305-306
62. Investigation Archive File 3. BEH Medical Records. P. 176
63. Investigation Archive File 3. BEH Medical Records. P. 176
64. Investigation Archive File 3. BEH Medical Records. P. 303
65. Investigation Archive File 3. BEH Medical Records. P. 302
66. Investigation Archive File 3. BEH Medical Records. P. 175
67. Investigation Archive File 3. BEH Medical Records. P. 301
68. Investigation Archive File 1. Broadmoor Clinical Notes. P. 144
69. Investigation Archive File 3. BEH Medical Records. P. 300
70. Investigation Archive File 3. BEH Medical Records. P. 174
71. Investigation Archive File 3. BEH Medical Records. P. 99
72. Investigation Archive File 3. BEH Medical Records. P. 174
73. Investigation Archive File 3. BEH Medical Records. P. 300
74. Investigation Archive File 3. BEH Medical Records. P. 299

75. Investigation Archive File 3. BEH Medical Records. P. 392-397
76. Investigation Archive File 3. BEH Medical Records. P. 398
77. Mr. & Mrs. D's Personal Archive
78. Investigation Archive File 3. BEH Medical Records. P. 345
79. Investigation Archive File 3. BEH Medical Records. P. 400
80. Investigation Archive File 3. BEH Medical Records. P. 401
81. Investigation Archive File 3. BEH Medical Records. P. 402
82. Investigation Archive File 3. BEH Medical Records. P. 403
83. Investigation Archive File 3. BEH Medical Records. P. 296
84. Investigation Archive File 3. BEH Medical Records. P. 297
85. Investigation Archive File 3. BEH Medical Records. PP. 291-292
86. Investigation Archive File 3. BEH Medical Records. PP. 294-295
87. Investigation Archive File 4. BEH Medical Records. P. 251
88. Investigation Archive File 4. BEH Medical Records. PP. 254-261
89. Investigation Archive File 4. BEH Medical Records. P. 262
90. Investigation Archive File 4. BEH Medical Records. P. 262 & PP. 268-269
91. Investigation Archive File 4. BEH Medical Records. PP 288-290
92. Investigation Archive File 4. BEH Medical Records. PP. 291-294
93. Investigation Archive File 2. GP Clinical Notes. P. 60
94. Investigation Archive File 4. BEH Medical Records. P. 307
95. Investigation Archive File 4. BEH Medical Records. P. 309
96. Investigation Archive File 4. BEH Medical Records. P. 310
97. Investigation Archive File 4. BEH Medical Records. P. 311
98. Investigation Archive File 4. BEH Medical Records. P. 312
99. Investigation Archive File 2. GP Clinical Records. P. 13
100. Investigation Archive File 2. GP Clinical Records. P. 13
101. Investigation Archive File 2. GP Clinical Records. P. 13
102. Mr. & Mrs. D's Personal Archive
103. Investigation Archive File 2. GP Clinical Records. P, 14
104. Investigation Archive File 2. GP Clinical Records. P, 14
105. Investigation Archive File 2. GP Clinical Records. P. 15
106. Investigation Archive File 2. GP Clinical Records. P. 15
107. Investigation Archive File 2. GP Clinical Records. P. 15
108. Investigation Archive File 2. GP Clinical Records. P. 15

109. Investigation Archive. Mr. & Mrs. D's Interview Transcription

110. Investigation Archive File 4. BEH Medical Records. P. 69

111. Investigation Archive. Mr. & Mrs. D's Interview Transcription

112. Investigation Archive File 2. GP Clinical Records. P. 1

113. Investigation Archive File 2. GP Clinical Records. P. 16

114. Investigation Archive. Mr. & Mrs. D's Interview Transcription

115. Investigation Archive. Mr. & Mrs. D's Interview Transcription

116. Investigation Archive. Mr. & Mrs. D's Interview Transcription

117. Investigation Archive. Mr. & Mrs. D's Interview Transcription

118. Investigation Archive File 2. GP Clinical Records. P. 16

119. Mr. & Mrs. D's Personal Archive

120. Investigation Archive File 4. BEH Medical Records. PP. 72-89

121. Investigation Archive File 4. BEH Medical Records. PP. 140-141

122. Investigation Archive File 4. BEH Medical Records. PP. 143-146

123. Investigation Archive File 4. BEH Medical Records. P. 169

124. Investigation Archive File 4. BEH Medical Records. P. 168

125. Investigation Archive File 4. BEH Medical Records. P. 168

126. Investigation Archive File 4. BEH Medical Records. PP. 176-177

127. Investigation Archive File 4. BEH Medical Records. PP. 183-184

128. Investigation Archive File 4. BEH Medical Records. P. 187

129. Investigation Archive File 4. BEH Medical Records. PP. 189-190

130. Investigation Archive File 4. BEH Medical Records. P. 192

131. Investigation Archive File 4. BEH Medical Records. P. 195

132. Investigation Archive File 4. BEH Medical Records. PP. 200-208

133. Investigation Archive File 4. BEH Medical Records. PP. 209-210 & PP. 204-205

134. Investigation Archive File 4. BEH Medical Records. P. 213

135. Investigation Archive File 4. BEH Medical Records. P. 214

136. Investigation Archive File 4. BEH Medical Records. PP. 248-249

137. Investigation Archive File 4. BEH Medical Records. PP. 248-249

138. Investigation Archive File 4. BEH Medical Records. PP. 254-261

139. Investigation Archive File 4. BEH Medical Records. PP. 262 & 268-269

140. Investigation Archive File 4. BEH Medical Records. PP. 262 & 268-269

141. Investigation Archive File 4. BEH Medical Records. PP. 312-313

142. Investigation Archive File 4. BEH Medical Records. PP. 140-141

143. Investigation Archive File 4. BEH Medical Records. PP. 200-208

144. Somatic Symptoms in Turkish and German Depressed Patients Psychosomatic Medicine 56:551-556 (1994). P.551

145. Investigation Archive File 4. BEH Medical Records. PP. 176-177

146. Investigation Archive File 4. BEH Medical Records. P. 295

147. Investigation Archive File 3. BEH Medical Records. P. 401

148. Investigation Archive File 4. BEH Medical Records. P. 312

149. Investigation Archive File 4. BEH Medical Records. PP. 223-225

150. Investigation Archive File 4. BEH Medical Records. P. 236

151. Investigation Archive File 1. Broadmoor Clinical records. PP. 60-61

152. Investigation Archive File 1. Broadmoor Clinical records

153. Investigation Archive File 4. BEH Medical Records. PP. 96-97 & 99-103, & 146-147 & 169, 214

154. Investigation Archive File 4. BEH Medical Records. P. 212

155. Investigation Archive File 4. BEH Medical Records. PP. 96-97 & 99-103, & 146-147 & 169, 214

156. Ms. M First Interview Transcription

157. Ms. M First Interview Transcription. P. 17

158. Ms. C Interview Transcription. P. 11

159. DoH, *Building Bridges: A Guide to the Arrangement for Inter-Agency Working for the Care and Protection of Severely mentally Ill People*, DoH (1995), London HMSO: Component of CPA

160. Investigation Archive File 4. BEH Medical Records. PP. 146-147 & 169

161. **Original CMHT File**

162. Ms. C Interview Transcription

163. Investigation Archive File 4. BEH Medical Records. P. 214

164. Ms. C Interview Transcription

165. Investigation Archive File 4. BEH Medical Records. PP. 133-134

166. Ms. M First Interview Transcription

167. Investigation Archive File 4. BEH Medical Records

168. Department of Health, *Mental Health policy Implementation Guide*, (30 March 2001)

169. Ms. C Interview Transcription

170. Ms. M First Interview Transcription

171. Ms. M First Interview Transcription

172. Ms. M First Interview Transcription

173. **Original CMHT File**

174. **Original CMHT File**

175. **Original CMHT File**

176. Ms. M Second Interview Transcription

177. Ms. M Second Interview Transcription

178. NMC

179. Enfield and Haringey Health Agency Joint Care Programme Approach Policy (1996), P. 3

180. Enfield and Haringey Health Agency Joint Care Programme Approach Policy (1996) P. 7

181. Enfield and Haringey Health Agency Joint Care Programme Approach Policy (1996) P. 17

182. **Original CMHT File**

183. Ms. M First Interview Transcription

184. Ms. M Second Interview Transcription

185. The United Kingdom Central Council for Nursing and Midwifery (UKCC) *Guidelines for Records and Record Keeping* (1998, revised 2002). P. 7

186. The United Kingdom Central Council for Nursing and Midwifery (UKCC) *Guidelines for Records and Record Keeping* (1998, revised 2002). P. 8

187. Enfield and Haringey Health Agency Joint Care Programme Approach Policy (1996) P. 7

188. GP's Interview Transcriptions

189. GP's Interview Transcriptions

190. GP's Interview Transcriptions

191. Mr. & Mrs. D's Interview Transcription

192. Investigation Archive File 2. GP Clinical Records. P. 16

193. Internal Investigation Report. Part 1. P.16

194. Investigation Archive File 4. BEH Medical Records. P. 312

195. Mr. & Mrs. D's Interview Transcription

196. Investigation Archive File 3. BEH Medical Records. PP. 305-306

197. Enfield and Haringey Health Agency Joint Care Programme Approach Policy (1996) P. 11

198. Enfield and Haringey Health Agency Joint Care Programme Approach Policy (1996) P. 17

199. Internal Investigation Report. Part II. P. 9

200. Fernando, S. *Race,* 'Culture and Ethnicity' *Mental Health, Race and Culture* (1991)

201. Mr. & Mrs. D's Interview Transcription

202. *"Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages, and Rehabilitation Centres of Turkey" is posted at* <*www.mdri.org/projects/turkey/turkey%20final%209-26-05.pdf*>*.*

203. Internal Investigation Report. Part II. P. 10

204. Investigation Archive File 4. BEH Medical Records. P. 236

205. Dr. 1 Interview Transcription

206. National Service Framework for Mental Health Services 1999

207. Internal Investigation Report. Part II. P. 10

208. Investigation Archive File 4. BEH Medical Records. PP. 3-4

209. Investigation Archive File 4. BEH Medical Records. PP. 6-7

210. Investigation Archive File 4. BEH Medical Records. P. 6

211. Investigation Archive File 4. BEH Medical Records. PP. 11-13

212. Investigation Archive File 4. BEH Medical Records. P. 13

213. Internal Investigation Report. Part III. P. 1

214. Memorandum of Understanding, 2006

215. Investigation Archive File 4. BEH Medical Records. P. 38

216. Investigation Archive File 4. BEH Medical Records. P. 39

217. Mr. D Interim Action Version Three 27 May 2006

218. Joint Strategic Implementation group Action Plan March 2008

Investigation into the Care and Treatment of Mr. D

Timeline and Critical Issues

1,	27 January 2000	Following an incident of 18 December 1998 Mr. D attended Wood Green Crown Court and pleaded guilty to Actual Bodily Harm (ABH), following which Mr. D was subject to a one year a Combination Order consisting of a one year Probation Order and 40 hours of community service and was expected to attend the 'Break Free' project. Critical Juncture No. 1. Mental Health Services were not aware of Mr. D's criminal record
1.	4 June 2000	Self-presented at North Middlesex A&E stating that he had no blood in him, that his heart ached and that he had itching all over his body. He is described as a 25 year old gentleman 'who is preoccupied with vague hypochondriacal and somatic symptoms. Locum SHO deemed him medically fit. However the SHO gained the impression of a psychotic mental illness, probably precipitated by Khat. Mr. D appeared to be distressed with thoughts of suicide. The plan: admission to the mental health unit via the ERC. Mr. D was admitted to Downhills ward via ERC. He was assessed as being of medium risk, and that he required PRN medication and routine blood and urine screening. It was noted that his parents spoke little English and that they were reluctant for him to stay in hospital. Mr. D agreed to stay informally as an inpatient. Meds. Droperidol 10 mg Lorazepam 2 mg.
2.	6 June 2000	W/R. Dr. 3, the Locum Consultant noted Mr. D had suicidal thoughts and was distressed by physical symptoms. Mr. D denied having a mental illness and refused medication. Mr. D's mother was present and explained that she did not wish him to stay in hospital. Medical advice was to stay in hospital. Plan: to stay in hospital, advised not to chew Khat, observe on ward before making a decision about meds., for review the following Tuesday at ward round. An urgent request was to be made regarding EEG and CT scan.

Mr. D left the ward after the ward round and did not return. Mr. D's father phoned the ward.

3. 8 June 2000 — Mr. D's parents were seen at the ward by Locum SHO. Mr. D did not accompany them. Mr. D's parents thought that he may be a little depressed, but refused to accept he had a mental illness. The parents asked for psychotherapy and were anxious that Mr. D should be married. Plan: Mr. D to be reviewed on Thursday. CT scan booked 7/7/2000.

4. 13 June 2000 — W/R: Dr. 1, Dr. 2, Dr. 3 present. Mr. D seen. Mr. D did not want to stay in the hospital. He continued to describe his physical symptoms. Mr. D expressed the belief that he was going to die. He had suicidal ideas, but tried to push them away. Doctors explained that he needed to stay in hospital. Mr. D refused to stay in hospital at night. Plan: Mr. D to stay in hospital during the day and to sleep at home at night, to have soluble Olanzepine 5mg and to leave the wards after his meds in the evening. Mr. D agreed to this.

Mr. D left the ward after the W/R and did not return as per plan (no medication taken on the ward).

5. 15 June 2000 — W/R: Dr. 1, Dr. 2 present. Mr. D not present. It was noted that Mr. D did not appear to be suicidal. Plan: discharge, CMHT allocation to be made and Mr. D to contact ERC if he had any concerns, EEG 20/06 and OPA Dr. 1 19/07/00 at Kate Marsden unit. Medication Olanzepine 5mgs, 2/52 TTAs. CPA completed in patient's absence (level 1).

Discharge slip outlined discharge plan and medication regimen. Diagnosed psychotic illness.

Critical Juncture Number 2.
Meds. Prescribed without sufficient assessment. Newly diagnosed psychosis. Mr. D and family appearing to be non compliant.

6. 23 June 2000 — Discharge summary Part II. Stated that Mr. D and his parents refused to keep him in hospital and did not accept his mental illness. They also refused medication. Mr. D was described as continuing to be psychotic with occasional suicidal thoughts. He was discharged in his absence on 15 June 2000.

A letter was sent to Mr. D from his allocated CPN requesting a home visit on 29/06/00 indicating 4/5 visits for assessment would be needed.

8. 29 June 2000 — Part II discharge summary sent out.

Home visit made by CPN. Mr. D and his parents were present. It is recorded that an interpreter would be needed in the future. CPN stated that Mr. D's mood appeared to be stable. ***(APPARENTLY AMENDED NOTES ADD 'NO***

PSYCHOTIC SYMPTOMS, DENIES HEARING VOICES AN VISUAL HALLUCINATIONS).

9. 7 July 2000 — CT Head results showed asymmetry in shape and size between right and left ventricle

10. 13 July 2000 — CPN visited Mr. D at home. His family stated that he was not in. ***(APPARENTLY AMENDED NOTES ADD'HOWEVER SAT AND SPOKE TO PARENTS TO ASCERTAIN WHAT THEIR CONCERNS WERE. MOTHER BELIEVES THAT HE DOESN'T HAVE MENTAL ILLNESS).***

Critical Juncture Number 3. Why did the Care Coordinator attend with no interpreter despite saying she would book one for future visits?

11. 15 July 2000 — A&E attendance for sore throat

12. 17 July 2000 — A&E attendance for SoB

13. 19 July 2000 — OPA Dr. 1. Mr. D had stopped taking his tablets 1 week before. Mr. D felt unwell, he had paranoid delusions that Satan "gives me signs" Mr. D had no hallucinations and poor insight. Dr. 1 felt that Mr. D had a depressive illness with paranoid delusion and that paranoid schizophrenia should be considered. Medication was changed to Citalopram 20 mg. Mr. D was to be followed up in further OPA.

Care Coordinator called Mr. D at his home. He was asleep. His sister said that he was fine. The sister informed the Care Coordinator that Mr. D did not want to see her anymore and that he was fine. Care Coordinator told the sister she would ring in three weeks time. ***(APPARENTLY AMENDED NOTE ADDS THAT MR. D WAS TO BE FOLLOWED UP IN OPA)***

There is no correspondence trail that gave the Care Coordinator this information at the time the notes are purported to be written.

Critical Juncture Number 4. Why was the Care Coordinator making phone calls instead of ensuring that she visited to assess his mental state as per the agreed care plan?

Critical Juncture Number 5.
Why was there no communication between the OP clinic and CMHT. If they had communicated properly at this juncture the Care Coordinator would have known that Mr. D was not taking his medication. If the Care Coordinator had let OP know she was having difficulty seeing Mr. D a different clinical perspective may have been taken.

14. 27 July 2000 — Mr. D was seen at the NMH A&E and then went to the ERC. Mr. D had pains in his heart and felt that his insides did not work. It was deemed that he was psychotic or suicidal. An informal admission to Downhills Ward was agreed so that he could be observed on the ward. Olanzapine 5 mg.

No meds are signed for this stay. The night round noted that Mr. D was missing

15. 28 July 20000 — Mr. D presented at the Whittington Hospital A&E

16. 29 July 2000 — Risk assessment partially completed by Ward Manager

17. 1 August 2000 — W/R Dr. 2. Mr. D not present. Dr. 1 present. CPA plan: early intervention team to visit and attempt to bring him back to hospital, meds to be taken to him. Paroxetine 20 mg now added to the Olanzepine 5 mg. Plan: If not agreeable to come back to hospital and not sectionable to be referred to day hospital. OPA 18/08/00. Attempts were made by the ward to contact Care Coordinator

18. 3 August 2000 — Medical notes state that “not seen yet by CPN” if not returned to ward to be discharged

19. 4 August 2000 — Mr. D is discharged.

Critical Juncture Number 6
Discharge without the assessment of whether he was sectionable or not. No record in the CMHT notes that any attempt was made to visit Mr. D with his medication. This is counter to the plan of 1/8/00.

20. 7 August 2000 — Urgent message left for Care Coordinator by the ward staff to visit Mr. D at home and give feedback.

21. 8 August 2000 — Ward staff spoke to Care Coordinator who said that had not been able to visit Mr. D, but that she placed the TTAs and OPA through the letter box. She said that she was due to see Mr. D at his home at 10.00am (8/8/00)

Care Coordinator visited Mr. D but he was out

Care Coordinator rang Mr. D but there was no reply. Care Coordinator wrote in the notes that she would contact Dr. 2 to state that she was having difficulty conducting the assessment. Care Coordinator stated that she thought Mr D was continuing to take drugs and that his parents were unhappy

Critical Juncture Number 7
There is no evidence to suggest the Care Coordinator ever made contact with Dr. 2 or attempted to contact Mr. D again. There are no clinical records in her file to demonstrate that she made any attempts to contact Mr. D at all between 8 August 2000 and 2 October 2000.

Critical Issue Number 8
Failure to comply with discharge plan of the 1/8/00

22. 17 August 2000 Discharge summary sent

23. 18 August 2000 Mr. D seen by Dr. 2 he appeared to have made progress. Psychotic element remitted but somatic element remained. Citalopam increased to 40 mg and to remain on Olanzepine 5 mg.

24. 12 Sept. 2000 A&E attendance with chest infection did not wait to be seen.

25. 21 Sept. 2000 Letter from Dr. 2 (private Doctor) to Dr. 2. Who stated that he saw Mr. D on three occasions and believed him to "be suffering from severe depression with psychotic features" Dr. 2 also considered that Mr. D may be suffering from mild schizophrenia and dysmorphia. The private Dr. started him on Melleril and sought Dr. 2's advice.

Critical Juncture Number 9
Why wasn't the 'severe depression' followed up by one of the team?

26. 28 Sept. 2000 Letter to Mr. D stating that he had an OPA on 10/10. Plus handwritten note asking him to contact ERC if he had any concerns before that time

There is no evidence that this appointment took place.

Another letter was sent out on this day cancelling an appointment for the 29/11/00

27. 2 Oct 2000 — Care Coordinator wrote in her notes that she had discussed Mr. D with Dr. 2 and that she did not think he was showing any symptoms of psychosis. She said that she would continue her assessment and that Mr. D will continue to be seen in OP.

Critical Juncture Number 10
There is no evidence in her clinical records to show that the Care Coordinator had had any contact at all with Mr. D or family in order to make this assessment

28 3 Oct 2000 — Letter from Dr. 2 to GP. In this letter he disagreed with the diagnosis and treatment that the private Dr. 3ad instigated. Dr. 2 also felt that Mr. D's application for incapacity benefit was not be appropriate

29. 10 Oct 2000 — OPA Dr. 2. Mr. D was feeling better. Prozac was increased to 30 mg. Mr. D states that he felt better since he saw the private Dr. Private Dr. prescribed 5 mg Kemedrin. Continued to wait for CT scan

A letter was sent to Mr. D from the Care Coordinator to make an appointment for a home visit with Mr. D on the 20 October 2000

Critical Juncture Number 11.
There is no record in the CMHT file to say that this meeting took place or why it was cancelled if that is what happened.

30. 11 Oct 2000 — Letter sent by Dr. 2 to neurologist for a CT scan

31. 24 Oct 2000 — Letter to Dr. 2 from private Dr. 1 stated that the Olanzapine made Mr. D feel drowsy and unwell so he stopped taking it. The private Dr. explained that because Mr. D appeared to have psychotic symptoms he had prescribed Melleril. Private Dr. requested copies of the medical notes as he was still planning on seeing the family

Critical Juncture Number 12
Difference in diagnosis not discussed

32. 25 Oct 2000 — Note in CMHT file shows that the Care Coordinator rang Mr. D to remind of a home visit planned on that day. His sister informed Care Coordinator that he was asleep. Care Coordinator rearranged the appointment for the 2/11/00

There is no note in the records to explain why the date of CM's visit had been changed from the 20 to the 25th October 2000.

		Letter from Care Coordinator sent to Mr. D to confirm home visit on the 2/11/00. A link worker was booked for this visit
33.	2 Nov. 2000	Care Coordinator made a Home Visit to Mr. D. His mother was there. Only the mother's account is given in the records. It is not clear that Mr. D was present. ***THESE NOTES APPEAR TO HAVE BEEN AMENDED***
34.	3 Nov 2000	Assessment form signed and dated by Care Coordinator. Her plan was to: complete mental health assessment, ascertain client's needs, offer education to the family, ascertain families understanding of mental illness
35.	21 Nov. 2000	OPA with DR. 2. Mr. D appeared to be improving and that he was compliant with his medication
36.	29 Nov 2000	Care Coordinator stated that several attempts had been made to contact Mr. D by phone but that the family informed her that he did not want to talk to her. ***APPARENTLY AMENDED NOTE ADDS THAT CARE COORDINATOR VISITED LATER IN THE DAY WITH AN INTERPRETOR AND CONDUCTED A DELUSIONAL RATING SCALE. MR. D'S MOTHER STATED THAT HE WAS COMPLIANT WITH MEDICATION. CARE COORDINATOR WROTE THAT SHE DISCUSSED EARLY WARNING SIGNS WITH MR. D. THIS ENTRY APPEARS TO HAVE BEEN ADDED AND THE DATE CHANGED. INFORMED FAMILY THAT THIS WOULD BE HER LAST VISIT.***
		Critical Juncture Number 13 Delusional scale not completed or dated. It did not appear to have been used to inform a care plan or to have been communicated to Dr. 2. The decision to stop seeing Mr. D also appears not to have been communicated to Dr. 2.
37	3 Jan 2001	Letter from neurologist to Dr. 2 explaining that previous referral did not arrive and agrees to a scan under sedation.
38.	16 Feb 2001	Care Coordinator's notes state that a home visit was made after having been informed that Mr. D had been admitted to St. Ann's. Mr. D said that he did not want to have visits from Care Coordinator preferring to meet Dr. 2 at OPA. Mr. D also declined the opportunity to attend the day hospital. Care Coordinator stated in the clinical record that Dr. 2 was informed *There is no record of this*
39.	19 Feb 2001	Letter from Care Coordinator explaining to Mr. D that she was on leave from the 19 - 26 Feb 2001.
40.	27 Feb 2001	DNA OPA

41. 28 Feb 2001 — Care Coordinator visited Mr. D at his home. She wrote that Mr. D felt alright and didn't want any involvement in his plan. Plan: letter to Dr. 2, give Mr. D her contact number, brief mental health assessment completed, Mr. D to agree to see Dr. 2 at OPA.

    Decision to have no further involvement with Mr. D unless requested to by him or the team

    Critical Juncture Number 14.
    There is no copy of any letter to Dr. 2 in the CMHT notes or any indication that he was informed of this decision

42. 20 March 2001 — DNA OPA. Mr. D discharged. Dr. 2 states that as he had missed two appointments no further ones would be made

    Critical Juncture Number 15
    Mr. D not engaging with any of the clinical team. No assessments completed and the decision to discharge made. Was this appropriate?

43. 20 May 2001 — Admitted under section 2 from the police station for criminal damage and agitated behaviour. He had been arrested by police two months previously but had been released. Required restraint and had pressured speech, he was also thought disordered. Paranoid ideation, non compliant with medication for the last four months. Mr. D was admitted to K2 ward

    Issue: was the contact that Care Coordinator had made with him two months previously anything to do with the police involvement in February. It is not recorded anywhere

44. 21 May 2001 — The diagnosis was a possible schizo affective disorder, drug induced psychosis, hypomania. Plan: Haloperidol PRN, drug screen, routine obs., section 2 application completed

    Mr. D presented with many somatic symptoms and appeared to be paranoid and thought disordered. He was restless on the ward, but took medication with encouragement. His drug screen was negative

45. 22 May 2001 — Mr. D's medication was reviewed. Haloperidol 5mgs BD, Olanzapine 10 mgs. Lorazepam 1 mg

46. 23 May 2001 — Took Medication. Stayed on Ward

47. 24 May 2001 — W/R. Not recorded who attended. Mr. D appeared to be relaxed and appeared to be improving mentally.

48.	25 May 2001	Mr. D appeared to be getting 'brighter', took PRN
49.	26 May 2001	W/R not recorded who attended. Mr. D judged to still have poor compliance with medication
50.	27 May 2001	Spent most of the day in bed. Took meds
51.	28 May 2001	Pleasant and compliant
52.	29 May 2001	W/R. Dr. 4, Interpreter and mother present. Mr. D due in court 16/7/01. Dr. 2 suggested the use of a depot, mother refused consent. Decided on Haloperidol in divided doses. W/R informed that Mr. D would be going to Turkey. Section 23 completed and Mr. D discharged from section 2 Mr. D given 1 weeks leave Critical Juncture Number 16 Mr. D given leave with no risk assessment having been carried out
53.	30 May 2001	Mr. D attended A&E with chest pains and depression.
54.	31 May 2001	W/R. Dr. 4. Pt and mother left without being seen. Medication reviewed. Mr. D contacted at home and informed that his meds had been changed. Haloperidol 5mg nocte, Risperidone 1 mg nocte, procylidine 5 mg BD. To be reviewed on Tuesday. Critical Juncture Number 17 Medication changed without seeing Mr. D, notifying him over the phone
55.	2 June 2001	W/R: not recorded who attended. Mr. D appeared a little better, no paranoid thoughts. Discharged on Risperidone 2mg for 3/7 increasing to 3mgs 4/7 and then 6mgs daily. Care Coordinator to follow up. Diagnosis schizophrenia Critical Juncture Number 18 No CPA documentation in CMHT file. No follow up or communication appears to have taken place. Mr. D discharged on an increasing drug regime when it was known that he was non-compliant.
56.	11 June 2001	Difficulties breathing

57. 27 June 2001 DNA OPA.

58. 7 Oct 2001 Letter from Dr. G to Dr. 2 informing him of DNAs at OPA re-MRI

59. 25 Sept 2001 OPA with Dr. 2. Whilst in Turkey Mr. D had not been well and had seen a doctor with possible side effects from the risperidone. Continued with Lustral 50 mg

60. 8 Oct 2001 Self presented to OPD. DR. 2 could not see him and referred him to the ERC.

61. 9 Oct 2001 Dr. 2 saw Mr. D where he presented with his somatic symptoms and general anxiety. Dr. 2 increased the Lustral to 100mg daily

Critical Juncture Number 19
Perhaps this should have been followed up more rigorously as Mr. D may have been becoming unwell, which would lead him to his admission shortly afterwards. Should this have been picked up at the time?

62. 5 Nov 2001 Fourth admission. Police contacted by the family of Mr. D. Mr. D wanting to slash his wrists and end it all. Mr. D believing that he was the Son of God. Verbally aggressive. The family very scared. Mr. D unable to accept he needed to be in hospital and required rapid tranquillisation. Seclusion and restraint.

Diagnosis depression with a relapsed schizophrenia. Admitted on a Section 4. his rights under section 132 were read to him. 1:1 observation.
Diagnosis paranoid schizophrenia not controlled on Risperidone.

63. 6 Nov. 2001 W/R. It was noted that Mr. D's key worker was his usual Care Coordinator and that she had not seen him for a while. Dr. C discussed the discharge plan with the Care Coordinator " who was seeing the patient today". It was decided that once the section had expired Mr. D was to be discharged. OPA were to be arranged. No CPA papers were completed. Mr. D was felt not to be sectionable.

Critical Juncture Number 20
Care Coordinator does not appear to have followed this patient up despite having had a phone conversation with Dr. C

No CPA was completed or initiated

64.	7 Nov 2001	Referred to the day hospital
65.	13 Nov 2001	Discharge summaries sent. Care Coordinator was contacted and told to arrange an urgent follow up in the community. The family reluctantly agreed to take Mr. D home
66.	22 Nov 2001	ERC notification of attendance at GP due to side effects from his risperidone. OPA follow up arranged
67.	30 Nov 2001	Urgent referral to Dr. 2 re-adverse reaction to Risperidone. Mr. D attends ERC the following day.
68.	10 Dec 2001	OPA with Dr. 2, Mr. D had been placed on Olanzapine 5 mg daily and appeared to have been tolerating it well. Mr. D appeared to be well.
69.	20 Feb 2002	OPA with Dr. 2. Mr. D appeared to be much better. Somatic symptoms in abeyance. Dr. 2 suggested a referral to the day centre.
70.	8 May 2002	OPA Somatic symptoms returned. Mr. D was due to go to Turkey.
71.	18 Sept 2002	OPA with Dr. 2. Mr. D could not work due to physical pain. Dr. 2 was concerned that Mr. D may not have been entirely compliant
72.	28 Jan 2003	***LETTER SENT BY CARE COORDINATOR TO MR.D TO ARRANGE APPOINTMENT. NO COPY IN NOTES OF THIS OR ANY REASON WHY THE CMHT SHOULD BECOME INVOLVED AGAIN AT THIS TIME. FAMILY CLAIM TO HAVE MET CARE COORDINATOR IN SUPERMARKET CARPARK, REQUESTING HELP AT THIS TIME . NO CLINICAL RECORDS EXIST OF THIS AND CARE COORDINATOR HAS NO MEMORY OF IT. FAMILY HAVE A COPY OF THE LETTER***
73.	15 Oct 2004	Mother and sister of Mr. D visit ERC and see Mr. C, ASW. They say that Mr. D is withdrawn and not taking his medication. Checked out on PIMS and ASW suggests that they make an appointment with their GP. ASW gives the family his contact details. Critical Juncture Number 21 Should ASW have asked for a duty visit at this point?
74.	8 weeks before	Father stated that he went to St. Ann's asked for help and got turned away.

	incident	
75.	6 weeks before the incident	Father claimed he went to St. Ann's and asked for Dr. 2 but got sent away
76.	Four weeks before the incident	Father claims he went back to find Care Coordinator and was told that she was on Leave. He was advised to go to the GP
77.	Three weeks before the incident	Father claims he went back and asked for the Care Coordinator to be told she was still on leave. Father went back later the same day with his daughter because Mr. D was aggressive the Trust sent them away and told them to go to the GP Critical Juncture Number 22 If the Trust had followed up these visits would the outcome have been different? Should they have followed this up. What would have been reasonable?
77.	30 Nov 2004	Family visit GP. Asking for rehousing for Mr. D. Arrangements were set in motion for a home visit that never occurred. Critical Juncture Number 23 If the GP had followed this up would the outcome have been different.

Appendix Two

1 ***Recommendation 1: That a medical review of the records with conclusions and recommendations be conducted.*** *Initial review to be completed by May 2005*

Action: Mental Health Trust

2 ***Recommendation 2: That there is a thorough review of current risk assessment and risk management mechanisms and that changes are implemented as required.*** *Initial review to be conducted by February 2005.*

Action: Mental Health Trust.

3 ***Recommendation 3: That there is an assessment of the current functioning of the wards in relation to ward management, admission criteria, engagement and therapeutic care planning, and that changes are implemented as required.*** *Initial assessment to be completed by February 2005.*

Action: Mental Health Trust.

4 ***Recommendation 4: That there is a review of the current functioning of CPA, and that changes are implemented as required.*** *Initial review to be completed by September 2005.*

Action: Mental Health Trust.

5 ***Recommendation 5: That there is a thorough review of the Community Mental Health Teams in the light of the questions above,*** (Part I, paragraph 46) ***and change is implemented as required.*** *Initial review to be completed by February 2005.*

Action: Mental Health Trust.

6 ***Recommendation 6: That all internal communication processes within the mental health clinical services be reviewed and changes implemented as required.*** *Initial review to be completed by February 2005.*

Action: Mental Health Trust

7 ***Recommendation 7: That the current practice*** (communication between primary and secondary care) ***is reviewed from both the primary care and secondary care perspectives and mutually agreed changes are implemented and evaluated.***

Initial review to be completed by September 2005.

Action: Mental Health Trust and Teaching Primary Care Trust

8 ***Recommendation 8: That there is a thorough review of the provision of language services and the uptake of provision in primary and secondary care.*** *Review of the language service provision to be completed by February 2005.*

Action: Teaching Primary Care Trust and Mental Health Trust.

9 ***Recommendation 9: That there is an assessment of the level of awareness of primary and secondary care staff of the importance of listening to and engaging families; that changes are implemented as required.*** *Initial review of the level of awareness around engaging families to be completed by February 2005.*

Action: Teaching Primary Care Trust and Mental Health Trust.

10 ***Recommendation 10: That a clinical record audit is undertaken, covering in patient, out patient and community mental health team records, and that changes are implemented as required.*** *Audit to be completed by September 2005.*

Action: Mental Health Trust.

11 ***Recommendation 11: That an appropriate mechanism for reviewing records in primary care is identified and implemented.*** *To be completed by September 2005.*

Action: Teaching Primary Care Trust.

12 ***Recommendation 12: That there is a thorough review of the Duty Service's current policies and practice, and that changes are implemented as required.*** *Review to be completed by July 2005.*

Action: Mental Health Trust and London Borough of Haringey.

13 ***Recommendation 13: That the Repeat Prescription protocol is reviewed and amended as required; that action is taken to ensure that all Haringey practices are aware of and commit to following the protocol.*** *The review to be completed by February 2005, with a roll out programme to all GPs by September 2005.*

Action: Teaching Primary Care Trust.

14 ***Recommendation 14: That a discharge protocol be developed covering discharge from sections of the secondary care service and from the secondary care service back to primary care, and that this is implemented and audited.*** *The*

protocol to be developed by September 2005.

Action: Mental Health Trust and Teaching Primary Care Trust

15 ***Recommendation 15: That the current shared care protocol is reviewed, and that a thorough revision is undertaken if indicated.*** *Review to be completed by October 2005.*

Action: Teaching Primary Care Trust and Mental Health Trust