An independent investigation into the care and treatment of service user Mr Z

March 2013

A report for NHS London
Undertaken by Verita

NHS London

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1. Introduction

1.1 Mr Z attacked and stabbed his father at his parents' home on 5 May 2010. His father subsequently died in hospital on 30 May 2010.

1.2 Mr Z's first contact with mental health services was in 1993. His diagnosis was that of paranoid state. In 1995 the diagnosis was revised to one of paranoid schizophrenia. He continued to receive services from West London Mental Health NHS Trust (the trust) until May 2010. This included outpatient appointments and periodic inpatient admissions including compulsory admissions under the Mental Health Act 1983. His GP oversaw the prescription of his medication.

1.3 Mr Z was in the care of Manor Gate Community Mental Health Team (CMHT), part of the trust, at the time of the incident. He was supported as part of the care programme approach (CPA).

1.4 Manor Gate CMHT was the main provider of mental health assessments and treatment for adults with severe mental health problems in Northolt, Greenford and Perivale. It was a multi-disciplinary team consisting of medical staff and social workers. The trust was reorganised in 2012 and the team no longer exists. The new structure replaced CMHTs with an assessment and treatment team and a recovery team.

1.5 Mr Z pleaded guilty to the manslaughter of his father at the Old Bailey on 1 April 2011. The court made him the subject of a hospital order under section 37 of the Mental Health Act 1983. The court also imposed a restriction order without time limit under section 41 of the Mental Health Act 1983. Mr Z is a patient in a NHS secure unit.

1.6 The trust commissioned an internal investigation into the incident in August 2010. The investigation was completed in November 2010.

1.7 In 2011 NHS London strategic health authority (SHA) commissioned this independent investigation into the care and treatment of Mr Z. NHS London asked Verita to lead the work, assisted by a nurse and consultant psychiatrist.

1.8 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Tariq Hussain, Collette Skinnion and Dr Anthony Akenzua carried out the investigation. Ms Skinnion and Dr Akenzua come from North East London NHS Foundation Trust and Oxleas NHS Foundation Trust respectively.

1.9 Derek Mechen, partner, peer-reviewed this report.

2. Terms of reference

Commissioner

2.1 This independent investigation is commissioned by NHS London in accordance with guidance published by the Department of Health in circular HSG (94) 27 *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 — 6 issued in June 2005.

Terms of reference

2.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr Z to include the following:

- A review of the trust's internal investigation to assess the adequacy of its findings, recommendations and action plans.
- Reviewing the progress made by the trust in implementing the action plan from the internal investigation.
- Involving the family of Mr Z as fully as is considered appropriate.
- A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident.
- An examination of the mental health services provided to Mr Z and a review of the relevant documents.
- The extent to which Mr Z's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies.
- The adequacy of the risk assessment and management of that risk to others.
- The appropriateness and quality of assessments and care planning.
- Consider other such matters as the public interest may require.
- Complete an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

Approach

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

2.4 The investigation team will follow established good practice in the conduct of interviews, ensuring that the interviewees are offered the opportunity to be accompanied and given the opportunity to comment on the factual accuracy of the transcript of evidence.

2.5 If the investigation team identify a serious cause for concern then this will immediately be notified to the manager, homicide investigations, NHS London.

3. Executive summary and recommendations

Executive summary

3.1 Mr Z attacked his father on 5 May 2010 in the family home.

3.2 Mr Z was a single man who had a daughter with a girlfriend. He lived in his own flat near his parents.

3.3 Mr Z has been in the care of mental health services for about 17 years. During this time he had two inpatient admissions including under section of the Mental Health Act 1983 but for the most part was cared for as an outpatient, by Manor Gate CMHT and his GP.

3.4 Throughout most of his care he was subject to the care programme approach (CPA) and reviewed regularly, usually by a locum psychiatrist.

3.5 Mr Z had a serious, enduring mental illness that required him to take regular anti-psychotic medication. By choice he took tablets and would sometimes reduce or stop them against advice. When he did, he usually relapsed and this prompted acts of aggression and violence usually as a result of his paranoia or feelings that he needed to defend himself.

3.6 The aggression and violence were usually towards family or neighbours and brought him to the attention of the police. He was charged and fined for his behaviour several times.

3.7 Mental health services and police did not liaise with one another about Mr Z's behaviour, probably because he never reached the threshold of seriousness to prompt such discussion.

3.8 Mr Z was in employment for some of the 17 years but never for long. His unemployment was a source of frustration to him and his family.

3.9 Mr Z's parents provided considerable support to him over the course of his illness. He got on well with them, though he sometimes described having a difficult relationship

with his father. His parents were never subject to a carer assessment. Similarly, we found no evidence that any health professional ever considered their safeguarding needs, although he had harmed his parents on one occasion.

3.10 In 2008 Mr Z told his locum psychiatrist at an outpatient appointment that he had been in trouble with the police for threatening his neighbour and brandishing a kitchen knife. The psychiatrist did not alert Manor Gate CMHT or his consultant psychiatrist.

3.11 In September 2009 Mr Z told another locum psychiatrist about the incidents in 2007/2008, though the psychiatrist assumed that they had taken place in 2009. This doctor referred Mr Z to Manor Gate CMHT for the allocation of a care coordinator because he considered Mr Z needed more support.

3.12 The CMHT allocations meeting did not consider the referral because the senior practitioner who received it did not bring it to the attention of his colleagues. Consequently Mr Z was not assessed. If he had been, the CMHT may have identified his deteriorating mental health and facing deteriorating social circumstances because his benefits had been stopped. We think the failure to allocate a care coordinator was an oversight with significant consequences.

3.13 Mr Z attacked his father eight months after the referral to the CMHT. Between September 2009 and May 2010 Mr Z became steadily more unwell. He appeared to stop taking his medication completely sometime in April 2010 despite being prescribed it by his GP.

Predictable and or preventable

3.14 We do not believe Mr Z's attack on his father was predictable.

3.15 If a care coordinator had seen Mr Z it would have been reasonably foreseeable that his mental health, personal and social circumstances would have been better understood. A care coordinator would likely have prompted Mr Z to be compliant with his tablets and to have ensured that his deteriorating mental health was risk assessed. This might have led to increased support and to that end intervention by Manor Gate CMHT might have prevented Mr Z stabbing his father.

Trust investigation

3.16 The trust commissioned an internal review into the incident. We agree with its findings except in one important respect. The review concluded that the failure to allocate a care coordinator to Mr Z in 2009 was a result of a systems failure in Manor Gate CMHT. We disagree. We think the senior practitioner who received the referral failed to act on it.

Notable good practice, new developments or improvements

3.17 We have identified examples of good practice including:

- locum staff-grade psychiatrist 2 recognising the risk Mr Z presented in 2009 and referring him to Manor Gate CMHT for the allocation of a care coordinator and for increasing the frequency of his outpatient appointments
- the persistence of team manager 1 in trying to get senior managers to deal with performance issues in relation to senior social worker 1
- the decisive action by the head of community care services in moving senior social worker 1 to a different role and dealing with outstanding performance issues
- the trust involving the family in the internal review
- the support lead nurse 1 provided to the family.

Findings

F1 Senior social worker 1 had a personal responsibility to ensure that his poor performance as a senior social worker in 2009-10 did not compromise client safety; he failed to do this. Senior social worker 1's poor performance directly led to Mr Z not receiving the extra support he needed. This support might have prevented deterioration in Mr Z's mental health and might have prevented the attack on his father.

F2 Senior managers failed to ensure that client safety was maintained while they performance managed senior social worker 1. This failure was a contributory factor in Mr Z not being allocated a care coordinator. A care coordinator might have prevented the deterioration of Mr Z's mental state and the consequent offence.

Recommendations

R1 The PCT should review Mr Z's former GP's training and management systems to ensure that his frontline administrative staff understand when to escalate issues to him and how to communicate with patients and relatives and other professionals appropriately.

R2 The trust and local authority must ensure that their human resources policies include processes setting out how immediate action can be taken to deal with clinical or social work staff who are reported as posing a risk to patient/client safety. This may include re-allocation to a non-patient/client contact area, restriction of their work or if necessary suspension from work. The policy must also include how staff will be assessed and deemed safe to practice before they return to patient/client contact work.

R3 The trust should provide evidence to the PCT that the lessons learned as a result of the internal trust investigation are carried forward to the operational policies in the new team structures.

4. Approach and structure

Approach to the investigation

4.1 The investigation was held in private. We interviewed 13 staff from the trust. We also interviewed GP 1, Mr Z's GP, at his practice and locum staff-grade psychiatrist 1 who was a locum in the trust in 2008. We tried to interview consultant psychiatrist 1 but the trust could not find his contact details.

4.2 We met Mr Z (accompanied by his solicitor and his mother) and had a separate meeting with his mother.

4.3 Mr Z gave consent for us to access his medical and other records. We told him that the SHA intends to publish the report. Mr Z was also given the opportunity to comment on the draft.

4.4 We saw the trust's papers produced at the time of the internal review. This included notes of interviews with practitioners and managers.

4.5 Our findings from interviews and documents are in ordinary text. Our comments and opinions are in ***bold italics***.

Structure of the report

4.6 Section 5 contains a narrative chronology including a detailed analysis of Mr Z's behaviour and care and treatment in the year before the incident.

4.7 Section 6 draws out themes from the chronology, diagnosis and forensic history. Sections 7 to 10 set out in more detail the themes we think had a key impact on Mr Z's care.

4.8 Section 7 discusses the management of Mr Z's primary care.

4.9 Section 8 discusses the management of Mr Z's care in the trust outpatient department.

4.10 Section 9 considers Mr Z's referral to Manor Gate community mental health team.

4.11 Section 10 considers the trust's management of a senior member of staff who worked in Manor Gate community mental health team.

4.12 Section 11 reviews the trust's internal investigation.

4.13 Section 12 considers the implementation of the recommendations.

5. Chronology of care and treatment of Mr Z

Sources of information

5.1 This narrative has been developed using the chronology in the trust internal investigation report as a starting point. The information in the chronology has been cross-checked against Mr Z's clinical records. Further information has been added where necessary to provide a more complete picture.

5.2 Mr Z was born in Shepherd's Bush in London in 1965 to Afro-Caribbean parents. His clinical records suggest a happy childhood but he was quiet and had few friends. Mr Z had disciplinary problems at school and often played truant.

Brief summary of care 1993 – 2003

5.3 Mr Z's mental health first began to deteriorate in 1993 and he was referred, by his GP, GP 1, to the trust. In 1994 he was diagnosed with a possible paranoid state and prescribed antipsychotic medication. Mr Z's mental state improved within a few months. However over the course of 1994 he stopped taking his medication due to side effects, failed to attend follow-up appointments and was discharged back to the care of his GP.

5.4 By the end of 1994 he had relapsed and was referred again to mental health services. He was non-compliant with his medication and in March 1995 was admitted to hospital under Section 2 of the Mental Health Act 1983. He was admitted because of the serious threat he posed to his family. He warned he would follow his impulses of violence if not detained and thought he could "*sort out the family*" in his own way.

5.5 During his admission Mr Z was diagnosed with paranoid schizophrenia. He remained as an inpatient until May 1995.

5.6 Mr Z was admitted as an inpatient again in October 1995 for a month, after he was detained by the police for stalking a female co-worker and because his family could not cope with his behaviour. His schizophrenic symptoms had intensified as a result of non-compliance with his medication.

5.7 Mr Z was allocated a key worker after his discharge who he initially saw regularly in 1996. However by the end of the year he was non-compliant with his medication again and regularly failed to attend outpatients and appointments with his key worker.

5.8 Over the course of 1997 Mr Z's mental state deteriorated, culminating in his mother referring him to Manor Gate CMHT in September 1997. She reported that he had been refusing his medication and behaving aggressively towards his family and that she was "*terrified to be in the home with him*".

5.9 Mr Z turned up at Manor Gate in December 1997 when he reported that he had discontinued his medication earlier in the year. He had lost his job and his girlfriend had ended their relationship. He reported that he had damaged someone's car and tried to attack his friend with a knife. Mr Z recognised that he should have continued treatment and had recently started taking his medication again.

5.10 Mr Z's mental state improved throughout 1998 and 1999, he regularly attended outpatients and was maintained on a low dose of oral antipsychotic medication. He was discharged back to the care of his GP in March 2000 as he had difficulty attending appointments at the CMHT due to work commitments.

2003 - 2006

5.11 Mr Z's girlfriend had a daughter in October 2003.

5.12 We found no record of contact with mental health services until August 2004 when Mr Z was referred to mental health services again by a locum GP because he was anxious, depressed and unable to cope with his job. He had restarted his anti-depressant (paroxetine) and antipsychotic (haloperidol) medication. He had also broken up with his girlfriend (the mother of his daughter). The locum GP thought he had insight into his illness.

5.13 Mr Z saw the duty team at Manor Gate CMHT in November 2004, where he reported that he had left his job. Mr Z seemed to have good insight and recognised the symptoms of relapse from his last breakdown. Mr Z denied any intentions of harming himself or others. His mental state was assessed as stable.

5.14 Mr Z was reviewed in outpatients in December 2004. Mr Z denied psychotic symptoms and described that his sleep and appetite were "*okay*". He said he had felt stressed for the past three months and attributed this to breaking up with his girlfriend and stress at work. The plan was that he should continue on haloperidol 5 mg twice daily and procyclidine tablets 5 mg daily. He was given an appointment with the locum staff-grade doctor working at the psychiatric outpatients and was to be reviewed again in five months.

5.15 Mr Z's mother called the duty team at Manor Gate on 2 March 2005 to say she was worried about Mr Z as he was not going to work, leaving the house or answering calls. The duty social worker at Manor Gate CMHT visited Mr Z at home. He discussed referring Mr Z to the assertive outreach team for community engagement and support. Mr Z agreed to bring forward his outpatient appointment to the following week.

5.16 On 17 March 2005 Mr Z did not attend his outpatient appointment. He turned up the next day and saw Manor Gate CMHT duty staff. He complained of anxiety over the split with his family and that he had fleeting thoughts of self-harm. Mr Z described erratic compliance with medication and agreed to wait until his outpatient appointment the following week for further assistance. Mr Z was given the out-of-hours number.

5.17 Mr Z was seen in outpatients on 21 March 2005 by a locum staff-grade psychiatrist. He was cooperative but seemed anxious and sad. He denied psychotic symptoms and suicidal ideation. He described erratic compliance with medication and a difficult relationship with his father. The care plan included taking haloperidol and procyclidine, referral to outpatients, Rainbow club (an anxiety management group) and a further outpatient appointment in April.

5.18 Mr Z called Manor Gate duty team on 24 March 2005. He complained about his relationship with his family, especially his father, and inability to maintain relationships. He was given the numbers of Relate and the Samaritans.

5.19 In March 2005 Mr Z was referred to Manor Gate Assertive Outreach Team (AOT) by the duty social worker at Manor Gate CMHT. The referrer was not his worker but Mr Z had approached him on two occasions while he was on duty and the duty social worker felt that Mr Z might be appropriate for engagement with the assertive outreach team.

5.20 The AOT assessed Mr Z in April 2005. They did not accept him because he had not been admitted as a mental health services inpatient since 1995 and was already seeing a CPN and psychiatrist.

5.21 Mr Z went to see Manor Gate duty staff on 12 April 2005. He wanted to talk about his family but had little time to do so as he had to leave early to attend a job-seeker's allowance appointment.

5.22 A locum staff-grade doctor saw Mr Z in Manor Gate CMHT outpatients on 14 April 2005. Mr Z said he had been arguing with his parents, especially his father. The locum doctor noted, however, that Mr Z appeared to be stable and advised him to continue on haloperidol twice daily.

5.23 Mr Z went to see the out-of-hours duty team at Manor Gate on 22 April 2005 but left before he could be seen. He was later phoned at home by a member of the duty team. Mr Z asked for details of counselling services in the area. He explained that he was stressed because of family problems. He felt his father was being sarcastic and that other family members were ignoring him. He requested help with budgeting. He told the worker that he had recently applied to receive benefits. He expressed no other significant concerns.

5.24 Mr Z was allocated a new key worker at Manor Gate in May 2005, but he failed to attend his appointment in June 2005.

5.25 Mr Z attended outpatients regularly between October 2005 and May 2006. He said he continued to see his parents regularly and that his relationship with his father had improved. He kept in touch with his ex-girlfriend (and two-year-old daughter) although Mr Z said he had relationship problems with her. He said he attended counselling weekly and continued with his medication.

5.26 Manor Gate CMHT multi-disciplinary team discussed Mr Z in June 2006 and discharged him back to the care of his GP. He was nonetheless offered an appointment in July with a locum staff-grade doctor, which he failed to attend.

5.27 A locum staff-grade doctor reviewed Mr Z again in November 2006. By this time his medication had been reduced. He was referred for help with employment. Mr Z said he

felt stressed that his family were not close and that his relationship with his father was not good.

2007 – 2010

5.28 Mr Z did not attend his next outpatient appointment in April 2007. A letter was sent to arrange another appointment but he was not seen again until that August. He was seen by consultant psychiatrist 1 and explained that since his last appointment he had lost two jobs. He showed no psychotic symptoms and expressed no thoughts of harm to himself or others. Mr Z was taking his medication but he had opted to take two doses at night instead of one in the morning and one at night as prescribed. He said this reduced his drowsiness.

5.29 He did not attend his outpatient appointment in December 2007.

5.30 RiO[1] records show that the police contacted Manor Gate CMHT on 3 December 2007 to ask for an appropriate adult because Mr Z had been arrested for carrying a large kitchen knife. The forensic medical examiner at the police station decided that he needed an appropriate adult due to his illness and vulnerability. The information was sent through to the youth offending team for action. This was standard process when an appropriate adult was requested.[2]

5.31 Mr Z did not attend his next outpatient appointment in February 2008. As a result he was discussed in a referral meeting in March 2008 at Manor Gate CMHT. The lead nurse at Manor Gate contacted Mr Z's GP surgery, who confirmed that GP 1 had not seen Mr Z for between four and five months but that he had collected medication that month. The lead nurse at Manor Gate requested that the surgery contact Mr Z to ask him to go to Manor Gate to see a member of the duty team for assessment.

5.32 Manor Gate CMHT went to visit Mr Z at his parents' home on 25 March 2008. We do not know who attended because the signature in the clinical records is unclear. His father

[1] RiO is an electronic patient record.
[2] The role of appropriate adult is normally fulfilled by the youth offending team and their role is to ensure that the client is not treated unfairly and not put under undue pressure. If a request for an appropriate adult is made, the team involved with a client should also make contact to carry out a risk assessment and organise a review of care.

said he had not lived there since 1997. Manor Gate had not updated their records and had been sending correspondence to the wrong address[1]. Mr Z was living alone nearby. His father confirmed that he and his wife saw Mr Z regularly but that his mood was low because he was struggling to find employment. The next day Mr Z turned up at Manor Gate CMHT and an appointment was made for April 2008.

5.33 In April 2008, a CPA meeting took place with a locum psychiatrist. Mr Z told the psychiatrist about two incidents involving the police, one in 2007 and one in January 2008, the latter concerning possession of a kitchen knife. The psychiatrist found no overt signs of major mental illness and planned that Mr Z should continue with his current medication and be followed up in six months.

5.34 A further CPA meeting in outpatients took place on 24 September 2008 with a new psychiatrist, locum staff-grade psychiatrist 1. Mr Z said he had been in trouble with the police in the past and charged with GBH twice, the last time earlier that year when he received a caution. His mental state was described as stable, with no evidence of mood disorder or perception abnormality. Locum staff-grade psychiatrist 1 planned that Mr Z should continue with medication and be seen in six months.

5.35 Mr Z remained on CPA and locum staff-grade psychiatrist 2 took over his outpatient care in October 2008. Locum staff-grade psychiatrist 2 carried out a six-monthly CPA review on 12 March 2009. Mr Z said he was sleeping well and visiting his parents daily; they were helping with his cooking. He had been taking his medication regularly and was attending the Acton Training Centre[2]. Locum staff-grade psychiatrist 2 wrote in his letter to the GP that Mr Z had no thoughts of harming himself or anybody else – no suicidal or homicidal ideation and that he had no perceptual abnormalities. The care plan was for Mr Z to continue with current medication. Locum staff-grade psychiatrist 2 arranged to see him in a further six months.

5.36 Locum staff-grade psychiatrist 2 saw Mr Z in his outpatient clinic on 4 September 2009. Mr Z confirmed he was compliant with his medication and was experiencing no side effects. Mr Z spoke of further incidents involving the police. He told locum staff-grade psychiatrist 2 that in January 2009 he had been in a fight with someone living near his

[1] Trust letters to Mr Z were routinely sent to his parent's home. Fortunately Mr Z visited his parent regularly so is likely to have received the letters.
[2] Acton Training Centre is a training company offering training in ICT and basic skills.

parents' home and was arrested before being released without charge but cautioned to stay away from the victim. In April 2009 he had been arrested after brandishing a knife in front of his neighbour. He had become angry with him after the neighbour bumped into him. The police arrested Mr Z and he was released without charge. He later made up with his neighbour[1].

5.37 Locum staff-grade psychiatrist 2 proposed that Mr Z continue with his current medication and referred him to Manor Gate CMHT for a care coordinator to be allocated. He arranged to review Mr Z in his outpatient clinic in December 2009, bringing forward Mr Z's next outpatient appointment by three months. Locum staff-grade psychiatrist 2 wrote to Mr Z's GP that Mr Z was aware of how to get urgent help if needed and that he might benefit from a referral to Twining Enterprise[2].

5.38 Locum staff-grade psychiatrist 2 saw Mr Z at an outpatient appointment on 7 December 2009, the last time that Mr Z was seen by mental health services before the offence. Mr Z said he was partially complying with his antipsychotic medication, taking it regularly but at a slightly reduced dose because he was attending job interviews. His state benefits had been discontinued and he was appealing against this decision. Locum staff-grade psychiatrist 2 assessed Mr Z as having no suicidal or homicidal ideation or thoughts of harming himself or others. Mr Z did not complain of experiencing auditory or visual hallucinations. Mr Z said he had not been in any more trouble with the police since his last outpatient appointment. Locum staff-grade psychiatrist 2 planned that Mr Z continued with his current medication at the higher dosage and be referred to a vocational adviser. He told Mr Z how to get help in a crisis, arranged for blood tests and suggested an outpatient appointment in four months' time.

5.39 Locum staff-grade psychiatrist 2 wrote to Mr Z's GP with details of the outpatient appointment and the plan of care.

5.40 Mr Z and his mother went to the GP surgery on 1 April 2010 to say that Mr Z's benefits had been cut at the end of 2009. GP 1 noted that he was waiting to hear from Mr

[1] Locum staff grade psychiatrist 2 told us at interview that he believed that the incidents were recent but with hindsight he believed that Mr Z was in fact referring back to the incidents Mr Z had reported in 2008.
[2] Twining Enterprise is an established London-based charity providing vocational support to people with mental health needs.

Z's solicitor and that Mr Z could restart fitness-for-work related benefits if his mental health deteriorated.

5.41 The internal review report chronology says Mr Z's mother told the trust she had written to his GP about her son's physical health but had received no reply. Mr Z's primary care record contains no reference to such a letter.

5.42 Mr Z's mother told the trust after the offence that his medication had been delivered to a different pharmacy and that this resulted in his not receiving it for a while. She also said she had been unable to contact Manor Gate CMHT or to leave messages to raise her concerns about Mr Z's mental health.

5.43 The clinical records show that locum staff-grade psychiatrist 2 phoned Mr Z on 16 April 2010 because Mr Z had not attended his outpatient appointment the day before. Mr Z said he had forgotten. He said he was aware of how to contact the service if he had a crisis and would be willing to attend a further appointment. A further appointment was sent for 12 July 2010.

5.44 On 5 May 2010 Mr Z stabbed his father, leading to his death on 30 May.

5.45 Mr Z was detained at Wormwood Scrubs after the incident.

5.46 The electronic patient record (RiO) for 10 May 2010 show that Mr Z's mother told the community team that Mr Z had been suffering from a number of personal problems before the incident and that she and her husband had been trying for months to help him. Mr Z's mother said Mr Z's mental health had deteriorated and that he showed evidence of delusions and paranoia. She said she had been unable to contact the mental health team.

5.47 Mr Z was suffering from a number of social stressors around the time of the offence:

- he was unemployed
- his benefits were cut at the end of 2009 with the consequence that he could not pay his mortgage or pay maintenance
- he was appealing against the benefit change
- he was relying heavily on his parents for support

- his father was urging him to get work.

5.48 Mr Z's mother also said that he had not been on medication for a while before the incident because his prescription had been issued to the wrong pharmacy. She added that she had noticed that Mr Z had been anxious before the incident; he thought people were watching him and felt unsafe. She also said Mr Z paced around the neighbourhood looking distressed.

Offending history as recorded in the trust internal review report

5.49 The following information is from the internal investigation report. It in turn comes from Mr Z's criminal record and police notes.

5.50 November 1994: Clinical records say Mr Z was obsessed with a woman and that police became involved.

5.51 February 1995: Clinical records say he spent two weeks in prison for damaging the cars of his mother and his brother-in-law.

5.52 March 1995: Clinical records say he damaged his sister's (and possibly his parents') flat. He was taken to St Bernard's Hospital, Southall, where he was detained under the Mental Health Act 1983.

5.53 October 1995: Clinical records say that he was obsessed with a female colleague with whom he had worked previously. Police attended her home several times and took him to St Bernard's Hospital on at least one occasion. There was an injunction taken out and he was admitted to hospital.

5.54 10 October 1997: Criminal record says he damaged a car and assaulted a police officer. He was put on probation for a year.

5.55 11 October 1997: Police notes say he threatened a neighbour with a knife, broke his window and later punched him in the face. Police dealt with the matter under Home Office Rule 8[1].

5.56 11 October 1997: Police notes say he assaulted both parents. His mother lost a tooth and went to hospital. His father suffered a small cut to his arm. His parents did not want to press charges because of his mental illness. The matter was dealt with under Home Office Rule 8.

5.57 August 2007: Police notes say he assaulted his friend and smashed his car. This was not reported until 24 January 2008, when he assaulted his friend again. He was cautioned.

5.58 3 December 2007: Criminal record says he threatened neighbours with a knife. His notes showed a request for an appropriate adult to be appointed. He was fined.

5.59 September 2009: Clinical records say he told locum staff-grade psychiatrist 2 that he had been arrested for fighting with someone who lives near his parent's home in January 2009 and was held for a few hours before being released with a caution. He had been arrested for brandishing a knife in front of his neighbour in April 2009 and he was released without charge after six hours. His detailed police notes contain no reference to either incident and police could find no further information.[2] Locum staff-grade psychiatrist 2, believing the incidents to be recent, acted on the information by referring Mr Z to Manor Gate CMHT to be allocated a care coordinator. We deal with this is detail in section 9.

[1] Before 1999 Home Office Rule 8 was "The guilt of the accused is clear but the victim refuses... to give evidence" It is now called Home Office Rule 4.

[2] Following our review of Mr Z's involvement with the police we are confident that Mr Z had confused these incidents with earlier events.

6. Themes from chronology, diagnosis and forensic history

6.1 The following themes are drawn from our examination of Mr Z's chronology, diagnosis and forensic history. We discuss some of these matters in more depth later in the report.

Diagnosis

6.2 Mr Z was diagnosed as suffering from paranoid schizophrenia. This diagnosis appears to be supported by his symptoms and was never revised.

6.3 Mr Z had a forensic history though it is not comprehensively documented in the clinical records. He was referred to the regional secure unit in December 1997 as a result of violence. This referral appears not to have been followed up. The reason for dropping the referral is not recorded in his clinical records. However, it seems likely that his mental state had improved by early 1998.

Deteriorating mental health and offending behaviour

6.4 Mr Z did not have a history of violence and aggression before the onset of his illness in 1993 as far as we can tell. However, his deteriorating mental health and his propensity for violence and aggression seem connected. This was particularly evident when he was not taking his medication. He appeared to be aggressive in response to his paranoia, feeling threatened and life stressors e.g. being unable to pay his mortgage. However, his violence and aggression were intermittent. Mr Z went for almost 10 years without a violent or aggressive incident being reported in his records.

6.5 Mr Z did not qualify for MAPPA[1] given that his level of offending was not sufficiently serious. We found no evidence to suggest that mental health services discussed his behaviour with the police.

[1] Multi Agency Public Protection Arrangements

Management by a single clinician

6.6 Mr Z was managed through the outpatient department for much of his time in the care of mental health services. He was seen every six months and often by a locum psychiatrist. The six-monthly appointments were treated as a CPA review with a follow-up plan sent to his GP. Mr Z appears never to have been seen by a consultant psychiatrist. His care and treatment were rarely discussed with the wider community mental health team.

6.7 This theme is discussed further in section 8 – Mr Z's management in outpatients.

Failure to escalate

6.8 Mr Z was seen in outpatients by a locum psychiatrist in April 2008, when Mr Z told the doctor about two incidents involving the police, one in 2007 and one in January 2008. The second incident involved possession of a knife. The locum psychiatrist did not escalate this by requesting further support from the CMHT or other trust services. He planned that Mr Z continue with his medication and be seen again in outpatients in six months.

6.9 Locum staff-grade psychiatrist 1 saw Mr Z as an outpatient in September 2008. Mr Z mentioned two occasions when he had been charged with grievous bodily harm, the last time earlier that year. We have seen no evidence to suggest that he was in fact charged. Locum staff-grade psychiatrist 1 did not escalate her concerns and continued to support Mr Z through outpatient appointments. Locum staff-grade psychiatrist 1 recommended that he remain on his current medication and be seen again in six months.

6.10 Locum staff-grade psychiatrist 2 saw Mr Z in outpatients in September 2009. Mr Z spoke of further incidents involving the police earlier that year. He had been in a fight in January with someone who lived close to his parents' home and in April had been arrested after brandishing a knife in front of his neighbour. Locum staff-grade psychiatrist 2 recommended that he be allocated a care coordinator with Manor Gate CMHT. This referral was not followed up. We deal with this in detail in section 9. Locum staff-grade psychiatrist 2 made another appointment for Mr Z in outpatients for December 2009, bringing forward the outpatient appointment by three months.

6.11 The fact that two psychiatrists in outpatients did not escalate the case is discussed further in section 8.

Safeguarding his family

6.12 Mr Z's parents provided considerable support to him throughout his illness. He lived nearby, saw them regularly and spent a lot of time watching television or going shopping with his father. His mother was a qualified nurse. Mr Z's GP sometimes observed tension between Mr Z and his mother and father though he stressed that the family had a caring relationship.

6.13 Mr Z caused damage to his family's property, in 1995, on two separate occasions. On the first he spent two weeks in prison and on the second he was detained in hospital under the Mental Health Act 1983.

6.14 Mr Z's mother told Manor Gate CMHT, in September 1997, that he was behaving aggressively towards his family and that she was "*terrified to be in the home with him*". The next month Mr Z assaulted both parents. His mother lost a tooth and went to hospital and his father suffered a small cut to his arm. His parents did not want to press charges because of his mental illness. Mr Z's clinical records contain no mention of this incident. We consider from speaking to his mother that both parents were capable of making informed decisions and could not be classified as vulnerable.

6.15 Mr Z told staff at Manor Gate outpatients, in 2005 and 2006 that he was arguing with his parents, especially his father. He felt stressed that his family were not close and that his relationship with his father was not good.

6.16 Mr Z had a daughter in 2003 though he did not live with her and her mother. From our interview with Mr Z and his mother we know that he saw his daughter regularly. He was distressed that he could not support his daughter after he lost his job. The records do not say how much contact he had with her. No health professional seems to have considered whether his daughter was at risk from him.

Knives

6.17 Mr Z threatened his neighbour with a knife in October 1997. This was reported to the duty CPN at Manor Gate in December 1997.

6.18 Mr Z threatened neighbours, in December 2007, with a large kitchen knife and was arrested and fined. Police contacted Manor Gate CMHT to ask for an appropriate adult. The information was sent through to the youth offending team for action.

6.19 Consultant psychiatrist 1 completed a CPA meeting and wrote to GP 1 on 8 April 2008 to say that Mr Z had told him he had been in trouble with the police in January 2008 for possessing a kitchen knife.

6.20 Mr Z was arrested after brandishing a knife in front of his neighbour in April 2009. He had become angry with him after the two bumped into each other. Police arrested Mr Z and he was released without charge. He later made up with his neighbour.

6.21 Locum staff-grade psychiatrist 2 saw Mr Z in his outpatient clinic on 4 September 2009. Mr Z told locum staff-grade psychiatrist 2 of his involvement in two fights earlier in the year.

Mr Z's ambivalence about taking medication

6.22 Mr Z was treated with depot injections and latterly with haloperidol tablets. Regular and recurrent relapses followed a period of non-compliance with medication throughout his contact with mental health services. The first time was in 1994 and incidents followed every year until 1997. Mr Z was not seen by mental health services from 2000 until a relapse in 2004, which also followed a period when he had not been taking his medication. Mr Z's mother said he was not taking his medication in the months leading up to the homicide in 2010. We return to this in section 7.

7. Management in primary care

7.1 This section of the report considers Mr Z's management by his family doctor.

7.2 Mr Z was a registered patient of GP 1. He had been a patient of the practice since 1993. Mr Z's parents were also registered with GP 1. Mr Z and his parents attended the practice regularly.

7.3 GP 1 is a single-handed family doctor. He has run the practice since 1993. He has a list of 1,800 patients and is supported by a small team of receptionists. The practice is located in a housing estate in a converted family house. GP 1 regarded Mr Z's family as long-standing patients whom he saw regularly because of their various health conditions.

7.4 The practice out-of-hours service is provided by a commercial firm.

7.5 Patients attend the surgery to request a repeat prescription. They complete a request form and hand it to the receptionist. GP 1 signs the new prescription and the patient can choose to collect it from the practice or have the prescription collected by and dispensed from one of two local pharmacies. This system was in place in April 2010.

7.6 Urgent patient requests during surgery hours are handled by the reception staff and they are responsible for bringing to GP 1's attention any concerns.

Mr Z

7.7 GP 1 told us that Mr Z suffered from schizophrenia and took regular medication. He said Mr Z was a quiet, measured individual who appeared well educated. GP 1 had never seen him aroused or aggressive in all the time he had been his doctor.

7.8 GP 1 shared Mr Z's care with specialist mental health services over many years. GP 1 took responsibility for prescribing Mr Z's tablets in accordance with the request of the psychiatrist. He also monitored Mr Z's mental state and compliance with medication when he came to the surgery for a consultation. Similarly Mr Z would be seen in outpatients every six months by a psychiatrist. This outpatient consultation was also a CPA review and

was usually followed by a letter to GP 1 which, among other things, would set out the care plan.

7.9 Mr Z attended the practice either on his own or in the company of his parents. GP 1 said he had sometimes observed tension between him and his mother and father though he stressed that the family had a caring relationship. He said Mr Z and his father appeared to spend time together watching television or shopping and that his parents provided a lot of support to Mr Z.

7.10 The practice records show that Mr Z was issued with six prescriptions for haloperidol in 2009. In all cases it appears that the tablets were dispensed to Mr Z. Mr Z usually collected his prescription from the surgery and took it to a pharmacy to have it dispensed. According to GP 1, he usually did this himself.

7.11 Alternatively, at the request of Mr Z or one of his parents, the prescription would be collected by one of the two local pharmacies. GP 1 said that sometimes one of Mr Z's parents requested his repeat prescription and either collected it or asked for it to be collected by one of the pharmacies.

Mr Z's care in 2010

7.12 The practice electronic clinical records show that Mr Z attended two consultations with GP 1 in 2010 and that the practice raised two prescriptions for his routine tablets for his schizophrenia.

7.13 Mr Z was issued with a prescription for 60 haloperidol tablets on 3 March 2010.

7.14 His first appointment in 2010 was with GP 1 on 16 March 2010 when he complained about a minor physical condition. GP 1 recorded observations about his outward appearance during the consultation including that he was "*not anxious*" and "*mentally appears stable*" and that he was taking his tablets.

7.15 At the same consultation Mr Z asked about his sick certificate and benefits. GP 1 had said that a "*Med 3*"[1] could not be issued following the letter from the job centre. Mr Z's benefits had been discontinued in late 2009. He was appealing against this decision.

7.16 Mr Z next attended the surgery to see GP 1 on 1 April 2010. His mother came with him. The notes described Mr Z as "*asymptomatic*" and "*calm, not anxious or aggressive*". Mrs Y (Mr Z's mother) was said to be "*more concerned regarding his benefits, saying that the solicitor is not listening or doing nothing*". GP 1 explained that the Med 3 could be "*re-started if his mental condition deteriorates*". The record shows Mr Z was prescribed haloperidol and procyclidine and was compliant with them.

7.17 Mr Z was issued with a prescription for 56 haloperidol tablets the same day. Assuming he had no medication left, this dose would have lasted until 28/29 April. The practice could not tell us whether he or another family member collected the prescription or asked for it to be sent to one of the two pharmacies.

Mrs Y's account

7.18 Mrs Y told us that Mr Z was not taking his medication in the month or so before the incident on 5 May and was becoming unwell. Mrs Y had gone to pharmacy 1 to collect the tablets and the pharmacy did not have the prescription. Mrs Y said the practice receptionist said the prescription had been sent to the pharmacy 2. Mrs Y told us she had gone to pharmacy 2 but they had not received it either.

7.19 Mrs Y said she wrote to and visited the practice in order to get help from GP 1 and asked for a new prescription as the original had been lost but that she could not get past the receptionist who told her that it had been sent to the pharmacy 2. As we say below, pharmacy 2 had no record of receiving the prescription.

7.20 Mrs Y also told us that following a break-in at her home all correspondence related to Mr Z had been stolen. She could not therefore show us letters that she had previously shown lead nurse 1, lead practitioner at Manor Gate CMHT.

[1] Med 3 form is issued by an NHS clinician for patients for whom they provide clinical care as a statement of fitness for work for social security or statutory sick pay.

GP 1's response

7.21 GP 1 told us he could not recall any visits to the surgery by Mrs Y or receiving requests for a new prescription. Nothing in the electronic clinical record suggests that Mrs Y or Mr Z visited the surgery after their visit on 1 April. The practice scans and attaches to a patient's electronic file all correspondence received. No letter is attached to Mr Z's notes and GP 1 told us that his receptionists could not recall receiving a letter from Mr Z's mother. GP 1 also told us that in the past Mr Z had visited the surgery when he was distressed or relapsing. GP 1 could not recall his doing so during this period.

7.22 Lead nurse 1 visited Mrs Y soon after her husband was stabbed to support her and try to understand her concerns. She told us:

> *"…she showed me a series of letters that she had written to the GP where she had highlighted concerns about her son's mental state, and within that were also concerns about his physical state… She had also put in the letters that she had found it difficult to communicate with Manor Gate, which we recognised and followed up. She said that she had also had telephone conversations with the surgery, with her son's GP and quite often found it difficult to get past the receptionist.*
>
> *"The GP she described as 'dismissive' of what she had been saying when she had been to see him."*

7.23 She told us about the missing prescription:

> *"…that they* [her and Mr Z] *had both gone to* [Pharmacy 1] *where he would normally collect it and it hadn't been there, and they had gone to the surgery and asked where it was and nobody could really say where it had gone. I felt very concerned about that."*

7.24 Lead nurse 1 decided to visit the surgery. She told us:

> "*I made an appointment, and I admit – and I did point this out to the GP – I found the receptionist very obstructive. Even though I was saying 'I am a healthcare professional, I am a mental healthcare professional, I need to make an*

appointment to see the GP, it is about a service user', etc., she was very, very difficult to get past and to make an appointment to see the GP. I found from the outset that what I was being informed by the service user's mother was probably correct in terms of her being able to contact the GP."

7.25 GP 1 told us that his receptionists:

"…make a reasonable decision to disturb or not to disturb the GP straightaway,…For other matters she tries to obtain as much information as possible to pass on to the doctor at a later period. Often asking a number of questions to the caller, one may get the impression that the receptionist is obstructive…"

Comment

Lead nurse 1's evidence was she had difficulty in making an appointment with GP 1 even as a healthcare professional wanting to see GP 1 following the homicide of one of his patients. Our experience was just as difficult and required several phone calls and repeat letters before we were able to secure an appointment.

7.26 GP 1 told us that he agreed that *"…there is always a room for improvement…"* and he would look for appropriate courses for his receptionists.

7.27 GP 1 said that neither Mrs Y nor the treating hospital had told him the cause of the death of Mr Z's father. Our discussion was the first time he had been given any official information about the homicide. He did not know what had prompted Mr Z to behave aggressively towards his father.

7.28 Lead nurse 1 visited the surgery after the incident and had spoken to GP 1 as a result of the concerns of Mr Z's mother and the confusion over the prescription. It is clear therefore that despite not receiving official information about the homicide he was aware of the incident soon after it occurred.

7.29 GP 1 also told us Mrs Y remained his patient. He was surprised to hear that Mrs Y had expressed concerns about the practice; she had never mentioned the matter to him though she came to the surgery regularly. He described her as being guarded with him about what happened to Mr Z's father and the whereabouts of Mr Z.

Mr Z's recollection of events

7.30 Mr Z told us that he probably went for a month without taking his tablets before his offence. He told us he could not remember going to see his GP about not having a prescription or whether he visited the practice during this period requesting help.

What the pharmacies told us

7.31 We asked the two local pharmacies what their dispensing records showed about Mr Z. Pharmacy 1 told us that the last prescription they had dispensed for Mr Z was on 16 March 2010 for a fungal nail treatment. However, the last time they dispensed haloperidol and procyclidine tablets for Mr Z was on 6 January 2010. GP 1's records show that he wrote a prescription in January 2010 for 112 tablets of each (a two-month supply).

7.32 Pharmacy 1 confirmed that they had not dispensed either of the prescriptions issued by GP 1 in March and April 2010. They also confirmed that they had regularly dispensed medication to Mr Z in 2009 and sent us corroborating information.

7.33 Pharmacy 2 told us that they had not dispensed any prescription to Mr Z since 13 May 2008.

Comment

We think GP 1 managed Mr Z appropriately. The practice issued a regular prescription to Mr Z and GP 1 saw him as needed. GP 1 saw him twice in early 2010 and recorded observations about his mental state on both occasions.

We have no reason to think that GP 1 would not have responded to Mr Z or his mother when Mr Z was becoming unwell. Mr Z and his parents were well known to him. We found nothing to suggest that Mrs Y or Mr Z visited the practice in April and GP 1 cannot recall their having done so.

We think it likely that Mr Z was not taking his medication from March 2010, given that he did not collect his tablets from either of the pharmacies he had used in the past. This pattern of non-compliance fits his history.

Both Mrs Y and lead nurse 1 from Manor Gate CMHT said they found the practice receptionists impeded communications with GP 1. We had a similar experience when we contacted the practice for this investigation. It is possible that messages of concern from Mrs Y did not come to the attention of GP 1.

Recommendation

R1 The PCT should review Mr Z's former GP's training and management systems to ensure that his frontline administrative staff understand when to escalate issues to him and how to communicate with patients and relatives and other professionals appropriately.

8. Medical management in outpatients

8.1 This section of the report deals with Mr Z's management in the outpatient department at Manor Gate CMHT. We focus on his last three years of care and treatment and briefly consider the earlier period.

8.2 Mr Z was an outpatient for 16 years. He was usually seen by a staff-grade doctor. The frequency of his appointments varied according to his mental state and the assessment of his doctor. Latterly he had two appointments each year including with locum staff-grade psychiatrist 1 and then locum staff-grade psychiatrist 2.

8.3 On four occasions Mr Z was also in the care of Manor Gate CMHT and regularly seeing a CPN. He was allocated a key worker (CPN) in 1996, 1997, 1998 and 2005. However, Mr Z was discharged from the CMHT because he either did not attend appointments or said he no longer needed to see a CPN.

Management in outpatients between late 2007 and October 2008

8.4 Mr Z attended an outpatient appointment/CPA review with a locum psychiatrist on 4 April 2008. He told the locum psychiatrist he had been in trouble with the police. The entry in the clinical records says "*said two incidents - of having trouble with police - last year and January 2008 for possessing sharp weapons*". The locum psychiatrist also told Mr Z's GP about this in a clinic letter soon after the appointment.

8.5 The locum psychiatrist discussed the case with consultant psychiatrist 1. Consultant psychiatrist 1 proposed that Mr Z continue with his current medication and be followed up in outpatients in September 2008.

8.6 Mr Z was next seen in outpatients in September 2008 by new psychiatrist, locum staff-grade psychiatrist 1, whose note of the consultation says:

> "*past problems with police. Charged with GBH twice. Most latest is early this yr. Fine £200 for 1st one, caution for 2nd one. Compliant with meds.*"

Locum staff-grade psychiatrist 1 proposed that Mr Z continue with his medication and be seen in outpatients in six months.

8.7 We have not been able to contact the locum psychiatrist who saw Mr Z in April 2008 but did interview locum staff-grade psychiatrist 1. We asked her why she did not refer Mr Z to the CMHT to be allocated a care coordinator. She told us:

> *"…looking through my letter and notes, it seems that his mental state was stable at that time, he was complying with his medication and he did not report any kind of deterioration in his thought processes nor was he getting any hallucinations or delusions or any other signs of relapse. In my notes, there is no mention of a knife but about two GBH charges in the past and I think the recent one it mentioned was early this year, in January 2008 and I saw him in September 2008…He was happy to stay on the medication and he wanted to see his daughter fortnightly, so the next appointment was offered for the next regular review.*

8.8 She also told us:

> *"If the incidents had been very recent and nothing had been done about it and we hadn't known about it, I would be discussing it with the team to initiate a plan of closer monitoring, because then his overall risk level would be high."*

Comment

Mr Z told the first locum psychiatrist and locum staff-grade psychiatrist 1 about potentially serious incidents. His history included compulsory admissions to hospital and evidence of anger and violence, usually as a result of deterioration in his mental state.

Locum staff-grade psychiatrist 1's assessment of Mr Z in September 2008 was that the reports of possible violence were from earlier in the year. His mental health was stable and he was taking his medication and seeing his daughter fortnightly. We therefore conclude that locum staff-grade psychiatrist 1's decision to continue with regular outpatient appointments was reasonable and that it was based on a proper assessment of risk.

We discuss below the integration of outpatients with the work of the CMHT.

Management in outpatients between October 2008 and April 2010

8.9 Locum staff-grade psychiatrist 2 took over Mr Z's care in October 2008 when he was employed by the trust as a locum staff-grade psychiatrist.

8.10 The internal review interview notes show that consultant psychiatrist 1, the consultant psychiatrist at Manor Gate CMHT, provided weekly supervision to locum staff-grade psychiatrist 2. Consultant psychiatrist 1 was Mr Z's responsible consultant psychiatrist.

8.11 Locum staff-grade psychiatrist 2 told us he had a large caseload of outpatients who attended his clinic at least every six months. Most of these patients were on standard[1] CPA. Locum staff-grade psychiatrist 2 estimated that about three per cent were on enhanced CPA. Trust policy at the time was that an outpatient appointment was treated as a CPA review for patients being seen six-monthly. The doctors' records of outpatient appointments and the summary letter sent to patients' GP constituted the CPA record. The trust CPA record was completed only for patients on enhanced CPA.

8.12 Mr Z was being seen in outpatients every six months at this point and his appointment was therefore a CPA review. The letters to his GP after these appointments confirmed this.

8.13 Locum staff-grade psychiatrist 2 first reviewed Mr Z in his outpatient clinic on 12 March 2009. Locum staff-grade psychiatrist 2 recorded in the notes that "*he* [Mr Z] *has been taking his medication regularly and he feels these are helping him*". He also recorded "*No thoughts of harming himself or anyone. No suicidal ideation. No homicidal ideation*". The proposed care plan was for Mr Z to continue with his medication and have a follow-up outpatient appointment in six months.

[1] In 2008 the Department of Health issued revised guidance that changed the previous standard and enhanced levels of CPA to just one level. The changes in practice at trusts were introduced over a period of time and these events occurred in this transition period.

8.14 Locum staff-grade psychiatrist 2 next saw Mr Z in his outpatient clinic for his six-monthly CPA review on 4 September 2009. Mr Z appeared well and was being compliant with his medication. Locum staff-grade psychiatrist 2 described him as having no suicidal or homicidal ideation.

8.15 Mr Z told locum staff-grade psychiatrist 2 of two fights he had been involved in earlier in the year. He had brandished a knife in front of his neighbour in the second incident. On both occasions Mr Z was arrested but not charged. Locum staff-grade psychiatrist 2 told us that Mr Z was confused about when these incidents had occurred and there was a possibility that one of them had happened in April after locum staff-grade psychiatrist 2 had seen Mr Z in outpatients in March. He told us:

> *"...he said the first one he had a fight with one of his parents neighbours and the police arrested him. He was cautioned and released and the second time, he said somebody bumped into him, that was the one in April and he told the person he was going to have a fight with them so he went into his apartment. Apparently that was in his own flat, he went into his flat and got a knife but the person had left but the other people saw him with the knife and called the police and he said he was arrested and detained for about 6 hours and was later released by the police."*

8.16 Locum staff-grade psychiatrist 2 subsequently wrote to the GP that Mr Z had said of the incident with his neighbour that "*he fetched the knife because he misinterpreted what happened when his neighbour bumped into him*".

8.17 Locum staff-grade psychiatrist 2 told us that he was concerned about Mr Z when he saw him in September and decided to refer him to the CMHT and discussed this with Mr Z during the appointment.

8.18 Locum staff-grade psychiatrist 2 described the care plan in his letter to the GP of 4 September (typed on 15 September):

- *"Continue on his current medication.*
- *I will be referring him for a Care Co-ordinator at Manor Gate CMHRC to monitor his mental state in the Community.*
- *He may benefit from a referral to the Twining Enterprise in the future.*

- *He is aware of getting urgent psychiatric help if the need arises and has been provided with the Crisis Line telephone numbers.*
- [Mr Z's] *next Outpatient review will be in December 2009."*

8.19 The letter is copied to lead nurse 1, lead practitioner. It was the formal referral to the CMHT.

Comment

We think the referral would have been strengthened if locum staff-grade psychiatrist 2 had also discussed Mr Z with other members of the CMHT. Locum staff-grade psychiatrist 2 followed up the referral when he discovered that no action had been taken. We deal in section 9 with the response to the referral.

8.20 Locum staff-grade psychiatrist 2 told us about Mr Z's response to the suggestion of having a care coordinator:

> "*When I suggested the idea of him having a CPN he actually agreed to it and said that he preferred that to coming to Manor Gate and that he would like to have a CPN that he would be able to contact from time to time without coming to Manor Gate because he said he doesn't really like coming there."*

8.21 Locum staff-grade psychiatrist 2 next saw Mr Z in his clinic on 7 December 2009. He appeared to be well and had had no further contact with the police since the outpatient appointment in September. Mr Z told locum staff-grade psychiatrist 2 that he had reduced his haloperidol (from 10mg to 7.5mg) because he had to attend job interviews. Locum staff-grade psychiatrist 2 wrote in the records that Mr Z had no thoughts of harming himself or others.

8.22 Locum staff-grade psychiatrist 2 dictated a letter to the GP immediately after the appointment but it was not sent until 16 December. Locum staff-grade psychiatrist 2 recorded the following plan:

- *"he is to continue with his current medication. He has been advised to go back on Haloperidol 10mg nocte*
- *I will be referring him to vocational advisor at Manor Gate*
- *he has information on how to access service for help when in crisis*
- *he has been given blood test for the following investigations…* [a range of six investigations]:
- *his next outpatient appointment will be in four months."*

8.23 Mr Z was next due to see locum staff-grade psychiatrist 2 on 15 April 2010 but did not keep the appointment. Locum staff-grade psychiatrist 2 rang Mr Z's mobile phone and Mr Z returned his call on 16 April. Locum staff-grade psychiatrist 2's entry in the clinical records says:

> *" .. He said he forgot about his appointment and would like us to send us another appointment date. He is aware of the duty system and out-of-hours number to contact if in crisis before his next appointment."*

8.24 Mr Z was sent a further outpatient appointment on 26 April. The plan was for him to see locum staff-grade psychiatrist 2 in the clinic on 12 July. He did not keep the appointment because he was in custody.

Comment

In addition to referring Mr Z for a care coordinator after the September appointment, locum staff-grade psychiatrist 2 brought forward Mr Z's outpatient appointments - the first by three months, the second by two months. He rang Mr Z when he did not keep his appointment on 15 April. Bringing forward the appointments and calling Mr Z shows that locum staff-grade psychiatrist 2 was alert to Mr Z's risks. Locum staff-grade psychiatrist 2's response to Mr Z's report of involvement with the police was good practice.

Medical outpatients and its relationship to the CMHT

8.25 We asked a clinical director from the time of the incident about the relationship between medical outpatients and Manor Gate CMHT. She thought medical staff worked in isolation in the outpatient department. She described the relationship:

> *"There was a sort of belief system, as I say, that you needed to refer to the CMHT notwithstanding that you're in the CMHT and that medical outpatients were a body with a separate life of their own……there was a belief that the medical clinic had a sort of existence of its own, policies and procedures e.g. using RiO[1], were things that the doctors were exempt from."*

8.26 Locum staff-grade psychiatrist 2 described having large clinics and practising in isolation from other members of the CMHT, though he could and did discuss cases with consultant psychiatrist 1.

8.27 Consultant psychiatrist 1 told us her view of the relationship between outpatients and the CMHT:

> *"I felt very much that the standard CPA patients – as they were called in those days – who were under a doctor, were considered to be the doctor's problem. That was a problem for me as a consultant because these standard patients aren't easygoing, no problems. Standard patients have many crises, and the only way in which any doctor can safely manage a large clinic is if the whole team helps you with that clinic when the need arises."*

8.28 Locum staff-grade psychiatrist 2 made an electronic record on RiO of Mr Z's outpatient appointment in September 2009. The appointments in March and December 2009 were not recorded electronically. The trust was in the process of moving from the use of paper clinical records to recording on RiO. Staff were under instruction to use RiO at this time, but practice was still mixed - especially in outpatient clinics.

[1] RiO is the trust's electronic patient record system.

Comment

The fact that locum staff-grade psychiatrist 2 had made a record of the September outpatient appointment on RiO meant that the information Mr Z gave him was available to CMHT staff when considering the referral for a care coordinator.

Role of the consultant psychiatrist

8.29 We have seen no record that consultant psychiatrist 1, although Mr Z's nominated consultant ever actually met Mr Z. Locum staff-grade psychiatrist 2 told us he met consultant psychiatrist 1 on a weekly basis for supervision and that while there is no record of which cases they discussed, he told us:

> *"My regular supervision, every week, every Thursday I would get all the notes together and discuss the difficult cases and I am sure I must have discussed this particular case with consultant psychiatrist 1 and it is just that we didn't record it and I can't really remember, but I am sure I must have discussed this case with her and she must have said, 'Oh, you have done the right thing referring him to a CPN'."*

9. Referral to Manor Gate CMHT

9.1 Locum staff-grade psychiatrist 2 addressed his September referral to lead nurse 1, lead nurse practitioner at Manor Gate CMHT. He did this by copying to her the letter to Mr Z's GP. Lead nurse 1 confirmed to us that referrals were made by a variety of means in 2009 including by copy letter. Senior social worker 1 also confirmed this process with us and said he would have looked at correspondence copied to him. Lead nurse 1 told us she now asked for referrals to be made by email.

9.2 In September 2009 all new referrals went to lead nurse 1. She took responsibility for discussing these with the CMHT management team, including senior social worker 1. The team would then decide who the case should be allocated to and the allocation would be made in writing to the responsible practitioner. In lead nurse 1's absence allocation requests would go to the sector manager or senior social worker/lead practitioner 1[1].

9.3 In this case lead nurse 1 was on leave when the referral was made so it went to senior social worker 1.

9.4 Lead nurse 1 told us that new allocations were entered into a document held on the CMHT's shared computer drive. This document contains no entry concerning locum staff-grade psychiatrist 2's request for a care coordinator to be allocated to Mr Z.

9.5 Lead nurse 1 said there was no evidence the referral was discussed at the regular Monday morning multi-disciplinary team meeting or with team manager 1. Locum staff-grade psychiatrist 2 said at his interview with the internal review panel that he spoke to senior social worker 1 about the matter on a number of occasions to prompt allocation of Mr Z.

9.6 Team manager 1 described senior social worker 1's handling of Mr Z's referral for allocation in the following terms:

> *"…he did not discuss it with me, he did not discuss it with the lead nurse, he did not discuss it with the consultant, so it was a unilateral decision that he made."*

[1] Senior social worker/lead practitioner 1 had two roles. For brevity we will refer to him as senior social worker 1.

9.7 Senior social worker 1 told us he remembered one conversation with locum staff-grade psychiatrist 2 about the referral. He also told the trust panel that the case had been discussed at the Monday allocation meeting:

> *"Well I think at the time that the referral was presented I don't think we felt it met the criteria for allocation at that time…"*

9.8 As we say above, lead nurse 1 was on leave at that time and team manager 1 said the referral was never brought up at an allocation meeting.

9.9 Locum staff-grade psychiatrist 2 told us that senior social worker 1 had told him that they had decided not to allocate a care coordinator for Mr Z. He said he challenged this decision after the December outpatient appointment and had a further conversation with senior social worker 1 about why he considered Mr Z needed a care coordinator. Senior social worker 1 told us that he took no further action on the matter, despite the conversation.

9.10 We asked senior social worker 1 why he had not entered the request for allocation onto the shared drive. He could not remember. He suggested that he might have been distracted by other matters or unable to access the computer system. He also said:

> "*I was having performance issues, I don't deny that. I didn't get trained on RiO until sometime after it had come in because when RiO first came in it was quite a task, it would break down and things would get lost in the system*".

9.11 Senior social worker 1 acknowledged that the referral probably "*slipped under the radar*" because of the pressure of work and his own performance issues.

9.12 We asked others about how locum staff-grade psychiatrist 2 should have gone about referring Mr Z to the CMHT. A former clinical director for the trust said:

> *"the locum should have got together with a senior CMHT person and said we need to do an assessment of this…without worrying whether it's a formal referral into the CMHT: 'In my outpatients he's told me this and we need to find out some more.'"*

9.13 Medical staff at CMHT did not routinely attend referral/allocation meetings. The team consultant confirmed this and said that if the multi-disciplinary team disputed a referral they should first take it up with the referrer. Any disagreement after that stage would come to her for resolution.

Comment

No one disputes that locum staff-grade psychiatrist 2 made a referral for allocation. He made the referral in a manner consistent with the system in place at the time.

However, senior social worker 1 failed to enter the allocation request into the system or act on the referral and there is no corroborating evidence to support his claim that Mr Z was discussed at the CMHT referral meeting. Senior social worker 1 also failed to bring the matter back to the attention of the referral meeting after locum staff-grade psychiatrist 2 had prompted him to do so in late 2009.

The fact that doctors did not routinely attend the CMHT allocation meeting meant an opportunity was missed to argue the case for appointing a care coordinator to Mr Z. If senior social worker 1 had followed the allocation processes in place at that time, locum staff-grade psychiatrist 2 would have been able to ensure that his referral was discussed and challenge the referral meeting's decision not to allocate Mr Z's case.

We think senior social worker 1's lapse was a missed opportunity to provide Mr Z with enhanced care and treatment. Mr Z went without a care coordinator between September 2009 and May 2010, despite locum staff-grade psychiatrist 2's referral.

If a care coordinator had seen Mr Z it would have been reasonably foreseeable that he would have been assessed and his social circumstances and stressors would have been better understood. No doubt a care coordinator would have prompted Mr Z to be compliant with his tablets and to have ensured that his deteriorating mental health was risk assessed. This might have led to increased support and to that end intervention by Manor Gate CMHT might have prevented Mr Z stabbing his father.

We used the following questions to assess whether Mr Z's attack on his father was predictable.

Was there any known history of violence?	*Yes. This had included an attack on his father in 1997*
Was the history of actual violence?	*Yes. As well as the 1997 incident he had reported to locum staff-grade psychiatrist 1 that he had had a fight with a neighbour and the police were involved*
Was the history recent?	*No. Locum staff-grade psychiatrist 2 was concerned it was in the last eight months: but it had actually taken place in early 2008.*
Was there evidence of threatened violence?	*No, but there was evidence that this might occur when his mental state deteriorated*
Was the potential violence risk assessed?	*No. The referral to the CMHT if accepted would have led to a risk assessment being carried out.*

We do not believe Mr Z's attack on his father was predictable but if the evidence summarised above had been collated and reviewed, it might have led to a judgement that he had an increased potential of a violent episode when his mental health deteriorated.

10. Staff management

10.1 Senior social worker 1 started work as a social worker for London Borough of Ealing (LBE) in October 1998. He was promoted to the post of senior social worker and lead practitioner at Manor Gate CMHT in November 2003.

10.2 As an employee of LBE senior social worker 1 was subject to local authority human resources processes, although he worked in a trust service. This was in keeping with the legal arrangements between the trust and local authority known as a Section 75 Agreement.

10.3 Section 75 Agreements can be complex. Under the terms of this Agreement the management of the social care mental health service including the social care functions were delegated to the trust who became the lead agency in providing integrated mental health care for service users and the responsible agency for the day to day development and management of the integrated service. However, the terms and conditions of council staff remained with the local authority and so the human resource support and procedures are those of LBE.

Summary of incidents and investigations involving senior social worker 1

10.4 According to the documents the trust gave us, senior social worker 1 was involved in three serious incidents at Manor Gate CMHT within about a year. He was subject to suspension and disciplinary investigations. One of these serious incidents occurred in October 2009 and was related to senior social worker 1 not completing a serious incident report form within the required timescale. The human resource department led investigation commenced in December 2009. Following this senior social worker 1 was off sick from March to September 2010. The December 2009 investigation concluded with a disciplinary hearing held on 23 September 2010. Senior social worker 1 received a written warning and he was allowed to return to work.

10.5 The second incident occurred in February 2010. Because of this incident senior social worker 1 was suspended from work but following an investigation no action was taken against him and he returned to work just prior to going off sick in March 2010.

10.6 In May 2010 Mr Z attacked his father who subsequently died on 30 May 2010. The responsible manager in the trust decided to wait for the internal investigation to be completed before deciding if senior social worker 1 should be subject to further disciplinary investigation. The trust investigation was finished in November 2010.

10.7 The trust reviewed the Mr Z internal investigation in October 2011 as part of their routine preparation before the start of an independent investigation. Following a review of senior social worker 1's performance by the head of community services in late October, he was moved from his lead practitioner post at Manor Gate CMHT to a junior position in another service.

10.8 In December 2011 senior social worker 1 was signed off on sick leave. He was away from work at the time we undertook this independent investigation, though he agreed to talk to us.

10.9 The human resources processes in relation to this incident did not conclude until July 2012 and senior social worker 1 was dismissed.

Views of team manager 1 and lead nurse 1

10.10 We reviewed evidence from a number of sources about the lack of support offered by senior social worker 1 to staff within the team. From the evidence we received from his line manager, team manager 1, his poor performance was a matter she had been dealing with since 2009.

10.11 Team manager 1 gave us more than 50 pages of correspondence with her senior managers that included requests for help and support with her team and the action she thought was needed to deal with the issues arising from senior social worker 1's performance. The letters dated from 2009 when she started working at Manor Gate. She also included an independent report from forensic services, emails raising issues about the phones at Manor Gate and evidence she was performance managing senior social worker 1 and other members of her team.

10.12 The bundle included an email to a senior manager in February 2010 about her specific concerns regarding senior social worker 1. She mentioned: lack of supervision of

social service staff; poor communication; lack of leadership; falling asleep at meetings; concerns to do with several serious incidents involving CMHT patients.

10.13 Team manager 1 expressed her concern about the difficulties she had experienced managing senior social worker 1's poor performance and said that the advice she was receiving from the LBE human resources department made it difficult to do this effectively. She told us that following senior social worker 1's return from suspension and sick leave she was told:

> *"…he was on a phased return. I was then told that I could not manage him while on a phased return. He has a long phased return and when he finally came back on his full time hours, I was then told by* [human resources]*, you have to start back again with the original performance targets"*

10.14 She said trust management had not given her enough support:

> *"I needed* [human resources] *support ... I had been asking senior management for assistance since 2009 with the issues I was facing with some of the members of my team."*

10.15 Team manager 1 and lead nurse 1 told us that the CMHT worked round senior social worker 1's shortcomings. For example, when she started as manager of the team, senior social worker 1 was unable to produce records of his supervision of social work staff covering the previous three months. Consequently team manager 1 and lead nurse 1 took responsibility for the supervision of the staff.

10.16 Lead nurse 1 was also given responsibility for allocations as:

> *"there was a history of* [senior social worker 1] *not making the allocations either in a timely manner or that they went missing, so this was historical."*

10.17 According to lead nurse 1, senior social worker 1's performance had an adverse impact on the CMHT team and as a result she took on the role of duty manager because:

> "*There was no feeling of real support or that people could trust his decision-making, and when discussions were being had in MDT* [multi-disciplinary team]

meetings he was never forthcoming. For me that is very alarming for a lead social worker or a lead practitioner, not to bring anything to the table during discussions."

10.18 Relevant extracts of a draft of this report was sent to senior social worker 1 and he wrote to us and said:

"The suggestion that I did not support staff was never raised with me either by the staff themselves or by [team manager 1] *in supervision.*

"Concerning the issue of MDT meetings there were occasions when another member of the management team made the same point I wanted to make before I was able to say it and so I felt that there no value in saying the same thing just for the sake of it."

10.19 One of the key responsibilities of a senior social worker was supervising social work members of the team. We interviewed one of the social workers that senior social worker 1 supervised and who took on the acting senior role when senior social worker 1 was moved out of the team. He told us that after 2007:

"*…supervision kept being cancelled, and very rarely did I get any supervision notes, any records. In the end I started writing my own supervision notes and emailing them to him, before the supervision, and go through them with him and he could make any alterations to that if he wished to, which isn't the best way."*

10.20 We asked him about the quality of supervision:

"It was reasonable. The verbal discussions, the advice, was reasonable. The guidance was quite good, yes. Certainly in terms of cases and the problems I was having with particular cases,"

Management response to team manager 1's concerns

10.21 Many of the documents team manager 1 sent us predated locum staff-grade psychiatrist 2's referral to the CMHT. One email sent after Mr Z's offence refers

specifically to concerns about safety if senior social worker 1 were to return to his position.

10.22 The email was sent on 16 June 2010 to a senior LBE human resources manager and copied to another manager. team manager 1 introduced the email by saying she had had a phone conversation with senior social worker 1 who told her he was planning to return to work after his sick leave in August. She said that this was when his salary was to be halved. We set out below extracts from the email:

> *"I have serious concerns if he is merely to return to his post and I feel that the risks continue to be high."*
>
> *"What can we do as I do not feel he is safe to practice?"*
>
> *"Can you please respond as a priority as I am very concerned."*

10.23 Senior social worker 1 was transferred out of the CMHT and to a junior position 16 months later.

10.24 In senior social worker 1's response to draft of this report he said:

> *"The fact that I returned to work around the same time that I was due to go on half pay is purely coincidental and I only returned because my doctor had concluded that I was fit to return to work."*

Comment

The reason for senior social worker 1's return to work has no bearing on our investigation and we therefore make no finding about it.

10.25 We asked the head of community care services about the trust's management of senior social worker 1. She said:

"someone did not get hold of it enough; I don't understand why the service manager at the time did not get a further grip on it, because [team manager 1] *was raising concerns, so why they were not being more proactive. The service manager at the time himself was a Borough employee, so he would know how the human resources worked in the Borough."*

10.26 She also described the delay in the performance management process:

"It has taken a long time – when I came into post, he was at Stage 2 of the Performance Management process. So, it has taken them a long time even to get to that stage of the process. That should not take that long."

Comment

Senior social worker 1 worked at Manor Gate CMHT for many years. He was promoted to senior social worker/lead practitioner in 2003. His performance declined in 2009 and 2010 to such a degree that he was implicated in three serious incidents. These were the incidents in October 2009, February 2010 and the incident which is the subject of our investigation.

Senior social worker 1 acknowledged to us that he had suffered from performance issues. All professionals whose performance decline have a clear responsibility to ensure that they do not put vulnerable clients at risk. It is clear that whatever the particulars of the incidents senior social worker 1 was involved in he was not coping with his responsibilities as a senior social worker/lead practitioner and at times not performing safely.

Finding

F1 Senior social worker 1 had a personal responsibility to ensure that his poor performance as a senior social worker/lead practitioner in 2009-10 did not compromise client safety; he failed to do this. Senior social worker 1's poor performance directly led

to Mr Z not receiving the extra support he needed. This support might have prevented deterioration in Mr Z's mental health and might have prevented the attack on his father.

Comment

Performance processes in health and social services like any other employment must be fair and follow good human resources practice. These processes must also be sensitive to the need to maintain safety as the highest priority. Senior social worker 1's line manager's concerns about his performance did not result in decisive action by more senior managers. It took the arrival of a new senior manager to take action to safeguard safety.

Finding

F2 Senior managers failed to ensure that client safety was maintained while they performance managed senior social worker 1. This failure was a contributory factor in Mr Z not being allocated a care coordinator. A care coordinator might have prevented the deterioration of Mr Z's mental state and the consequent offence.

Recommendation

R2 The trust and local authority must ensure that their human resources policies include processes setting out how immediate action can be taken to deal with clinical or social work staff who are reported as posing a risk to patient/client safety. This may include re-allocation to a non-patient/client contact area, restriction of their work or if necessary suspension from work. The policy must also include how staff will be assessed and deemed safe to practice before they return to patient/client contact work.

10.27 As part of finalising our report we met with trust managers to understand what changes to staff performance management procedures have been made. The following is an extract of the information supplied to us by the trust.

"…since this incident there has been a significant service reconfiguration across the Trust inclusive of community services. A new senior management team has been appointed, inclusive of the appointment of a new Head of Community in October 2011. This role provides clear leadership and partnership working across all community services in providing effective management of community patients. Following this appointment clear actions were taken to support [senior social worker 1] *through Human Resources processes inclusive of the immediate change to his work and supervision.*

At the time of this incident the Trust had undergone a complete review of their serious incident review process which may have contributed to the confusion between senior manager's in both the mental health Trust and the local Borough resulting in the delay in the initial Human Resources processes. …since this the serious incident review process has embedded across the Trust and staff involved in the review process are aware that no Human Resource process should ever be delayed due to any other governance process.

Human Resources arrangements have strengthened within local services following the reconfiguration. Each team manager and the respective service managers meet on a monthly basis with the Head of Community to look at performance of their team. This performance meeting will discuss in detail, staff sickness, supervision, mandatory training, performance reviews, capability and disciplinary issues, in addition to looking at other performance indicators such as finance and performance targets. Team managers are expected to complete a monthly return on these issues for the service manager and Head of Service and are expected to be scrutinised on this within the meeting. Performance is then also scrutinised across the whole of community as part of the Community Senior Management Team Meeting.

In addition, the Head of Community and the Borough Director meet monthly to examine and discuss any issues and they also meet monthly with the borough staff side representatives. The head of community also receives monthly HR reports from the borough and will meet with HR on a regular basis to discuss any matters in more detailed as required."

11. Trust internal review

11.1 The trust commissioned an incident review in August 2010. A panel of four carried out the work. Two members were external to the trust. The report was completed in early November 2010 and the trust board signed it off. It was submitted to NHS London the same month.

11.2 The review consisted of a review of documents and six interviews including with Mr Z's mother. The review team did not interview Mr Z because of the criminal proceedings. All interviews were recorded and transcribed.

11.3 The review team also met the trust's safety and security management specialist to discuss how liaison with police could be improved. They reviewed the recommendations and developed the action plan in conjunction with the Ealing service development unit director.

11.4 The trust provided support to Mr Z's mother and other relatives after the incident. The review team wrote to Mr Z's family at the outset of the review and met Mr Z's mother and her granddaughter in August 2010. The team offered them the opportunity to ask questions and explained the process for the review.

11.5 The review team met the family to discuss the outcome of the review.

11.6 The outcome of the review was also shared with Manor Gate CMHT staff, though some staff did not see the report until this independent investigation began.

11.7 The internal review made an assessment of the organisational and operational matters arising from the care and treatment of Mr Z. They compiled a psychiatric history and obtained Mr Z's criminal record and associated police notes to build up a picture of his offending behaviour. The review had written terms of reference and its work consisted of:

- a brief psychiatric history
- an offending history
- a chronology of events leading up to the incident

- an assessment of the care and service delivery problems associated with Mr Z's care
- an analysis of the factors that may have contributed to the incident
- an assessment of good/notable practice
- a conclusion, lessons learned and recommendations.

11.8 The report also described how Mr Z's relatives and trust staff were involved and supported at the time of the review.

Themes from the internal review team's interviews

11.9 The internal review team heard information about a range of organisational matters relevant to the care and treatment of Mr Z. They included:

- an apparent shortage of staff in the CMHT
- a significant number of staff subject to performance management procedures including senior social worker 1
- concerns about staffing being reported up the organisation by the CMHT sector manager and the lack of action in response
- medical staff maintaining paper records in outpatients and being slow to migrate to RiO
- lack of supervision and appraisal of social work staff.

11.10 The review found the following about the care and treatment of Mr Z. The following list is not a quotation but we have used the report's words where possible:

- Mr Z had not been allocated a care coordinator.
- A risk assessment and management plan had not been formulated once Mr Z's contact with the police was known.
- Mr Z had reported incidents with the police and the police had contacted the CMHT on one occasion but this information had not been acted on. Mental health services had not liaised with the police.
- Mr Z missed planned outpatient appointments.
- His outpatient appointments were mainly with locum doctors.
- He was non-compliant with medication and resistant to having a depot injection.

- The CMHT processes for allocation were inadequate.
- There was no evidence that the allocation was discussed.
- The CMHT management team had no plan in place for dealing with a poorly performing staff member.
- There was a lack of integration between medical staff and the wider team.
- Social workers were not supervised.
- The CMHT had not responded appropriately in the past to requests for help from Mrs Y. It had taken too long to give Mr Z an outpatient appointment in 2004.
- Mrs Y had reported difficulty contacting the CMHT by phone in April 2010.
- The CMHT system for leaving messages was complicated.
- Liaison with police was poor.

11.11 The review team concluded the following.

- Mr Z was a chaotic person who struggled to maintain jobs and relationships.
- Mr Z was not supported in comprehensive ways, particularly after incidents where he reported being in trouble with the police
- Mr Z was not allocated a care co-ordinator in 2009. His presentation should have been discussed with the police and a full risk assessment and management plan put in place. This might have reduced his risk to the public.
- CMHT processes for allocation and decisions about allocation were wholly inadequate.
- The CMHT should have communicated with police.
- CMHT systems for operational and clinical management were extremely poor.
- The lack of a risk management plan left the public potentially more vulnerable to Mr Z's aggressive and violent behaviour.
- Mr Z's threats to his parents and his mother's fear of him should have been recorded and addressed. A carer's assessment should have been completed.

11.12 The report identified lessons to be learned and made 10 recommendations.

11.13 The report comprises 28 pages. Its factual basis comes from a wide range of sources including documents, interviews and discussions with staff and Mr Z's mother.

11.14 At interview with us staff reported that they thought the internal review report had not addressed matters to do with senior social worker 1's performance.

CMHT staff comments about the internal review report

11.15 Team manager 1 told us that the panel's report had not taken into account many of the points she raised in her interview and after she had seen the draft. She thought the report was "*grossly inaccurate*".

11.16 The major example she cited was that the trust's internal investigation ascribed the failings in the Mr Z case to poor CMHT systems rather than to the failings of senior social worker 1. She did not accept this analysis.

> "*…I had a solid allocation system which was very similar to that of other CMHTs.* [Senior social worker 1] *chose not to use it and a system is only as good as the person using it."*

11.17 Lead nurse 1 also expressed concerns about the findings of the internal investigation report, particularly the criticisms of the lack of systems at the CMHT. She described the allocation system in place at that time as robust but that the problem in this case was that senior social worker 1 had not acted on the request for the allocation of a care coordinator.

> *"… I feel that in* [the internal investigation] *report that was completely missed… even though it had been brought out by a number of different people that certain processes had been followed, but nothing actually happened. It has felt from the report that there was an agenda behind the investigation and the investigating Panel and the* [serious untoward incident] *Panel were only looking for those particular things."*

11.18 She went on to say how she thought the internal report panel had missed the important factors in the Mr Z case.

> *"the fact that the allocation wasn't carried out, the phone lines at Manor Gate, the fact that the prescription for the service user wasn't sent to the pharmacy*

that it would ordinarily have been sent to, and so there was a delay in him receiving his normal prescription. I felt those were the really important parts of this and what I would be looking for, and I didn't understand why they weren't pursuing that."

Comment

The trust promptly commissioned an internal review into the care and treatment of Mr Z, conducted by people independent of local services. The review team saw documentary evidence and spoke to the appropriate staff. They met Mr Z's mother although they were not able to talk to Mr Z.

The findings of this independent investigation broadly support those of the internal review team. However, we think the panel did not identify the concerns about senior social worker 1's performance.

The internal review team heard from team manager 1 that senior social worker 1 was being performance managed, that the allocation of Mr Z had not been handled in keeping with CMHT established practice and that she thought this was the responsibility of senior social worker 1. They interviewed senior social worker 1 after interviewing team manager 1 but did not ask him about any of these matters. Furthermore, they concluded that the problem was systemic. We think there was a system in place for allocating patients. If the internal review team had explored this further and reached the same conclusion, then the trust senior management team would have heard about senior social worker 1's shortcomings. This might have prompted earlier action.

12. Implementation of recommendations

12.1 The trust internal review made 10 recommendations. It also supported one further recommendation from another internal report - we refer to this as recommendation 11. It was to be monitored by the service development unit incident review group and the trust risk management team. The report findings and recommendations were discussed with the staff involved in Mr Z's care and treatment. An action plan was developed to address the recommendations.

12.2 We assessed the progress the trust had made in implementing the recommendations by speaking with current staff and managers at Manor Gate CMHT. We also reviewed the up-to-date action plan (dated 11 October 2011).

12.3 As we say above, the structure of teams has changed, so where we talk about new processes, they relate to a team that no longer exists in the same form.

12.4 The internal report recommendations are set out below in italics. An explanation of the evidence we found in support of their implementation follows each recommendation.

Recommendation 1

The trust develops straightforward guidance as to when and how clinicians contact the police. There is guidance in section 3 of the trust CPA policy about when people pose an increased risk. This could be used as the basis of the guidance. We recommend that this should be a single side of A4 and that it should be disseminated to all clinical areas for prominent display and included in mandatory training. The guidance should include police contact by staff when a person reports incidents of violence or aggression.

12.5 Recommendation 1 appears not to have been implemented. The A4 guidance for police liaison has not been produced and displayed or included in mandatory training.

12.6 A number of interviewees felt that such guidance was inappropriate because they did not feel there was a blanket way of dealing with all cases. The team consultant said:

> *"It is still, to me, case by case. But I think that how quickly we go is different today, I think, as a consequence of this incident. It is very easy to go to the police when the patient is carrying the knife currently ...If we did get an A4 guidance, then it would in some ways be helpful but it would still be case by case. Because I don't think that every time someone reports to you that they have carried a knife, that you go to the police right away."*

Recommendation 2

The trust and partner council social services departments review their supervision policies and set out what supervision should cover (including client issues) and how it should be recorded. The guidance should also set out managers responsibilities for auditing that supervision is being carried out and recorded effectively within their team. The supervision policy should also be clear about how doctors are supervised and how managers ensure that the systems for supervising doctors in their areas of responsibility are adequate.

12.7 We have seen the trust's *Supervision policy* implemented in February 2011. It outlines best practice in supervision content, implementation and monitoring. It sets out both manager and staff responsibilities. The policy covers all staff groups including doctors and local authority staff working in integrated services.

12.8 The trust sector manager confirmed that supervision guidance had been reviewed and revised:

> *"There is now a new policy ... that people are familiar with. We have it linked to an IT system which is based on our exchange, which has within the HR element a place to record staff supervision where you can bring up reports and audits and things of that."*

12.9 Team manager 1 and lead nurse 1 told us that they had been completing supervision regularly and consistently with all nurses and social workers before the incident.

12.10 We asked lead nurse 1 if supervision was different since the incident:

> *"For me, no, I don't think so. No. I have kept the same standards, I have ensured that I give supervision regularly and more if I have requests to be seen earlier."*

Recommendation 3

The systems at Manor Gate CMHT for allocating clients are reviewed by the sector manager to ensure that all referrals for allocation are considered by the consultant, lead social worker, lead nurse and the CMHT manager against agreed criteria, that decisions are recorded and that these are communicated to the referrer. This should be regularly audited by the CMHT manager.

12.11 The process for referrals and care coordinator allocation at Manor Gate CMHT was reviewed and updated after the incident. Up until then the request to allocate a care coordinator was sent either to the lead nurse or to the lead social worker. The request could be in the form of a letter or email. They recorded this electronically in a central location and discussed it with the CMHT manager. The situation now is that referrals must always be sent in the first instance by email (and may be backed up by a letter) to the lead nurse, social worker and manager to ensure that they are not missed. The referral process is set out in the CMHT operational policy.

12.12 A weekly meeting takes place between the lead social worker, lead nurse and CMHT manager to discuss allocations. The team consultant does not routinely attend allocation meetings but is part of the process. She told us that disputed cases would come to her attention:

> *"if there is a disagreement ... the person who is responsible for allocation comes in the first instance to the referrer ... if they cannot, then both the junior doctor and/or the allocation care coordinator will come to me and we discuss it together.*

If necessary we will discuss it in the whole team if there is still further disagreement between us ... I am always part of the process."

Recommendation 4

The trust CPA review group consider how medical outpatient appointments can be recorded effectively on RiO.

12.13 Interviewees agreed that doctors now recorded the outcome of their outpatient appointments on RiO. The senior clinical lead and consultant described it as a "*universal expectation*" that RiO should be the single record of all clinical records. She undertakes a quarterly CMHT "*housekeeping*" audit of RiO to check that entries are validated and entered less than 24 hours after the event.

Recommendation 5

That discussions and decisions from the daily meetings at Manor Gate CMHT are recorded on patient's RiO notes within 48 hours.

12.14 When patients are discussed in daily multi-disciplinary team (MDT) meetings, pertinent details should be added to RiO.

12.15 Team manager 1 confirmed that when a new allocation came in and was discussed at the MDT, the outcome was entered on RiO. She told us that staff had had "*clear instructions*" that when they bring a case to the morning meeting they must enter details onto RiO. She admitted that this was "*still not consistent*".

12.16 Lead nurse 1 admitted that this was not audited but thought that problems would come to light during supervision.

12.17 The trust sector manager said the trust was working towards every discussion being entered onto RiO:

> *"it was a bit hit and miss, and that's what we're aiming to strengthen now in terms of being clear that all morning discussions have to be highlighted within RiO ... I'm more confident that is beginning to happen on a consistent basis, but it wasn't. I think people were applying it, they were having the meetings, they were discussing it, they were recording it. Some of that information wasn't then ending up on RiO. That's what we're tackling now."*

12.18 He completed a "*review of the zoning implementation and practice*" in May 2012 that found no RiO recording of risk management plans and outcome and no RiO recording of REDS[1] action agreed on the day. His action plan included using administrative help to ensure recording on RiO.

Recommendation 6

That the processes for police liaison across the trust are strengthened. The panel heard examples of effective liaison that are in place across the trust and we recommend that these examples of good practice are shared and rolled out across all localities.

12.19 Interviewees told us two police officers were now based in the risk department and that their contact details were available to the CMHT. They told us that trust staff were much better at contacting police since the incident with Mr Z. The lead nurse described the support police liaison provided:

> *"We can ask for information about a service user, we can ask them to give us any criminal activity in their adult life, and I suppose their younger life as well, and we can ask them for advice as to whether this should go to a formal investigation or maybe on to MAPPA, etc"*

[1] REDS actions are alerts added to a patients file when there are immediate actions to be taken.

12.20 A quarterly police liaison meeting takes place in which clinicians and managers from across community services, inpatient and forensic health services meet police representatives to discuss policy. The purpose is to "*promote joint working arrangements as an example of best practice that can be shared across Trust services and nationally*" (terms of reference).

12.21 The trust sector manager had not experienced a meeting where a particular client was discussed though felt that this could be an opportunity to raise concerns. In contrast, the CMHT manager said she had discussed cases of concern with police at these meetings.

12.22 Lead nurse 1 told us the CMHT manager had developed links with local neighbourhood police officers and gained "*a lot of information and advice from them*."

Recommendation 7

That all clients at Manor Gate CMHT are reviewed to identify who are their most vulnerable/potentially violent patients and that their risk management and care plans are regularly reviewed by the senior management team at the CMHT at their weekly meeting and audited on a quarterly basis by the SDU [service delivery unit] *manager.*

12.23 Interviewees told us a daily morning MDT meeting took place where any cases of concern were discussed. Managers and doctors attended. A bigger MDT meeting was held on a Tuesday each week where cases could be discussed. All concerns were therefore highlighted at the earliest available opportunity.

12.24 A zoning system was employed at the daily morning meeting. When a patient is deemed to be unstable or at risk and requires active management they are added to a list. This list is clearly visible on a board and patients are classified as red, amber or green. Those that are classified as red are the highest risk and action must be taken that day. This could be, for example, if staff are trying to set up a Mental Health Act assessment or are conducting a home visit that day. Those service users classed as amber have shown some improvement but are still at risk. Those on green are improving but remain on the list for a couple of weeks to be monitored in case of relapse.

12.25 Interviewees felt that the zoning system was working well to minimise risk, provide continuity and reduce the chances that a patient of concern would be missed. The team consultant said:

> *"I think it highlights people: it is very, very good for current risk."*

12.26 We discussed with the trust sector manager whether this zoning system had been implemented as a learning point across the trust.

> *"I'm on the recovery work stream in terms of developing those teams, and it's being written within the recovery operational policy ... that's going to be within the policies for all the recovery teams across Ealing, Hammersmith and Fulham and Hounslow. That process will be embedded in the recovery teams in those three boroughs in terms of adult services. I know the assessment team in Ealing will use it. I can't say definitely it's in the operational policy. I'll need to check that when I go back that it's been put in the one for the assessment intake team as well."*

12.27 The trust sector manager completes a quarterly audit of zoning practice. The last audit was completed in late 2011. It found the zoning system employed consistently and discussed every weekday to identify immediate risks but there were failings:

- *"Inconsistent recording on H-Drive - poor use of local tracking-table devised*
- *Poorly understood REDS criteria by MDT*
- *Unclear risk management plans as outcome and no RiO recording of the same*
- *No recording on RiO of REDS action agreed on day*
- *Poor shared involvement in MDT decision making by non-Dr professionals*
- *Poor ownership of decision making - tended to be left to Dr".*

The report had a robust set of actions to address these shortcomings.

Recommendation 8

That Manor Gate CMHT review their systems for clients, carers, professionals and the public to contact the team and leave messages, especially out-of-hours, and ensure that these are communicated to all patients and carers.

12.28 This recommendation has been implemented. A simple leaflet/card setting out contact arrangements has been distributed to all clients and carers. An A4 poster is displayed in CMHT waiting areas and in all GP surgeries in the Manor Gate CMHT catchment area.

Recommendation 9

That the management team at Manor Gate CMHT receive urgent support from the human resources departments at the trust and the council to develop an action plan to address the performance and staffing issues in the team.

12.29 The action plan says that an "*allocated HR manager will support the CMHT top team to draw up an action plan*". It says that this human resources action plan was completed by March 2011 and embedded into locality management arrangements. The specific individual staff issues were dealt with separately.

12.30 The trust sector manager told us that human resources in the trust had been restructured since the action plan was developed and there had been changes to the services. The trust human resources approach was now to equip managers with the skills to take on human resources-related issues in their own teams. He therefore supported team manager 1, the service manager at CMHT, through performance and staff related issues in the team. He told us that the CMHT manager had not had much support from her service manager before he joined the trust.

Recommendation 10

That the CPA and risk management processes at Manor Gate CMHT are reviewed by the management team to make sure that they are compliant with trust policies.

12.31 The trust CPA policy was last revised in October 2010.

> *"Reports on CPA activity and content can be derived from RiO via the Trust's Data Warehouse (using the Information Delivery Tool) ... Information is to be used to assist in managing caseloads. It must also be made available to answer relevant audit questions and to support service planning and implementation. Regular Audits will be conducted to address quality issues in CPA practice. A general audit of CPA practice will be conducted at least yearly and will be the responsibility of the Audit Department."*
> *"Local audits are conducted in each service considering pertinent issues in CPA practice. Local managers are responsible for formulating action plans to address any deficiencies in CPA practice identified in Incident Investigations."*
>
> *"Clinical supervision using information derived from RiO to monitor supervised clinicians CPA caseloads and practice is a core component of clinical supervision within the Trust."*

12.32 Team manager 1 told us that the frequency and number of risk assessments and CPA reviews were regularly audited.

12.33 A CPN described the improvement in CPA processes:

> *"At one point we had something like 14 percent of our people on CPA weren't having their CPAs at the six-month period, they were over that, and we've now brought that down to two percent, which in terms of KPIs and stuff is green. We've improved and we've had to spend a lot of time with teams doing that."*

12.34 He went on to described how RiO has helped improve CPA processes by providing information on a spreadsheet which shows the number of face-to-face contacts, whether the risk assessment has been done and whether the CPA review is on time.

12.35 Team manager 1 told us that the quality of CPA documentation was audited through supervision. The team consultant confirmed that doctors monitored the quality of CPA:

> "*Through supervision ... when the patient is in there for a CPA, one of the things that we do, and I ask all of the doctors to do it... Whether the patient has had a copy of the care plan, what does the care plan look like, does it actually reflect what we are doing together with the patient.*"

12.36 She told us that the audit of CPA and risk assessments could be improved if RiO could be reviewed as part of MDT meetings, but it would require hardware such as laptops and projectors to be installed.

Recommendation 11

12.37 The panel also endorsed a recommendation from another trust internal review that:

> *"guidance be developed and circulated for all staff regarding liaison between community and inpatient services, when patients are admitted and during their stay in hospital. Regular and formal communication and liaison is key to defining the purpose of admission and effective care management. The panel suggests the development of a protocol to be adopted by the trust, outlining the responsibility for this liaison".*

12.38 The protocol for inpatient/outpatient liaison is part of the trust-wide CPA policy (October 2010). On admission the CMHT care coordinator must ensure that all inpatient care planning and assessments proceed in line with the current community care plan. The CMHT care coordinator liaises with the inpatient coordinator to formulate an initial care plan. This should all be documented in the problem/intervention format in the RiO care plan. The policy encourages close liaison between the CMHT care coordinator and inpatient coordinator on admission and during their stay in hospital.

12.39 The action plan states that care coordinators ensure that key points from admissions are recorded in clinical records and that this is checked through supervision by the lead nurse and social worker.

Summary note

12.40 Changes in team structures mean it is important that lessons learnt by the trust as a result of the internal investigation are implemented as appropriate in the new team structures.

Recommendation

R3 The trust should provide evidence to the PCT that the lessons learned as a result of the internal trust investigation are carried forward to the operational policies in the new team structures.

Appendix A

Documents reviewed

Clinical records

- Mr Z's medical and nursing clinical records
- Mr Z's GP records

Policies and procedures

- Care programme approach, October 2010
- CMHT operational policy, January 2010
- Safeguarding adults policy, July 2010
- Supervision policy, February 2011

Internal report

- Serious untoward incident level 1 review report, 9 November 2010
- Action plan, 9 November 2010
- Transcripts of internal investigation interviews
- Updated action plan, October 2011

Operational police liaison group

- Terms of reference, 5 February 2009
- Minutes of group meetings on; 18 January 2010, 10 January 2011, 21 January 2011

Other

- Selection of emails and documents from Manor Gate CMHT manager

Appendix B

Interviewee list

- Team manager 1, team manager, Manor Gate CMHT, WLMHT
- Community psychiatric nurse, Manor Gate CMHT, WLMHT
- Consultant psychiatrist 1, consultant psychiatrist, Manor Gate CMHT, WLMHT
- Head of community care services, WLMHT
- Senior social worker 1, former lead social worker, Manor Gate CMHT, WLMHT
- Acting lead social worker, Manor Gate CMHT, WLMHT
- Locum staff-grade psychiatrist 1, former locum staff-grade psychiatrist, Manor Gate CMHT, WLMHT
- Sector manager, WLMHT
- Locum staff-grade psychiatrist 2, former locum staff-grade psychiatrist, Manor Gate CMHT, WLMHT
- Independent chair for the trust internal report, WLMHT
- Senior clinical lead, Ealing Borough, WLMHT
- GP 1
- Consultant child psychiatrist/adult safeguarding lead, WLMHT
- Lead nurse 1, lead nurse practitioner, Manor Gate CMHT, WLMHT

Meeting with

- Mr Z
- Mr Z's mother
- Mr Z's solicitor

Appendix C

Biographies

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Dr Anthony Akenzua

Dr Akenzua is a consultant psychiatrist and clinical director at Oxleas NHS Foundation Trust. He works in the adult acute directorate and has been involved in a number of trust serious incident investigations.

Collette Skinnion

Collette is an experienced senior community nurse at North East London Foundation NHS Trust and has recently taken on the role of lead nurse for the mental health liaison team in A&E. She has just completed a year's secondment to the governance and assurance department undertaking serious incident investigations.