REPORT OF AN INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF [redacted]

Date of birth: [redacted]

Tony Drew,
Independent Investigator
27 November 2006

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7. Findings and Recommendations

1. INTRODUCTION AND SUMMARY

1.1 This is the report of an independent investigation into the care and treatment of [redacted], a service user known to the Mental Health Services provided by Berkshire Healthcare NHS Trust and Slough Social Services Department. The purpose of the investigation was to review the care and treatment provided to [redacted] with particular reference to events on 23 April 2006, and to make recommendations as appropriate.

1.2 [redacted] first contact with adult mental health services was in 1989, when he was admitted to Wexham Park Hospital with a diagnosis of drug induced psychosis. Following his second admission to Wexham Park Hospital in November 2003, [redacted] maintained contact with mental health services, attending outpatient appointments. On 23 April 2006 [redacted] killed his mother and he was subsequently charged with her murder. [redacted] is currently detained at the Oxford Clinic under Section 37 (41) of the Mental Health Act.

1.3 The main findings of the investigation in relation to [redacted] care and treatment are as follows:

1) I have seen no evidence that the arrangements for [redacted] care and treatment were unsuitable, given the diagnosis that was made and the assessment of his needs in December 2003.

2) From 2004 onwards outpatient appointments were arranged at appropriate intervals and were appropriately recorded; there was good communication from the psychiatrist to the GP.

3) [redacted] had trust in his GP, and perceived mental health services as being there to help him.

4) There was a weakness in the system whereby because [redacted] was on standard CPA, there was no virtually no communication by mental health services with family members after his discharge from hospital. While this reflects normal practice, this practice needs to be reviewed in cases where the service user lives with a family member and has a history including psychotic episodes and risky behaviour.

5) The lack of communication with the family meant that the family did not know of the existence of the Crisis Resolution Service, or how to access it. There is a weakness in the system in that there is no mechanism whereby family members in close contact with a service user on standard CPA will necessarily be made aware of this information.

6) The involvement of the Access Team after [redacted] November 2003 admission was not properly recorded so that it was not possible to be certain that the aims of the care plan had been addressed.

7) Given the diagnosis and assessment in December 2003, the decision to place [redacted] on standard CPA was reasonable and in accordance with Berkshire Healthcare Trust's CPA policy.

8) The care plan formulated for [redacted] discharge in December 2003 appears to have been based upon an inadequate period of assessment. While the process of formulating the care plan appears deficient, the content of the care plan was reasonable.

9) During [redacted] 2003 admission to Wexham Park there were some practice deficiencies:
   - it was not ideal practice to reallocate [redacted] bed so early in his admission; this must reflect bed pressures at the time;
   - his home leave should have been preceded by a care plan and contingency plan which should have been agreed with his family;
   - the clinical team should have engaged in more direct communication with his family not only to assist in assessing [redacted] needs and formulating a care plan, but also to advise the family on his care and management and involve them in crisis and contingency planning which would affect them directly.

10) I have concluded that the events of April 2006 could not have been predicted.

2. TERMS OF REFERENCE

The investigator was asked to:
- carry out a detailed review of the multidisciplinary notes;
- interview and obtain statements from professionals involved in [redacted] care and family members as appropriate;
- produce a written report with recommendations for practice and improvement of the service;

The investigation has sought to consider the adequacy and suitability of the care and treatment given to [redacted], the effectiveness of multidisciplinary working and communication, and the engagement and contribution of the service user, and involved family members. The investigation has also considered the extent to which care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.

3. EVIDENCE CONSIDERED

3.1 I have contacted the following people in the course of the investigation:

Detective Sergeant Ailsa Craig, Thames Valley Police
Telephone call on 30 August 2006

Ann Stavro, Manager, Slough Housing Department
Telephone call on 30 August 2006

Karen Golding, Community Psychiatric Nurse
Telephone call on 29 September 2006

[redacted], and [redacted], sister and brother of [redacted]
Interview on 12 October

Dr Emmanuel Olawale, Staff Grade Psychiatrist, Berkshire Health Care Trust
Interview on 13 October 2006

Susannah Yeomans, Team Manager, Slough Community Mental Health Team
Interview on 2 November 2006

Julie Render, Manager, Slough REAP
Interview on 2 November 2006

Manager, CASCADE drug and alcohol service
Telephone call in October 2006

Dr Bain, GP, Langley Health Centre
Interview on 7 November 2006

[Bill Day, Access Team Leader no longer works for the CMHT]

1.2 In addition to the above contacts, I have viewed copies of the Slough CMHT case records, the Wexham Park Hospital case records, and Slough Housing Department records, and a report prepared by Dr Jenny Jack, Specialist Registrar in Forensic Psychiatry, on 26 May 2006.

4. SUMMARY OF KEY EVENTS

4.1 The following chronology summarizes some of the main events relating to [redacted] care and treatment from Mental Health Services, drawn from the Trust and Social Services case records and from information obtained from interviews during the investigation. A more detailed account is provided in the analysis in section 6 of this report.

February 1989	[redacted] reported to his GP that he was experiencing suicidal ideas and thought he was the devil.
29 March 1989	[redacted] reported to his GP that he had put his fingers in an electric socket and tried to circumcise himself; he was admitted to Wexham Park Hospital where drug induced psychosis was diagnosed; he was prescribed chlorpromazine.
10 April 1989	[redacted] was discharged from Wexham Park Hospital; he was seen at outpatients on 24/4/06 when he appeared well and declined medication.
5 May 1989	[redacted] was treated at A&E Wexham Park for lacerations after putting his arm through a window following an altercation at work.
December 2000	[redacted] was assessed by a psychiatrist following concerns about stress relating to a police request for him to be a witness at a murder trial; he was said possibly to be in the early stages of relapse of his psychotic condition. In February 2001 he failed to attend an outpatient appointment and was discharged from mental health services.

20 November 2003	[redacted] was admitted to Wexham Park Hospital in an acutely psychotic state, having been assessed in A&E where he had to be restrained by police. A diagnosis of acute psychotic episode was made.
22 December 2003	[redacted] was discharged from hospital with a care plan including short-term support from the CMHT Access Team, outpatient appointments and prescription of Olanzapine.
29 January 2004	[redacted] attended an outpatient appointment, and appeared well and compliant with treatment.
30 March 2004	The CMHT Access team decided to refer [redacted] to REAP and close the case.
10 May 2004	[redacted] attended an outpatient appointment; his dosage of Olanzapine was reduced from 10mg to 5mg because of excessive sedation.
20 October 2004	[redacted] failed to attend an outpatient appointment.
19 January 2005	[redacted] attended an outpatient appointment; he appeared mentally stable
1 June 2005	[redacted] failed to attend an outpatient appointment.
9 August 2005	[redacted] attended an outpatient appointment. No psychotic symptoms were noted.
2 February 2006	[redacted] attended an outpatient appointment. He was prescribed Sertraline in addition to 5mg Olanzapine, and advised against cannabis use.
13 April 2004	[redacted] moved his belongings to a new flat at Churchill Road, Slough, and moved in on 17 or 18 April
21 April 2006	[redacted] went to stay at his mother's house
23 April 2006	[redacted] killed his mother, then attempted to harm himself and called for an ambulance. He was detained by police at 8.20am on 23 April 2006.

5. CARE AND TREATMENT PROVIDED

Family and Personal History before 1989

5.1 [redacted] is the oldest of three siblings, and has a sister and brother. He grew up in the family home in Slough with his parents and siblings. [redacted] is said to have been teased at school. At 11 years [redacted] was seen by a child psychiatrist following concerns about 'hoarseness' which was thought not to be organic in origin. No particular concerns arose from that consultation. His sister said their father was frequently violent and threatening throughout their childhood, and bullied [redacted] and taught him to bully others.

5.2 His sister reports that [redacted] became increasingly aggressive and abusive at home at around the age of 16 years. On one occasion she recalled him urinating on the door of the front room. He went out a lot with a group of friends, many of whom are said to have alcohol problems and [redacted] is said to have used alcohol and cannabis with his friends. [redacted] parents were divorced when he was aged 17 years and his father moved out and subsequently remarried. [redacted] got on well with his mother and sister, but his relationship with his younger brother was tense and this has persisted.

5.3 After leaving school [redacted] had various jobs including being a postman for two years; there is a record in his notes that he was sacked for fighting with an Asian co-worker. He subsequently worked as a plumber for Westminster Council.

5.4 His sister and brother recalled an incident in 1984 when [redacted] was aged 23 years, when [redacted] stepped aggressively towards his mother. His brother intervened and placed himself between [redacted] and their mother. [redacted] then physically picked his brother up and threw him through a window, causing him very serious lacerations which required hospital treatment. [redacted] poor behaviour led his mother to seek an eviction order and he moved out into lodgings at the age of 24 years.

5.5 [redacted] sister and brother report that in about 1987 [redacted] started spending more time with his father in Langley at weekends. His sister went to see him there and described him as a changed person: he was thin with his hair shaved and was subdued and withdrawn. His sister believed he had psychiatric problems, and from that time saw him as a mentally vulnerable person who needed a lot of support. [redacted] asked to return to live with his mother and this was agreed.

First admission to Wexham Park Hospital in 1989

5.6 Due to their concerns about his mental state, the family took [redacted] to see his GP at the end of February 1989. [redacted] reported suicidal ideas and thought he was the devil. He had not slept for four or five days. The GP prescribed prothiaden and referred him for an urgent psychiatric outpatient appointment by letter on 1 March 1989. A handwritten note on the referral letter suggests that an appointment was to be arranged for 15 April 1989.

5.7 [redacted] first admission to Wexham Park Hospital was on 29 March 1989. The family had again become concerned about [redacted] mental health, for example he had put his fingers in an electric socket and was observed at home apparently trying to circumcise himself. [redacted] was seen by his GP who arranged for his admission to hospital where he remained as an in-patient for twelve days. The hospital records indicate that [redacted] was expressing bizarre ideas and hearing voices but that these symptoms resolved. He was prescribed chlorpromazine. [redacted] was discharged from hospital on 10 April 1989 and attended an outpatient appointment on 24 April 1989 when he appeared well and told the doctor that he would not continue taking medication. He was given the option of returning in six weeks.

5.8 The ASW report dated 23 April 2006 refers to [redacted] sister giving as an example of his mental ill health, that when she visited [redacted] during his first admission to Wexham Park Hospital he made inappropriate sexualised comments to her.

History from May 1989 to November 2003

5.9 On 3 May 1989 [redacted] got a job as a porter, but there was an incident at work on his second day (5 May 1989) when, apparently in response to being taunted, [redacted] put his arm through a window, causing lacerations which necessitated treatment at A&E at Wexham Park. [redacted] was assessed by a member of the psychiatric team (designation not recorded) who recommended early review by Dr Maddocks' team the next week, and that [redacted] may need to be admitted over the weekend. The GP records in May 1989 indicate that [redacted] continued to take chlorpromazine 25mg bd. There is no further entry in the mental health file until December 2000.

5.10 On 8 August 1989 [redacted] saw his GP who noted he appeared strange. His GP asked for a Community Psychiatric Nurse to contact him to offer support and encourage him to take medication. The CMHT file contains no record of this referral and, if it was received, it appears not to have been actioned.

5.11 In October 1989 [redacted] mother expressed further concern to the GP about [redacted] becoming quiet and wanting to stop medication. The GP saw [redacted] who reluctantly agreed to continue with a reduced dose of chlorpromazine 25mg once a day.

5.12 The GP had no further contact with [redacted] until January 1991 when he appeared bright and alert, but reported having lost three jobs. [redacted] had one further contact with the GP for a minor physical ailment in 1993, and was not seen again until 10 May 1996 when he was seen by an out of hours doctor who noted bizarre behaviour and prescribed stelazine.

Psychiatric assessment in 2000

5.13 From May 1996 there was no further contact with the GP until September 2000 when [redacted] presented as suffering from anxiety in relation to a request from police for [redacted] to be a witness at a murder trial. At interview [redacted] sister explained that [redacted] had initially been approached by solicitors acting for the two defendants, Messrs Mulcahy and Duffy, who wanted [redacted] to provide a character reference. [redacted] is said to have become distressed by this and disclosed to his family that he had previously lodged with these two men and that they had bullied him and tied him up and burned him with cigarettes. This became known to police who then wanted [redacted] to be a prosecution witness. It was reported that police officers placed [redacted] and his family under considerable pressure, and that he became very stressed and disappeared from home for three days. On 14 December 2000 [redacted] was taken by his sister to the CMHT where he was assessed by Dr Santos. [redacted] was anxious and expressed his belief that what he heard on the radio and TV was related to his situation; he also mentioned having suicidal ideation for some months involving burning himself or overdosing, and that he had taken an overdose a year ago. He reported drinking three or four cans of strong lager at night and increasing his use of cannabis. Dr Santos considered [redacted] could be in the early phase of a relapse in his psychotic condition, and might also be suffering from depression. Dr Santos observed that it may be advisable to monitor his mental state in the community more closely in order to prevent a further deterioration. [redacted] was prescribed Olanzapine 10mg nocte and given an outpatient appointment, but was reluctant to have contact with a CPN. Following this assessment [redacted] attended the Old Bailey but on receipt of a faxed psychiatric report, police decided not to call him as a witness. On 11 January 2001 [redacted] received treatment at A&E to an injury to his right index finger, which was thought to be an accidental injury. [redacted] failed to

attend a follow-up psychiatric appointment on 27 February 2001 and it appears he was discharged from mental health services at that point. [redacted] sister reports that from about this time he started drinking strong lager more regularly. He also continued to smoke cannabis which he had done for many years.

5.14 [redacted] saw his GP once in 2002 for a minor physical ailment, when there was no indication he was mentally unwell. On 29 January 2003 [redacted] saw his GP and reported depression and anxiety, although there was no evidence of bizarre behaviour.

5.15 While [redacted] had no contact with mental health services from the time of his assessment in December 2000 until November 2003, his sister reports that his behaviour continued to cause periodic concern to the family. There were episodes when he became unusually quiet and compliant, when he would hear voices, and express strange ideas about the electric switches, and wanted the television switched off. There were also occasions when he was seen in the bathroom with a knife trying to cut his penis. [redacted] mother took to removing all knives and razor blades from the house, carrying them to work in her bag every day because she feared he would harm himself.

Second admission to Wexham Park Hospital in November 2003

Presentation on admission

5.16 [redacted] was taken to A&E at Wexham Park on 20 November 2003, with a letter from his GP stating that he had not slept for three nights, was garrulous and had been behaving bizarrely, eg. removing all the fuses from the fuse box. He claimed not to have used alcohol or cannabis for the past week. While at A&E he was said to be running around in a threatening manner and was restrained by police. He agreed to be admitted to Ward 11 at Wexham Park Hospital. He had started a new job as a driver which he had lost three days before his admission. [redacted] sister reports that [redacted] found the job difficult to cope with and became very stressed. She believed this had precipitated the episode. On assessment [redacted] was agitated and elated and admitted to auditory hallucinations and described seeing ants and dogs crawling on his face. He also reported seeing red and green lights and trying to punch the red lights. He appeared to be thought disordered, talking about judgement day. He claimed people were interfering with him through electrical appliances and the telephone. He was commenced on Olanzapine 10mg and reported to settle well. Home leave was agreed to take place four days after admission. Two days later the records indicate that [redacted] family telephoned expressed concern about his bizarre behaviour and threats to harm himself; he had stormed out and said he was unwilling to go back to hospital. After a further four days [redacted] twice telephoned the ward asking to return, mentioning that he feared a confrontation with his brother. His bed had been reallocated and he was offered a bean bag. [redacted] eventually returned to the ward on 1 December 2003.

Risk assessment

5.17 Risk assessment the day after his admission indicated a high risk of deliberate self-harm, suicide or accident, and high potential risk to others. On subsequent assessment the risk levels were assessed as reduced, and the last in-patient risk assessment on 18 December 2003 indicated level 2 for risk to self and others, and risk of exploitation, the only high risk category being risk of relapse which was assessed as level 4. The only recorded evidence of [redacted] having previously self-harmed was the incident in 1989 when he injured

his arm, and his disclosure to Dr Santos in 2000 that he had taken an overdose of paracetamol in the past.

Communication with [redacted] family

5.18 Hospital and CMHT records confirm that during [redacted] period of in-patient treatment, communication his family was recorded as follows (direct communication in bold):

- **20/11/03 – pre-admission nursing record: by A&E liaison nurse who spoke to [redacted] sister and obtained a history**
- **26/11/03 – nursing record: two telephone conversations with [redacted] sister, the first call stating that [redacted] had started acting bizarrely and threatened to harm himself, and had been consuming alcohol; the second call stating that he had stormed out and driven off in his car; the family had informed police**
- 28/11/03 – nursing record: *"Bill Day said that he will ring [redacted] mother to get a feed back about [redacted] mental state since he was sent on leave;'* a referral by Bill Day to the emergency duty team that day states: *'mother deeply concerned re [redacted] attitude behaviours whilst on leave from ward 11'*
- 1/12/03 – nursing record: relatives have expressed some concern about [redacted] being difficult and irritable at home
- **5/12/03 – nursing record of telephone conversation with [redacted] mother who reported he was argumentative, hyperactive and agitated, and not ready to be discharged yet**
- 12/12/03 – nursing record: *'family feel he is alright, no concerns'* – there is no indication of the source of this information
- 19/12/03 – nursing record: [redacted] said to staff that *'his mum is happy about him'*
- 22/12/03 – nursing record: *'has been on home leave, no problem reported'*
- Letters were sent to [redacted] family on 25 November 2003 and 2 December 2003, inviting them to an initial CPA meeting on 1 December and 22 December 2003.
- [redacted] reported to staff that there was tension between him and his brother during [redacted] home leave.

Care planning before discharge

5.19 A Ward Review was recorded on 1 December 2003, attended by '*Dr De Souza and team, C/N Jambocus (WPH) + Pt'*. This indicated concern from the family about [redacted] mental state. A further Ward Review form was recorded on 22 December 2003 which did not specify those in attendance. The form indicated that [redacted] had no psychotic symptoms, and there were no concerns, and Bill Day and the Access Team would provide brief follow up and look into problems of housing. Bill Day was identified as care coordinator. CPA care planning and discharge planning meeting was held on the day of discharge, 22 December 2003. There is no record of family members being invited. The care plan specified a diagnosis of *'psychotic episode'* and included the following elements:

- Dr Olawale to review [redacted] in outpatients and monitor medication (Olanzapine 10mg nocte)
- Bill Day of the Access Team to provide practical and financial support, to help with social problems and reduce stress
- [redacted] was advised he could contact CASCADE about alcohol or drug problems
- The care plan identified [redacted] as requiring the standard level of CPA.
- Relapse indicators were identified as lack of sleep, irritability, pressured speech, paranoid delusions and hallucinations.

- Trigger factors were identified as stress, illicit drug use, excess alcohol, and stopping medication.
- Crisis contact information consisted of Bill Day of the Access Team, the GP, the Consultant psychiatrist, and Berkshire out of hours social services emergency duty cover.
- The form was signed by [redacted], by Dr De Souza (consultant psychiatrist) and by Dr Bain (GP) although it is not clear on what date.
- The CPA form identifies "SCMHT (Access Team)" as care coordinator.
- A CPA Review date of 3 months is recorded
- The form was dated 1 December 2003 and gave a discharge date of 1 December 2003. The date on the form had been altered to 22 December 2003.

Care and treatment from January 2004 onwards

Psychiatric outpatient appointments

5.20 [redacted] attended an outpatient appointment with Dr Olawale, staff grade psychiatrist on 21 January 2004 when [redacted] was noted to be mentally well and compliant. [redacted] attended his next outpatient appointment with Dr Olawale on 21 April 2004, when no concerns were expressed. [redacted] failed to attend his next appointment six months later. He attended a further appointment with Dr Olawale on 12 January 2005 when he was said to be depressed because of his social situation, but reported no family problems or problems with drugs and was observed to be stable. [redacted] did not attend his next appointment in June 2005. He attended a further appointment with Dr Olawale on 3 August 2005 when he was keeping well and complying with his medication. It was noted that he had put on weigh. His housing situation was not resolved. [redacted] attended his next appointment on 2 February 2006. This was [redacted] last appointment before the incident in April 2006. Dr Olawale's record of that appointment is as follows:

- *'no change*
- *need the tablet to help with sleeping*
- *appetite not very good*
- *energy – takes 2-3 joints of cannabis daily*
- *feels depressed but does not want to take medication*
- *denied any strange experience*
- *no active suicidal thoughts*
- *no homicidal ideas*
- *no money worry*
- *Plan – with persuasion will try Sertraline; advised to stop cannabis, review in three months'*

5.21 At interview, Dr Olawale explained that he had asked [redacted] about homicidal ideation at the appointment on 2 February 2006 because of [redacted] profile as a young man living with his mother, taking drugs, and there might be a potential risk of paranoia towards others. However there was no evidence of this. [redacted] appeared to have been experiencing a depressive episode, and Dr Olawale therefore prescribed Sertraline.

5.22 Dr Olawale said that on hearing of the incident on 23 April 2006, he was very surprised. He said [redacted] had never stood out in his mind, and the behaviour he had exhibited was quite common amongst psychiatric patients. Dr Olawale said he understood that as the sole mental health professional involved he automatically became care coordinator under standard CPA. He did not invite the family to outpatient appointments because this was

not routine practice for people on standard CPA, and [redacted] had not expressed a wish to be accompanied by his family. Dr Olawale said that he would have referred [redacted] for additional CMHT support if he had been worried about him, or if [redacted] had expressed concern or indicated that he needed more help with housing or other issues. Neither of these applied. Dr Olawale explained that the consultant psychiatrist leading his team was originally Dr De Souza, but that from December 2004 Dr Joshi took over. Dr Joshi never met [redacted]. Had Dr Olawale had significant concerns about [redacted] he said he would have sought advice from Dr Joshi, but the need did not arise.

The GP's contact with [redacted] from January 2004 onwards

5.23 Dr Bain, the GP, received regular reports from Dr Olawale after each psychiatric appointment outpatient appointment. [redacted] continued to receive repeat prescriptions for his Olanzapine from the surgery. [redacted] saw a GP on three occasions during 2005 for minor physical ailments including acid reflux and inflammation of the elbow.

5.24 [redacted] saw Dr Bain on 8 March 2006, when said he had stopped taking Sertraline, which Dr Olawale had prescribed for him in February, because he was unhappy with the side effects. Dr Bain changed this to Fluoxetine 20mg, in addition to the 5mg Olanzapine.

5.25 Dr Bain said he had seen no warning signs which might indicate that [redacted] was a potential risk to others. He got on well with [redacted], who was always cooperative and amenable, although rather reticent. Dr Bain thought [redacted] had a positive attitude towards his treatment and saw mental health services as being there to help him. Dr Bain did not have a definite view of [redacted] diagnosis. He noted the diagnosis of acute psychotic episode from Dr De Souza and Dr Olawale. Dr Bain commented that in his view communications with mental health services were excellent and this had been the case for the past three years.

CMHT contact with [redacted] from November 2003

5.26 The Hospital file indicates that Bill Day, Team Leader of the Access Team, liaised with Ward 11 during [redacted] admission in November 2003, and that he planned to offer brief support after discharge as specified in the CPA care plan. Bill Day told ward staff that he had seen [redacted] on 28 November 2003 while he was on home leave, although there is no record of this contact on the CMHT file.

5.27 On 16 January 2004 Bill Day wrote to [redacted] inviting him to visit him at the CMHT on 22 January 2004. It is not known whether this meeting took place. The next recorded intervention is a letter sent by Bill Day to Dr Olawale on 30 March 2004 setting out a care plan for [redacted] to apply for housing, and to be referred to REAP for assistance with this, to continue medication and outpatient appointments, and to use New Horizons as a social base. The letter informed Dr Olawale that the CMHT would close the case. On 1 April 2004 Bill Day wrote to REAP asking them to assist [redacted] with his housing application. The letter stated that [redacted] mother was to retire at the end of the month and intended to move to East Anglia and that she had given [redacted] notice to quit. Bill Day closed the case on 1 April 2004.

5.28 There is only one entry on the CMHT file confirming Bill Day's face to face contact with [redacted], on 7 May 2005, although from other documents on file it is evident that there may have been some other unrecorded contact.

5.29 On 6 May 2004 the CMHT file indicates that Bill Day received a telephone call from [redacted] mother, reporting that [redacted] was stressed and not doing anything about his accommodation. [redacted] also telephoned Bill Day who arranged to see him the next day when he helped him complete a referral form and a risk assessment form which REAP required. The referral form, written by Bill Day, stated *"I am supported by Slough CMHT at the present moment".* Bill Day noted that [redacted] relationship with his mother had deteriorated since she had decided to move. Assistance with the form was a 'one-off' intervention and the case remained closed to the CMHT.

5.30 On 13 May 2005 Bill Day responded to a request for a risk assessment from Slough Housing Department, sending them a risk assessment dated 7 May 2004. It appears that this form may have been completed retrospectively based on Bill Day's last contact with [redacted] the previous year. The risk assessment indicated that [redacted] was normally low risk but becomes agitated and unpredictable when using alcohol and drugs together, which tends to happen under stress. He was said to be *'responding well to support at present (REAP and CASCADE) so the risk of relapse is lower, but should further problems/stresses emerge the risk of drug/alcohol misuse would increase significantly'.* There is no record of further involvement by the CMHT.

Involvement of REAP

5.31 [redacted] attended his first appointment at REAP on 1 June 2004, and after further meetings he was accompanied by his REAP worker to an appointment with the housing department on 28 September 2004. He was said to be very unhappy with the outcome of that meeting, because he was told he had no immediate prospect of being rehoused by the Council. [redacted] did not keep further appointments at REAP and REAP closed the case in December 2004. REAP did not inform the CDMHT about the case closure because they understood from [redacted] that he was no longer in contact with the CMHT, and there were no obvious concerns about [redacted]

Involvement of CASCADE

5.32 Before his discharge from hospital in December 2003, [redacted] was advised that he could refer himself to CASCADE for advice and support in relation to drug and alcohol issues. CASCADE confirmed that they have no record that [redacted] ever made contact with their service.

Involvement of Slough housing department

5.33 The housing department received an application from [redacted] on 2 April 2004. Following a meeting on 28 September 2004, [redacted] was advised that he did not qualify for priority housing and was sent a list of organisations he might approach for advice. [redacted] submitted a further housing application in April 2005 which was considered by the housing panel on 31 May 2005 but not agreed. On 13 June 2005 [redacted] mother wrote appealing the decision. This resulted in the housing department agreeing in July 2005 to look for privately rented accommodation for [redacted]. He was eventually offered and accepted a privately rented tenancy in Churchill Road, Slough and moved in on 13 April 2004.

Views of the family about [redacted] care before April 2005

5.34 [redacted] sister confirmed that after [redacted] discharge from hospital in December 2003, his mother was keen that [redacted] should move to independent accommodation. [redacted] mother planned initially to move to East Anglia, to be near her other son and his family, but she wanted to see [redacted] settled first. [redacted] mother and sister pressed the housing department

to prioritise [redacted] case for housing and this eventually resulted in [redacted] being offered a private tenancy in Churchill Road. [redacted] was said not to be keen on this offer, because the property was in shabby condition and it was available on a 6 month let which caused [redacted] some anxiety because he did not cope well with change. He felt he had no other choice so agreed to take it. [redacted] sister as with him when he accepted the tenancy and confirmed he was quite rational at the time.

Events following [redacted] move to Churchill Road on 13 April 2006

5.35 [redacted] sister helped him to move his belongings into his new tenancy, and commented that he seemed harassed by the move. The following day she went on holiday overseas. From [redacted] account given to Dr Jack on 26 May 2006, he moved into the Churchill Road flat on 17 or 18 April, and said he felt under a lot of stress and started drinking more alcohol to cope with this. [redacted] said he went round to his mother's house on Friday 21 April, having slept badly the night before.

5.36 On her return on 21 April 2006, [redacted] sister telephoned her mother from the airport. [redacted] answered and she knew straight away he was unwell. Her mother confirmed this and said that he had not taken his medication the day before and it was at his flat. [redacted] did not want the radio or television on, which the family regarded as a sign he might be hearing voices. He was also drinking beer. [redacted] mother and sister discussed what they could do. They thought from past experience they might get no response if they took [redacted] to hospital. [redacted] mother decided it would be best to take [redacted] to see the GP on Monday. [redacted] last words to her daughter were *'He's alright here. I'm looking after him'.*

5.37 From [redacted] accounts given to the ASW on 23 April 2006, and to Dr Jack on 26 May 2006, he had slept in his mother's double bed with her on the night of Friday 21 April. The following day, Saturday 22 April 2006, his mother asked a friend to get his medication from Churchill Road. He drank four cans of strong lager and a quadruple vodka and went to bed in the early hours of Sunday morning. He said he woke to find the key to his flat under his back and thought his mother had put it there. His mother was downstairs and later returned to bed. [redacted] then went downstairs, picked up a knife and returned and stabbed his mother 42 times. [redacted] said he then tried to use the knife to cut his wrist, and then to curt his penis off arrival. He said he then so climbed to the loft naked, and tried to hang himself using his dressing gown cord. In jumping from the loft he fractured his left wrist. He then telephoned the police and told them he had killed his mother. He was taken into police custody at 8.30am on 23 April 2006.

5.38 Following Mental Health Act assessment on 23 April 2006 it was decided that [redacted] did not require admission to hospital, and he was detained in police custody and remanded to HM Prison Bullingdon. He was subsequently transferred to hospital at the Oxford Clinic under Section 48/49 of the Mental Health Act.

6. CARE AND TREATMENT - ANALYSIS

[Following a summary of the relevant facts, the investigator's opinion is given in italicised text.]

Background history

6.1 Before [redacted] first psychotic episode in 1989, there were various social factors of note including:

- The break-up of his parents' marriage when he was aged 17 years
- His use of alcohol and cannabis, apparently from adolescence onwards
- His poor behaviour at home in late adolescence and early adulthood and tensions with his family
- His continuing poor relationship with his brother, notably an assault on his brother in 1985, after which he had to move out of the family home
- A generally positive relationship with his mother and sister
- A history of sustaining employment in various jobs until 1987 when his periods in employment became shorter
- His association with Mulcahy and Duffy (later convicted of a series of murders and rapes) in the 1980s who may have been abusive towards him
- His return home in 1987, when he presented as mentally vulnerable

6.2 From the account of the family, it appears [redacted] mental health had deteriorated when he returned home in 1987 and from that time they viewed him as mentally vulnerable and in need of their support. No diagnosis of mental illness was made before 1989.

Care and treatment from 1989 to November 2003

First admission to Wexham Park in 1989

6.3 [redacted] first contact with mental health services was in 1989. Following his brief admission to Wexham Park hospital with a psychotic episode, contact with mental health services was not maintained. The records indicate that [redacted] was given the option of returning for a further outpatient appointment but did not do so.

Comment: Good practice would have been to have offered [redacted] a specific outpatient appointment when he attended on 24 April 1989, to have recorded this fact in the notes, and to have recorded his attendance or non-attendance together with a decision whether or not to take further action giving reasons.

6.4 There is no evidence of follow-up by mental health services to a recommendation for further review following a self-inflicted injury in May 1989, or to a referral from the GP for CPN support in August 1989.

Comment: [redacted] should have been offered a specific outpatient appointment following his attendance at A&& in May 1989. If the clinical team considered this was not necessary, this decision and the reasons for it should have been recorded. He should also have been contacted by the CMHT if they had received the GP's referral in August 1989. The GP commented that communications with mental health services at that time were poor but have since improved markedly.

Contact with mental health services from December 2000

6.5 [redacted] next contact with mental health services in December 2000 consisted of a one-off psychiatric assessment at which further monitoring was recommended. At that time [redacted] was not keen to have contact with a CPN at home and he did not attend a follow up psychiatric appointment. [redacted] diagnosis in 1989 had been drug induced psychosis at

assessment in December 2000 no specific diagnosis was recorded, except that he could be in the early phases of relapse of his 'psychotic condition' and could be suffering from depression. Antipsychotic medication was prescribed.

Comment: the intervention offered in December 2000 was appropriate and helpful. Given the presentation at that time, the existence of a precipitating stressor in the shape of [redacted] potential role as a witness in a murder trial, and the evident support provided by his family, the decision by mental health services to take no further action after [redacted] non-attendance at his appointment on 27 February 2001, appears reasonable.

6.6 From 2000 to 2003 no major concerns about [redacted] mental health arose, and he did not come to the notice of mental health services. It is apparent from the family that there continued to be some worrying behaviours but that these did not reach the threshold for the family or [redacted] to seek outside help.

Second admission to Wexham Park Hospital in November 2003

6.7 [redacted] second admission to Wexham Park Hospital was the start of a period of continuous care and treatment by mental health services which continued up to the events of April 2006. The level of care coordination that was offered, together with the content of the care plan, flowed from the assessment made during this hospital admission.

6.8 Given the acute presentation and the level of risk on admission, it is surprising that [redacted] went on home leave after just four days, and that his bed was then reallocated causing difficulty when he wanted to return. A provisional care plan appears to have been formulated based on a very brief period of four days in-patient care which had not gone well. The CPA care plan agreed on 22 December 2003 when [redacted] had been on the ward for only four days before returning after home leave.

Comment: it was not ideal practice to reallocate [redacted] bed so early in his admission, although this must reflect bed pressures at the time. [redacted] home leave, intended to be for a week, should have been preceded by a care plan and contingency plan which should have been agreed with his family. The care plan which was formulated for [redacted] discharge appears to have been based upon an inadequate period of assessment.

6.9 There is evidence of only limited involvement of the family in the formulation of the care plan, although more communication may have taken place than was recorded.

Comment: [redacted] had been admitted in an acute psychotic condition, and it was proposed that he would return to live with his mother. The clinical team should have engaged in more direct communication with his family not only to assist in assessing [redacted] needs and formulating a care plan, but also to advise the family on his care and management and involve them in crisis and contingency planning which would affect them directly.

6.10 A decision was made to place [redacted] on Standard CPA, and this reflects the diagnosis made of 'acute psychotic episode'. The thinking was that [redacted] psychotic symptoms had resolved quickly, that he had had long periods of relative stability, and that stress and

excessive alcohol and drug use were triggers. His care plan on discharge reflected that assessment.

Comment: Given the diagnosis and assessment, the decision to place [redacted] on standard CPA was reasonable and in accordance with Berkshire Healthcare Trust's CPA policy. While the process of formulating the care plan appears deficient, the content of the care plan was reasonable.

Care and treatment from December 2003 to April 2006

Medical care

6.11 [redacted] was seen by Dr Olawale for outpatient appointments. He attended most appointments and on the few occasions when he defaulted he was sent a further appointment which he then kept. The family were not invited to attend.

Comment: Outpatient appointments were arranged at appropriate intervals and were appropriately recorded. There was good practice in informing the GP by letter after each appointment. [redacted] appears to have co-operated well, to have had trust in his GP, and to have perceived mental health services as there to help him.
The fact that the family were not invited and did not attend any outpatient appointments reflects normal practice for people on standard CPA. In cases where the service user lives with family members and has a history including psychotic episodes and risky behaviour, this is a weakness in the system.

6.12 At [redacted] last appointment with Dr Olawale on 2 February 2006, there was a change in medication with the addition of Sertraline. [redacted] sister has expressed concern that this change, and the subsequent change made by Dr Bain, the GP to Fluoxetine may have had some impact on [redacted] mental state and represented an apparent confusion of responsibilities.

Comment: Dr Olawale wrote to Dr Bain about his plan to add Sertraline, and Dr Bain responded to [redacted] concerns about adverse effects by changing the prescription to a similar SSRI antidepressant. Both actions appear to have been reasoned and logical and in line with the respective responsibilities of the GP to provide ongoing medical care and the psychiatrist to provide specialist advice.

CMHT Access Team involvement

6.13 Because Bill Day's involvement was not fully recorded, it is not possible to be certain how extensive or limited it was. It appears that he met [redacted] on perhaps one or two occasions before closing the case. The aim was to provide brief support including stress reduction, but there is no indication in the CMHT file of the level of support that was planned or implemented. The decision of the Access Team to close the case was taken without prior discussion with Dr Olawale.

6.14 Bill Day's communication with REAP and with the housing department after he had closed the case, implied to REAP that [redacted] was receiving support from the CMHT, and implied to

the housing department that [redacted] was well supported by REAP and CASCADE. Both these communications were misleading.

Comment: All contacts with service users should be properly recorded in accordance with accepted standards of good practice. This did not occur.
Bill Day should have discussed his intention to cease his involvement with Dr Olawale before confirming the decision writing. Irrespective of whether it was reasonable to close the case, it is good practice for such a decision and its timing to be discussed with the sole remaining mental health professional to ensure that the overall care plan aims are met.
The lack of recording of contacts or of aims and objectives and how they were met, creates the impression that the Access Team's aim from the outset was to move [redacted] on from the service. Misleading communications to REAP and the housing department may have been motivated by a desire to assist [redacted] in obtaining support from those agencies. However, it cannot be good practice to mislead as there may be unintended consequences including a loss of trust.

Housing need

6.15 [redacted] rehousing was the source of significant stress. His mother wanted [redacted] to move out, and he accepted this. At the same time he had lived with his mother most of his life and the move and separation were going to require adjustments to his lifestyle and were likely to have some emotional impact. At the time of the housing move, [redacted] had support from his family but no agency was involved in providing additional social support. REAP had closed the case because of [redacted] non-attendance. The CMHT had closed the case two years earlier. Dr Olawale had seen [redacted] at outpatients in February 2006 but he did not know of any impending housing move at that point.

Comment: With hindsight it may have been desirable for additional support to be available to [redacted] and his family from the CMHT during the period of [redacted] rehousing. The reality, however, is that [redacted] did not raise any concerns at his last outpatient appointment which would have triggered a referral, and he did not present in such a way as to cause housing department staff to make contact with the CMHT. The family were hopeful that the housing move would help [redacted] situation in the long term, and from [redacted] apparent previous reluctance to engage with community support agencies it is not certain that he would have accepted any such intervention.

Events following 21 April 2006

6.16 When [redacted] sister and mother discussed how they could obtain help for [redacted] on 21 April 2006, they had serious concerns about his mental state. They needed urgent help and advice but were not sure how they could obtain it. [redacted] mother decided to take [redacted] to the GP after the weekend. Tragically the event occurred before that could happen.

Comment: [redacted] sister said that she and her mother had been unaware of the Crisis Resolution Service. Information about this service is normally made available to service users through the contingency and crisis plan within their CPA care plan. In the case of a service user on standard CPA receiving only outpatient appointments, a crisis plan may not be explicitly recorded, or if it is recorded in the notes it may not be copied to the service user. In any event, there appears to be no mechanism for family members to be informed of the existence of Crisis Resolution Service. In the case of a young man living

with his mother, using alcohol and drugs, and having experienced psychotic episodes with bizarre behaviour and ideas of self-harm, the potential risks appear to be such that steps should be taken to ensure that family members are informed how they can access a crisis service.

7. FINDINGS AND RECOMMENDATIONS

Findings

7.1 I have seen no evidence that the arrangements for [redacted] care and treatment were unsuitable, given the diagnosis that was made and the assessment of his needs in December 2003.

7.2 From 2004 onwards outpatient appointments were arranged at appropriate intervals and were appropriately recorded; there was good communication from the psychiatrist to the GP.

7.3 [redacted] had trust in his GP, and perceived mental health services as being there to help him.

7.4 There was a weakness in the system whereby because [redacted] was on standard CPA, there was no virtually no communication by mental health services with family members after his discharge from hospital. While this reflects normal practice with standard CPA, this practice needs to be reviewed in cases where the service user lives with a family member and has a history including psychotic episodes and risky behaviour.

7.5 The lack of communication with the family meant that the family did not know of the existence of the Crisis Resolution Service, or how to access it. There is a weakness in the system in that there is no mechanism whereby family members in close contact with a service user on standard CPA will necessarily be made aware of this information.

7.6 The involvement of the Access Team after [redacted] November 2003 admission was not properly recorded so that it was not possible to be certain that the aims of the care plan had been addressed.

7.7 Given the diagnosis and assessment in December 2003, the decision to place [redacted] on standard CPA was reasonable and in accordance with Berkshire Healthcare Trust's CPA policy.

7.8 The care plan formulated for [redacted] discharge in December 2003 appears to have been based upon an inadequate period of assessment. While the process of formulating the care plan appears deficient, the content of the care plan was reasonable.

7.9 During [redacted] 2003 admission to Wexham Park there were some practice deficiencies:

- it was not ideal practice to reallocate [redacted] bed so early in his admission; this must reflect bed pressures at the time;
- his home leave should have been preceded by a care plan and contingency plan which should have been agreed with his family;
- the clinical team should have engaged in more direct communication with his family not only to assist in assessing [redacted] needs and formulating a care plan, but

also to advise the family on his care and management and involve them in crisis and contingency planning which would affect them directly.

7.10 I have concluded that the events of April 2006 could not have been predicted.

Recommendations

I recommend that managers ensure that actions are in place or planned in relation to the following:

- Standard CPA cases should be reviewed to identify any cases where the service user lives with a family member and has a history including psychotic episodes and risky behaviour; where this applies, consideration should be given to reviewing whether the CPA level is appropriate and whether there has been adequate communication with family members.

- Steps should be taken to ensure that family members in close contact with a service user on standard CPA are made aware of the existence of the Crisis Resolution Service, and how to access it.

- Recording practice in the Access Team should be checked.

- The deficiencies apparent during [redacted] second admission to Wexham Park Hospital should be brought to the attention of the hospital clinical team so that the risk of recurrence of can be evaluated and addressed if appropriate.

Tony Drew
Independent Investigator
27 November 2006