An independent investigation into the care and treatment of PT

A report for NHS London

January 2010

NHS London

Content

Abbreviations and references

We refer in the footnotes to transcripts of meetings with witnesses. For example, the reference 'M3 transcript page 14' refers to page 14 of the transcribed evidence of M3.

Throughout the text we have attributed references and quotations to the various documents listed in annex 5. So therefore P2-322 to 324 refers to the risk assessment and risk management plan completed respectively by DR2 on 17 January 2003 and PSY1 on 24 March 2003.

ASW	Approved Social Worker
BEHMHT	Barnet Enfield and Haringey Mental Health Trust
CHI	Commission for Health Improvement
CMHT	Community Mental Health Team
Code	Mental Health Act 1983 Code of Practice 1999
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution and Home Treatment Team
GP	General Practitioner
HTPCT	Haringey Teaching Primary Care Trust
JSIG	Joint Mental Health Clinical Services Improvement Group
MHA	Mental Health Act
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
RMN	Registered Mental Nurse
RMO	Responsible Medical Officer
SOAD	Second Opinion Appointed Doctor
SHA	Strategic Health Authority
SHO	Senior House Officer
SpR	Specialist Registrar
SUI	Serious Untoward Incident

1. Introduction

1.1 On 15 April 2004 PT killed SB. He had become increasingly irritated and disturbed by building works SB was carrying out. (SB's family and PT's family were next door neighbours.) Having planned to kill him for several weeks, he took a kitchen knife and waited for SB to return from a regular evening engagement. On hearing SB's van returning, PT immediately approached him and without warning stabbed him several times in the chest. SB managed to stagger to his front door and alert his wife to what had happened, but despite being immediately taken to hospital by ambulance, he died of his injuries soon afterwards.

1.2 PT had received psychiatric care and treatment from Barnet Enfield and Haringey Mental Health NHS Trust (the trust) in 2003. Guidelines issued 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 33-36 issued in June 2005, require an independent inquiry (now referred to as an investigation) to be undertaken when a person in contact with mental health services commits a homicide.

1.3 On 15 October 2007 the independent investigation into the care and treatment of PT was commissioned by NHS London. It follows two investigations by the trust into PT's care and treatment. It was envisaged that the independent investigation would take about six months from the date of the commission to delivery of the report. This target time was not achievable for a number of reasons. PT refused consent to disclosure of all records concerning his case and the nursing records relating to his inpatient care and treatment have been lost. Public interest in an investigation of this nature means the absence of the consent of the perpetrator of the homicide does not prevent disclosure. However, agencies were understandably reluctant to proceed without express consent. This caused delay. It was not until we were able to review the police records on 21 March 2008 that we were clear that the original records were not in the possession of the police and the investigation could start.

1.4 Our terms of reference include a requirement to work closely with two teams conducting equivalent investigations into the care and treatment of two other trust patients. From the terms of reference:

"The reason for this approach is that the three investigations are expected to identify common trust-wide themes and issues. The three investigation teams will provide specific and joint recommendations which will be strong and consistent. The recommendations will be made to the trust and NHS London to help ensure future best practice in the provision of mental health care."

1.5 Annex 6 contains an analysis of common issues and areas of concern arising from the three investigations.

1.6 The investigation was conducted by Anthony Harbour (chair), Dr Tim Amor and David Watts.

Anthony Harbour is a solicitor and partner in a London solicitor's practice specialising in health and social service law. He has chaired other inquiries and investigations of this nature. He is a tribunal judge.

Tim Amor is a consultant psychiatrist. He now works with a community mental health team in Central London and has previously worked in a forensic inpatient setting. He is a medical member of the Mental Health Tribunal.

David Watts is a registered mental health nurse. He has worked as a practitioner and manager in a number of different clinical settings. At the later stages of this investigation he left Verita and took up a risk management post in a Central London mental health trust.

1.7 The terms of reference of the investigation are attached in annex 1. A draft report was delivered to NHS London in November 2008. This report was based on the testimony of a number of witnesses (annex 4) and relevant documentation (annex 5). We could not have completed this report without help from many individuals, in particular the team at Verita. The police service helped by allowing us to review the documents in their possession. These investigations depend on the co-operation of professionals engaging in the investigation process. We therefore want to thank the mental health professionals who met with us and

provided information about PT and the context of his care and treatment. Retired professionals and others who no longer work for the trust met with us and shared their recollections and views.

1.8 When we first delivered this report to the SHA we referred to people by name, apart from the members of PT's family. We considered maintaining the anonymity of witnesses by referring to them by initials or some other naming system. We decided that the public interest in these investigations required us to write a report which does not look as if it had anything to hide and so witnesses were named. We gave consideration as to whether the identity of any particular witnesses needed protecting and decided that was not necessary. The SHA took a different view concluding that the public interest would be served no less if the report was published in an anonymised form. At their request we therefore anonymised the report.

1.9 The complexity of the subject matter obliges us to refer throughout to the many health and social care professionals. The job titles of these professionals can be found both in the text and in annex 4.

1.10 The nursing records relating to PT's inpatient care and treatment have been lost and no copies were made. The original CMHT records have also been lost, although there are copies. The absence of this documentation has made the process of investigation significantly more difficult and has prevented us from reaching clear conclusions in some important areas.

Key events

1.11 SB was born on 23 August 1952. He lived with his wife DB and his two sons SS1 and SS2. PT lived next door to SB's family. His mother and father spent some months every year in Crete where they had a house. The family is Greek Cypriot. PT has two brothers.

1.12 On 14 January 2003 PT was arrested for damaging some of SB's property: using a meat cleaver he broke downstairs windows in the house and some car windows. He was bailed to return to the Hornsey police station on 16 January 2003. He did not answer his bail and was arrested at his home that day. He was

taken to the police station and charged. Before being charged he was assessed under the MHA and arrangements were made to transfer him to St Ann's Hospital.

1.13 PT received inpatient psychiatric treatment in Haringey Ward at St Ann's Hospital. Haringey ward is a Psychiatric Intensive Care Unit (PICU). He was admitted to the ward on 17 January 2003. He absconded on 14 March 2003 and returned to his parents' home. The last time he was seen by any mental health professional was on 24 March 2003 when he attended a meeting on Haringey ward.

1.14 PSY1, a consultant psychiatrist, was in charge of PT's care and treatment as an inpatient. PT's named nurse was N1. PT saw PSY2, a consultant forensic psychiatrist, on 12 March 2003.

1.15 PT's case was referred to the Wood Green Community Mental Health Team on 16 July 2003. N2 (Community Psychiatric Nurse) and DR1 (Specialist Registrar) were asked to assess him. They tried to assess him on 15 August 2003 at his home but could not meet him. His case was closed following a weekly team meeting at the CMHT on 27 August 2003. He was offered an outpatient appointment with a doctor on 24 October 2003, which he did not keep. PT killed SB on 15 April 2004.

Overview of the report

1.16 The report includes both chronological and schematic analyses. There is inevitably some repetition and overlap because of this approach.

1.17 Chapter 2 provides information about SB's family and considers the impact of SB's death on his wife and children.

1.18 Chapter 3 provides information about PT and his family.

1.19 Chapters 4 and 5 describe chronologically the care and treatment PT received from mental health services from January to July 2003. Chapter 4 deals with his time as an inpatient. Chapter 5 describes the period after his discharge from hospital in March 2003 until July 2003 when his case was referred to the CMHT.

1.20 Chapter 6 analyses the July 2003 referral to the CMHT and the assessment and follow-up by mental health professionals.

1.21 Chapter 7 discusses the Care Programme Approach (CPA) in the national context and with reference to local policies current in 2003-2004 and their application to the management of PT's case.

1.22 Chapter 8 deals with the application of the Mental Health Act (MHA) 1983 to PT's case: the use of section 4 MHA, the assessments for sections 2 and 3 MHA, the role of the Responsible Medical Officer (RMO), the use of section 17 MHA leave, PT's discharge from section and his entitlement to section 117 MHA aftercare.

1.23 Chapter 9 covers the period from April 2004 and focuses on PT's diagnosis and psychiatric care and treatment.

1.24 Chapter 10 describes PT's contact with the police, the courts and the forensic service after his arrest in January 2003. This includes: the charge of criminal damage, arrest and bail, subsequent re-arrest and entry into the PICU, his appearance in courts and the decision to discontinue criminal proceedings and the referral and assessment by forensic services.

1.25 Chapter 11 covers the responses of the trust after the homicide. Two inquiries followed the homicide: a Serious Untoward Incident investigation and another described by the trust as a 'panel inquiry'.

1.26 Chapter 12 considers the working environment and the organisational context in which PT's care and treatment was delivered and analyses responsibility for the delivery of his care and treatment during this time.

1.27 Chapter 13 deals with the medical responsibility for PT's care and treatment and focuses on the role of PSY1, the consultant psychiatrist responsible for PT's care and treatment.

1.28 Chapter 14 contains an analysis of changes in local mental health services since 2003 to ask: 'how would a case similar to PT's be dealt with today?'

2. SB's family

Introduction

2.1 This chapter provides information about SB's family and describes the traumatic impact on them of the death of SB. We rely on a number of sources. DB met the team twice, once informally and once on 23 May 2008 when her evidence was transcribed. SS1 and SS2 chose not to meet us. DB, SS1 and SS2 were interviewed by PSY3 (a consultant psychiatrist) in the context of preparing reports for litigation against the trust. Leigh Day & Co, acting for SB's family made these reports available to us. We have seen other documents including the Victim Impact Statement DB gave to the police on 27 April 2005.

Family composition

2.2 In 2003 SB and DB's immediate family consisted of: SB, DB and their two sons SS1 and SS2. SB was born on 23 August 1952. He was a self-employed builder. DB was born on 19 December 1951. She trained as a secondary school teacher. She met SB when she was 29 and they married when she was 33. SS1 was born on 4 October 1985 and SS2 on 9 February 1987. She took seven years off work after she had children but returned and worked full time until SB's death.

2.3 DB's mother died of pancreatic cancer on 10 February 2003. SB's mother died in 2002, also of pancreatic cancer. DB's father was staying with the family the evening his son was killed.

Events preceding the homicide

2.4 SB's family moved to their current home in 2002. The previous occupants of their house told SB's family there was a Greek family next door who spent '*a lot of time abroad*'[1].

2.5 SB began work to remove a chimney breast on the party wall between his property and that of PT's family home in late 2002. PT's family complained that a

[1] DB transcript page 11

crack appeared on one of their living room walls as a result of this work. SB agreed to repair it between 7 and 10 January 2003. He was not able to fulfil this promise because he could not employ a plasterer on those dates but still intended to carry out the repair as soon as possible.

2.6 On 14 January 2003 PT caused damage to the windows of SB's family cars and some of the downstairs windows of the house with a meat cleaver. His explanation for his actions is considered later in this report (see chapter 4).

2.7 SB was reading downstairs and SS2 was asleep in the front downstairs room (his bedroom at the time) where the windows were smashed. DB told us:

> *"I must have been asleep and then suddenly I heard SB scream. I don't think I heard the smashing of the windows but I heard SB scream so I came downstairs, and SB looked really, really terrified. We just found all the downstairs windows had been smashed and we did not know who had done it, no idea who had done it."*[2]

2.8 After PT's arrest SB was told by the police that PT had gone to hospital and the case against him had been withdrawn[3]. SB decided to repair the damage caused to the family home and cars through their insurance policies, rather than accept PT's family's offer of money[4]. SB repaired the damage inadvertently caused to PT's family house because of the building work within days of PT having smashed their windows.

2.9 SB planned to build a loft extension later in the year. He told his neighbours about this because the work would have an impact on the party wall. He also sent, as required by law, a 'party wall notice' to PT's family on 23 October 2003[5]. PT's parents did not return from Crete until the middle of November[6]. They objected to the proposed work because it might cause structural damage to their house. SB's family altered their plans so the loft extension did not extend to the party wall and started to build in January 2004[7].

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[2] DB transcript page 2
[3] P3-206
[4] DB transcript page 14
[5] P3-338
[6] P3-58
[7] P5-119

Comment

We believe that many people would have considered moving away after such an attack by a neighbour. The unique circumstances of SB's family may explain why they did not. They had recently moved in having lived in rented accommodation for several months after selling their previous house with the intention of downsizing. They had therefore moved twice within a year. They had also suffered a series of family health problems. SB's mother had died of cancer in 2002 and DB's mother had just been diagnosed with cancer. DB was very involved in caring for her mother and worried about her father who was blind from macular degeneration. These stressful events made it less likely for SB's family to consider a move away from their home, which they had chosen as it was in a quiet, attractive area in which to live.

They had also been told by the police that PT had been admitted to psychiatric hospital and felt it was unlikely he would return home. DB told us[8]:

> **A. I have a personal experience of my cousin who has been in Broadmoor and Rampton and I had been to see him in Rampton several times. I know that when my auntie tried to get him moved from Broadmoor to Rampton and when she wanted him out of Rampton how difficult it was. She was involved in the production of a television programme through MIND on trying to get him out of Rampton. I suppose I thought he had been admitted into a mental health unit and responsibility is now with them, let them sort him out, let them treat him.**
>
> **Q. And that it would be harder for him to get out?**
>
> **A. Yes. My cousin had a terrible road accident when he was 12 coming out of school and had an eight hour brain operation and had severe epilepsy as a result of it, and was put into Broadmoor – years ago this is – and when my Uncle [C1] died she tried to get him moved to Rampton to be closer to her. In the end when he was really recovered, and he is to**

[8] DB page 7

this day, he is out and he is absolutely fine, how hard it was and what we went through as a family to support her to try and get him out of there. I suppose that is what I thought, because that was my only experience of it.

The unusual experience of having a family member admitted to a high security psychiatric hospital unfortunately falsely reassured DB about PT's admission to St Ann's Hospital.

Contact between SB's family and PT's family

2.10 SB's family had little contact with PT's family. DB had not met PT's parents until they came to apologise for their son's behaviour in damaging the car and smashing the windows of the house. (This was on 14 January 2003[9]).

2.11 PT had two brothers: PTB1 and PTB2. DB did not realise that PTB1 spent time living at his parents' home until about the time her husband was killed but she met PTB2 once in the back garden when he was visiting from Germany[10].

2.12 In the summer of 2003 DB recalled 'bumping into' PT outside their house and introducing herself to him. He apologised for what he had done in January. Later the same day he apologised to SB in similar circumstances[11]. DB does not recall either of them seeing him or hearing anything more about him until the night he killed SB. She told us she and her husband both assumed he was still in hospital and had simply been on home leave when they saw him in the summer[12].

2.13 DB does not remember any meetings or altercations with PT's family before her husband's death other than a brief conversation between herself and PT's family. In March 2004 DB and her family went on holiday. Following their return DB went to check with PT's family that there had been no disturbance from the building work and to reassure them that the chimney would not be removed.

Response to the killing of SB

[9] DB transcript page 5
[10] DB transcript page 11
[11] DB transcript page 12
[12] DB transcript page 13

2.14 PT killed SB on 15 April 2004. PT's explanation for his actions is discussed later in this report (see chapter 9).

2.15 DB tried to go back to work after her husband was killed but was on sick leave for several years before resigning in 2008. She was an able teacher who loved her work and now greatly misses it.

2.16 DB has been severely affected by her husband's death. She has been diagnosed as suffering a major depressive episode and post-traumatic stress disorder[13]. She still lives in fear of PT and wants to move away from her home although she is scared of doing so before she knows which hospital PT will be moved to after Broadmoor.

2.17 SS1's 'A' level studies were severely affected by his father's death. He was also a talented musician. He attended a college for young musicians and played in a symphony orchestra. His mother told us he had not played since SB died. Both SS1 and SS2 from a very young age shared a common love of music with their father. DB described how important this had been for all three of them. She considered the fact that both her sons had had to turn away from music following their father's death reflected their sadness and deep sense of loss.

2.18 SS2's 'A' level studies began in the autumn of 2003. He did not do as well as his school predicted however he went on to university. Both SS1 and SS2 have suffered from anxiety and depression since the death of their father.

2.19 In her 'victim impact' statement, dated 27 April 2005, DB told the police:

> *"My family has a lack of trust now in the authorities having placed total trust in the NHS and the Police. Taking into consideration the 1st incident involving the defendant, it is evident that the handling of the whole episode was flawed. It became known that the defendant was sick and clearly needed treatment and as such his care was entrusted to the NHS. If*

[13] P2-562

this aspect had been dealt with, as one would have expected, then maybe SB would still be with us today."[14]

2.20 She concluded:

"SB and I believed very strongly in compassionate reasoning. SS1 and SS2 were brought up in a totally non-aggressive environment. SB was a very quiet and eloquent man. I feel that SS1, SS2 and myself are still shocked by this violent outrage on one we love, on our own doorstep. The boys have never had reason to use defensive behaviour, as they do not possess those skills. Trying to develop and use survival skills for all of us this year has been extremely painful. The outcome we would wish for is for [PT] to receive treatment in a secure hospital unit as far away from us as possible, thus enabling our devastated family to feel secure in our everyday lives."[15]

2.21 In 2004, after a Serious Untoward Incident investigation, the trust also commissioned a panel inquiry to consider the circumstances surrounding the homicide (see chapter 11). DB discussed with us her involvement with this inquiry. She met the inquiry team and went through the report with a victim liaison officer. She described to us her response to what she read:

"To me it was just a catalogue of disasters. When PT was sectioned into hospital as an ordinary person on the street we do not know the mechanics, and I still do not know the mechanics. That is what I would like to find out. I would like to know what happens and where the responsibility lies and with whom, because he was sectioned into hospital but then again he was allowed out of hospital. He absconded from hospital and that was acceptable. I do not know whether that is acceptable, so that side of things - all the catalogue of disasters throughout the whole public inquiry, the breakdown of communication between PSY2 and the community mental health team. I do not know whether PT was sectioned and the police were involved, and therefore when he absconded should the police have

[14] P3-297
[15] P3-298

retrieved PT, and if PT had been retrieved by the police would we have been part of the plan as his neighbours?"[16]

2.22 She told us that in June 2005 she understood that the trust promised to instigate a public inquiry. We asked her what she expected from such an inquiry:

"We wanted clarification to see where things went wrong, and I feel that we have been completely depersonalised, desensitised, left alone. We have entrusted our lives in a way to the Health Authority in that we thought PT was under their care and responsibility, and given that it went so desperately wrong in their hands they have made no effort whatsoever to make us feel at any point reassured, until now when this inquiry started to take place."[17]

Comment

The trust's initial response to DB after the homicide was sensitive and timely. CE1 (the then chief executive) wrote to her on 21 April 2004 offering condolences and the offer of a meeting.[18] When the trust established a 'panel inquiry' to review the circumstances surrounding the homicide DB was interviewed and the report was discussed with her. We comment elsewhere about the quality of the panel inquiry (see chapter 11).

The delay and uncertainty that followed in relation to the establishment of an independent investigation contributed to the distress DB and her family had already experienced. The reasons for this delay are unclear. The decision about commissioning an independent investigation fell to the SHA. In making this decision the SHA were reliant on information provided by the trust.

In 2004 the Department of Health was in the process of reviewing circular HSG (94)27 which establishes the necessity for independent inquiries (now referred to as investigations) in certain circumstances. The circular was amended in June 2005. The revised criteria for deciding when an independent investigation should take place included cases where the perpetrator of a

[16] DB transcript page 18
[17] DB transcript page 17
[18] 3-292

homicide committed the offence when subject to standard or enhanced CPA in the previous six months. PT should have been regarded as an enhanced CPA patient and his circumstances fell within the amended guidance for the commission of an independent investigation. However the trust was, proceeding on the basis of incorrect information. When dealing with a request for information from DB's solicitors it was noted (in an internal memorandum) that: 'PT was discharged from services and case closed 27 April 2003'[19].

Conclusions

2.23 In addition to a formal meeting with DB on 23 May 2008 we had a number of informal meetings with DB prior to the delivery of this report to the SHA. She was given an opportunity to comment on the final draft of the report and at her request some amendments were made to this chapter. The final meeting with her was on 6 April 2009. Despite this meeting taking place nearly five years after SB's death it is quite clear that the events of 15 April 2004 continue to have a devastating impact on her, her sons and their family.

[19] M7 Serious Incidents Manager to DN1 Director of Nursing 4 July 2005 1-1023. PT's case was closed on 27 August 2003 and he should have been offered an outpatient appointment in January 2004.

- **PT's family**

Introduction

3.1 We have not met any member of PT's family despite our requests. The information about PT's background is largely taken from a social history report written by SW1, Forensic Social Worker based at Broadmoor Hospital, on 27 April 2005[20].

Family composition

3.2 PT's parents were born in Cyprus. His father came to the UK in 1950's, his mother in the 1960's. They have three sons: PT is the oldest, PTB1 is the middle child and PTB2 the youngest.

PT's background

3.3 PT was born in North Finchley, at his aunt's house, after a normal pregnancy. His development was normal. He spoke Greek at home until the age of five. He apparently started school a year late.

3.4 Not only did he start a year late, PT recalled that when he did start he missed the first few days of school. According to SW1's report he felt an outsider for the first few months, saying it was the 'hardest thing I've ever done starting infant school'. He also recalled being bullied and described the school as '*hell*' although his mother believed he got on well there. He eventually developed friendships and said that despite the problems junior school represented his '*golden years*'.

3.5 PT recalls that his first few years at secondary school were okay but then '*things started to go a bit wrong*'. When he was 13 the school merged with another school and he found it difficult to cope with the increased number of pupils. He became socially withdrawn and lived a predominantly isolated life. He also began to 'get low' and 'bear grudges'[21]. During his 'O' level year staff became concerned

[20] P5-208-226
[21] P2-345

that he stopped going to school and said he did not wish to take his exams. He left school without taking 'O' levels deciding that he wanted to rebel. He said: '*I didn't think I'd do so well as I wanted, so I thought I'd have nothing rather than second best*'[22].

3.6 At home, PT and PTB1 had increasing problems getting on. They apparently had several fights before PT told his mother he was no longer going to speak to PTB1 as '*someone will get hurt*'. They stopped speaking before PT left school.

3.7 At 16 PT worked in a brake and tyre centre at weekends for a couple of months before starting an art course. He left the course when he was expected to complete some written work which he felt was unnecessary. He then worked for six months as a trainee cloth cutter at his cousin's factory and later as a porter for 18 months. During this time he was occasionally off work with depression.

3.8 At 18 he began a stage management and technical theatre course which required him to study two evenings a week. He did not complete the course but gained a certificate. His tutor arranged a job for him at a London theatre which he started in April 1989. He left after three months, suffering from depression, but returned three months later. He then stayed for five years although he took some time off with depression. He saw his GP because of this.

3.9 He was then out of work for several months before getting a job as a scene shifter a London theatre. He had difficulty settling in because there were a large number of people in the 'crew'. He walked out in the middle of a show, feeling (as reported by SW1) 'overwhelmed – like a panic attack'. He never returned to the theatre even though he was owed money. He later worked in a theatre in the Strand for nine months and was then unemployed for two years before getting work another London theatre for 14 months. He left after becoming depressed and having an argument about his salary. He subsequently worked in another London theatre for three months before leaving because of problems with his employer.

3.10 PT's mother said her son was promoted to supervisor in one theatre but asked to be demoted again as he disliked managing people. She also said he was

[22] P2-346

reluctant to join colleagues for a drink after work but did so on some occasions. He refused to drink alcohol and was concerned about his drinks being 'spiked'.

3.11 In September 1993 PT bought his own studio flat in Edmonton putting down an £8000 deposit. He had problems with one of his downstairs neighbours being noisy and at one point banged on the neighbour's door with the intention of breaking it down. He was, though, apparently unclear what he would have done if he had been successful. This incident is referred to in the risk assessment completed when PT was admitted to St Ann's Hospital on 17 January 2003 (see chapter 4[23]). He left the flat in 1995 when the service charges increased from £150 to £600 a year saying the flat was 'rubbish'. He returned to his parents' home and remained there until his arrest in April 2004. He did not try to discuss the flat with the mortgage company. This led to its being repossessed and to PT losing a substantial amount of money.

3.12 From 1995 to his admission to St Ann's Hospital in January 2003 he developed a rigid routine. His father described this in a statement to police in April 2004[24]:

> *"PT does not speak to his mother and me but he spends most of his time in his own room. He only ever has a meal with us on Sundays. On the other days of the week he prepares his own food. He follows his own set routine. He gets up every day at 8.00am and has his breakfast. At precisely 9.00am he leaves the house and goes for a walk on his own. He might go to Alexandra Palace or to Highgate or somewhere else. He will return at 10.30am. He will then have some tea or a glass of water and go to his room. At about 1.00pm he will come down and make himself a sandwich and then go back to his room. He will come down again at about 4.00pm and make some tea. He will then leave some chicken, for instance, to marinade and go back upstairs. At 6.00pm he will take a shower and then come down and put his food in the oven. He usually sits in the kitchen to eat and then comes and sits with us in the living room and watches television with us. Sometimes he will discuss something he has seen on television, especially with his mother. We normally go to bed at around*

[23] P2-322-323
[24] P3-56

10.30pm to 11.00pm while he might stay up till later, sometimes until 12.00am or so, and I will hear him coming upstairs later…On Sundays his routine is a little different. He comes down at 10.00am or 10.30am. He has some tea and eats something and then comes down again at 1.00pm and we have Sunday lunch together. He does not go out on Sundays. He does not have any friends and does not telephone anyone. He has followed this routine ever since he stopped work. This is now his life – a life of loneliness."

3.13 PT confirmed this routine when PSY2 (consultant forensic psychiatrist) interviewed him in HMP Wandsworth in May 2004[25] (see chapter 9). He also described what he did during the time he spent in his own room. He said he would do some 'light exercise', 'listen to classical music' or meditate on 'whatever comes into my mind', including 'sexual fantasies'. After January 2004 he began to have violent thoughts about his neighbour and 'what I was going to do to him'.

3.14 PT's father told the police in 2004[26] that the family bought a house in Crete and since 1999 or 2000 he, his wife and PTB1 had spent 'some months of the year' there. He said that after PT was admitted to St Ann's in 2003 his wife and PTB1 went to Crete but he remained in London until approximately two weeks after PT returned home at the end of March. PT's father then joined the rest of the family in Crete leaving PT on his own in the house. The other family members remained in Crete 'until the middle of November'[27]. He made clear that PT did not like to spend much time in Crete, preferring to remain on his own in London.

[25] P5-119
[26] P3-55
[27] P3-58

4. The care and treatment of PT from January to March 2003

Introduction

4.1 This chapter focuses on the care and treatment PT received during his admission to Haringey ward (PICU) between 17 January 2003 and 14 March 2003. The last time he stayed overnight on the ward was 14 March 2003. He remained 'on the books' until 17 June 2003 (see chapters 6 and 7 which link with this chapter as the processes described in them also took place between January and March). We have been severely disadvantaged by the absence of the nursing notes for PT's admission. We have relied entirely on the medical notes (which at the time were filed separately) and the CMHT file. The absence of the original CMHT records has also caused difficulties.

4.2 Haringey ward is a 12-bed psychiatric intensive care unit (PICU) for 'compulsorily detained patients who are in an acutely disturbed phase of serious mental illness'[28] based at St Ann's Hospital, Tottenham. In 2003 it admitted both male and female patients according to demand but now admits only men.

4.3 At the time of PT's admission there was an acting ward manager - M1. Medical cover was provided by PSY1, consultant psychiatrist, who worked there five sessions per week (two and a half days) and a junior trainee doctor or SHO - DR3 until 4 February 2003 and then DR4. DR2 also worked on the ward as a SpR (senior trainee doctor) for part of the week. Ward rounds were conducted on Mondays and Fridays. PSY1 usually attended, but not always.

Friday 17 January 2003

4.4 PT was admitted in the morning, having been assessed in Hornsey Police Station by DR5 (SpR) and SW2 (ASW) and detained under section 4 MHA. Written reports from DR5 and SW2 were made available to the inpatient team. DR5 also telephoned PSY1 to discuss his findings (see chapter 10 for details).

[28] P2-168

4.5 On the morning of PT's admission, PSY1 (RMO) conducted a ward round. Both he and DR3 (SHO) made entries in the file[29]. PT is recorded to have said:

> *"Streets would be a safer place with me locked up…I would have hurt someone."*
>
> *"I smashed my neighbour's windows with a meat kleaver (sic). He had smashed up my parents property. He took down his chimney breast causing a crack in my parents ceiling. And he keeps smashing the doors continuously until the early hours."*
>
> *"I was lying in the bed with a Stanley knife against my vein. Then I thought about my neighbour and something snapped in my head. 'I've got to change something'."*[30]

4.6 He mentioned an incident when he believed workmen had called him 'the kebab man'. He admitted to thoughts of harming children and referred to an incident at Halloween when children had:

> *"…put fireworks through my letterbox. I would have killed them seriously I would have lost control."*[31]

He said he:

> *"Felt worse since my neighbours moved in in October 2002."*
>
> *"Felt suicidal since a few days ago. Happens once a month…a few days. Never tried to kill myself."*

4.7 PT said he slept badly because of his neighbour. He could not get to sleep at first and then woke up in the early morning. He did not experience mood changes during the day. He did not know if his appetite had changed and said he

[29] P2-338-342
[30] P2-339
[31] P2-340

could enjoy 'Tai Chi type exercise and meditation'. However, he also said that: 'freedom has become a burden…I'd rather be locked up'.[32]

4.8 PT went on to say he had:

"…no further feeling of wanting to harm him"[33] *(meaning his neighbour, SB).*

4.9 PSY1 recorded the clinical impression from the first interview as[34]:

"?depression… but not sustained"

"Mood swings secondary to affective disorder secondary to personality instability"

"Low frustration tolerance".

4.10 He recorded the risk as:

"High to self and others (but now in contained environment)."

4.11 DR3 recorded the plan as:[35]

1. Forensic referral
2. CMHT referral
3. CPA next Friday (this would have been 24/01)
4. Drug urine screen

4.12 PSY1 asked for further information on PT including information about his school history, childhood and adolescence. He did not want PT to be given medication and suggested the level of nursing observations should be 'general'. He said he thought PT needed further observation.[36]

[32] P2-340
[33] P2-341
[34] P2-342
[35] P2-338
[36] P2-342

Comment

A risk assessment was completed by DR2, SpR to PSY1[37] (see chapter 7). The section 4 MHA that PT was placed on at the police station was converted to a section 2 MHA on 17 January 2003[38] (see chapter 8).

All staff made appropriate plans to observe and manage PT after his admission. There was an immediate plan to refer him to the relevant CMHT, to request a forensic assessment and to organise a CPA meeting in the near future. DR3's statement for the SUI inquiry in 2004 said:

> **"Another part of the plan was to refer [PT] to the appropriate CMHT – I think I misunderstood this at the time as an instruction to make sure PSY4's team/the appropriate open ward were aware he had been admitted, rather as an instruction to complete the referral form for the appropriate CMHT, which I did not do."[39]**

DR3's reference to consultant-led teams rather than multi-disciplinary CMHTs reflects a lack of awareness of changes to integrate health and social service teams to perform functions such as operation of the CPA. Both PSY4 and PSY5 were consultant psychiatrists working part-time for the CMHT. 'PSY4's team' was in fact the CMHT and the way to involve the CMHT (and either PSY4 or PSY5) was to make a referral. Any member of the inpatient clinical team could have made the referral but this would normally have been either the primary nurse or the junior doctor. In January 2003 making contact with the open ward although important in facilitating PT's eventual transfer from the PICU, would not have resulted in a CMHT referral taking place.

This was PT's first contact with psychiatric services. Staff correctly identified, even before his admission, that because of his address and GP registration he would eventually be referred to the Wood Green CMHT based at the Canning Crescent Centre. Although the CMHT was contacted at this

[37] P2-322-323
[38] We think the likely date to be 17th, see P2-303, although P2-317 states that the section 2 runs from the 18th.
[39] P2-131

stage by ward staff this was not interpreted by CMHT staff as a referral. The team saw it as a request for help in arranging for a second doctor to carry out a MHA assessment on PT in the PICU, with a view to converting the section 4 MHA to a section 2 MHA.

CMHT staff told us they routinely waited for the ward to formally refer patients to them. At this time (2003) it would have been unusual for them to receive a referral from the PICU as it was assumed that patients would move to an open ward before a referral for allocation of a care coordinator was made. The assumption about the move was correct. The Haringey ward discharge policy states very clearly:

> **"It is <u>not</u> [their underlining] Haringey Ward policy to directly discharge a patient into the community. All patients will therefore be transferred back to their respective sector admission ward."**[40]

However, the assumption about the delay in the allocation of a care coordinator was incorrect. The same policy (see chapter 7) underlines the need for speedy involvement of the CMHT to allow a care coordinator to be appointed. For a patient such as PT who had not previously been under the care of secondary mental health services and who was eligible for enhanced CPA the need for speedy involvement of the community team should have been clear. M3 (CMHT manager) identified an impediment:

> **"...we would be waiting for an invitation to attend a CPA meeting to review his care, that is what we would normally be waiting for then."**[41]

We discuss elsewhere the need to allocate care coordinators within a target time for patients receiving inpatient treatment (see chapter 7 and 13).

Monday 20 January 2003

4.13 PT's parents attended a ward round with PSY1 and DR3[42]. His mother said they were afraid of him because of his verbal aggression. PT had been violent to his

[40] Haringey Healthcare NHS Trust Mental Health Directorate Haringey Ward Operational Policy SAH58 January 1999 paragraph 12
[41] M3 transcript page 15
[42] P2-343

brother PTB1 and there was jealousy between the two. She also said that during the recent Christmas holiday he did not speak to his parents for two weeks.

4.14 PT's parents confirmed that SB had damaged their chimney and agreed to mend it, but then did not. PT told his mother that if he had not attacked the neighbour's car he would have cut his [own] throat because 'he cannot get on with people and needed to go to prison'.

4.15 They talked about PT's work as a stagehand and said he did very well until 'he was made a supervisor'. He did not then return to work and said he wanted his old job back.[43] They described him as shy, with no friends and no girlfriends. He had become isolated from the age of 14 or 15 and left school before sitting exams. PT previously had interests in guitar playing, reading and TV but now only watched TV.

4.16 DR3 listed a differential diagnosis for PT of[44]:

Autistic spectrum [disorder]

Schizotypal or paranoid personality disorder.

Schizophrenia with negative symptom picture.

4.17 The recorded plan was to arrange a CPA meeting in two weeks and to investigate further PT's background history.

Thursday 23 January 2003

4.18 PT was seen by DR3 for further enquiries into his personal and family history[45].

4.19 PT told her he did not get on with his middle brother PTB1 and that his 'older' brother [this is a mistake, PT was referring to his youngest brother] worked as an English teacher in Germany.

[43] P2-344
[44] P2-345
[45] P2-345-8

4.20 He said he did 'okay' academically at secondary school but started to 'get low' and 'bear grudges'. He did not take exams because 'I wanted to rebel' and 'I didn't think I'd do so well as I wanted, so I thought I'd have nothing rather than second best'. He then worked for five years as a stagehand and 'enjoyed this'. Since then he had worked for several months at a time only. He said he had no friends since school and got lonely.

4.21 PT's mental state was assessed. He was described as calm and co-operative, with good eye contact and rapport. His affect was 'flat' but his mood was subjectively 'okay'. He had poor self-esteem and a pessimistic view of the world, saying that he had 'no future', 'I'm unemployable, I have no social skills.' His sense of enjoyment was reduced and his motivation was poor. He denied any suicidal thoughts.

4.22 He said he became suspicious, paranoid and easily angry but denied any paranoid delusions or psychotic symptoms and did not express homicidal ideas. There may have been perceptual abnormalities but they were not detected.
He was alert and oriented. PT said of his own condition: 'I should be locked up and the key thrown away'.

4.23 DR3 considered the diagnoses of:

Depression,
Schizotypal or paranoid personality disorder
Dysthymia

4.24 Her recorded plan was:

1. No medication at present
2. Discuss in ward round on Monday (27th)
3. Routine bloods taken; FBC, U&Es, LFT, vitB12 and Folate, TFT.[46]
4. Risk assessment (ticked, as already done by SpR – DR2[47]), needs part 1 and forensic referral.

[46] P2-288-289
[47] P2-132, 322-323

4.25 She later completed a physical examination which was normal.

Comment

The differential diagnoses were reasonable. PT's clinical assessment and care plan continued to be of an acceptable standard.

Friday 24 January 2003

4.26 A ward round with PSY1[48] was minuted. It noted PT 'is at court today' so he was discussed in his absence (see chapter 10). Nursing staff said he appeared rather emotionless but had not displayed odd behaviour.

4.27 The recorded plan was:

1. Forensic referral
2. Discuss with psychology department
3. Try to chase up school reports, previous employers
4. Trial of antidepressants – Cipramil 10mg *(this is strictly speaking wrongly recorded, as escitalopram was prescribed[49]. This is similar to but not the same as Cipramil, which is the proprietary name for citalopram).*

Comment

It was reasonable for PSY1 to decide to use an antidepressant after one week's observation of PT on the ward. The fact that the name of the medication was wrongly recorded in the medical notes is unfortunate but this did not affect PT's treatment as the medication chart was correctly completed.

Monday 27 January 2003

4.28 PSY1 was not present at this ward round[50]. Nursing staff said PT was calm and accepting his medication, but:

[48] P2-349
[49] P2-285
[50] P2-123

"was annoyed that his court case [in relation to the criminal damage charge] had been dropped as he thought his parents had paid the neighbour."

4.29 The SHO had spoken to PT's mother by telephone. She denied any money had been paid.

4.30 PT was seen and described as calm and co-operative. He said he was not depressed since being in hospital but could not see an alternative to being locked up forever 'which he knows is unrealistic'. He did not think he would be good at psychotherapy as he was poor at expressing himself. He was accepting medication but complained of a decreased appetite.

4.31 The only plan recorded was to continue the 'citalopram' *(really escitalopram)* 10mg per day.

Thursday 30 January 2003

4.32 DR3 saw PT[51]. PT described his mood as more stable in hospital. He was feeling confused about whether he needed to be in hospital or not and said he had considered going home but worried the 'blackness' would come back. He was still not keen on psychology. His sleep and appetite were described as okay but he still felt he had 'nothing to offer'.

4.33 He talked about courses he had done, such as maths and IT, and said he had given them up. He had finished a stage management course but could not get into drama school.

4.34 PT found the medication acceptable but was unsure yet if it had made any difference.

4.35 DR3's clinical impression was:

"Self esteem remains low

[51] P2-351-352

Slightly less pessimistic about the future

? paranoid personality disorder (tendency to bear grudges)

+comorbid depression."

4.36 Her plan was:

1. Continue antidepressants
2. Discussed with psychology who suggest Halliwick referral *(The Halliwick clinic is located on the St Ann's site and provides psychotherapy services)*.

PT was still not keen for this to happen.

Friday 31 January 2003

4.37 A ward round took place with PSY1 and DR3[52] present. PT's parents attended and his mother said she was keen for him to have counselling. PT said he did not want his parents to see him in hospital. Staff questioned whether he felt embarrassed or ashamed.

4.38 The recorded plan was:

1. Halliwick referral for personality assessment
2. CPA meeting 3 February 2003
3. Continue escitalopram 10mg od (7 days so far)

4.39 DR3 wrote a forensic referral [53] to the North London Forensic Service. (See chapter 10).

Monday 3 February 2003

4.40 A CPA meeting took place on the ward (see chapter 7).

[52] P2-353
[53] P2-383

Tuesday 4 February 2003

4.41 DR3 saw PT and told him she was leaving. This was a planned move as SHOs generally move to their next six-month training post at the beginning of February and August each year. She was replaced by DR4.

Friday 7 February 2003

4.42 A ward round took place with PSY1 and the new SHO DR4[54].

4.43 Nursing staff said PT was:

> *"Still guarded. Not opening up. Seems quite settled, appears to be a model patient. Able to concentrate to play fantastic pool games."*

PT was seen in the ward round. He appeared calm and had no complaints. He said he had not been depressed since he had been on the ward and he showed no psychotic symptoms. He was asked about the incident that led to his admission. He said he felt wronged so he did something about it. He felt no remorse. He repeated that if he had caught the children at Halloween he intended to kill them. He said he lost control. He was asked if they deserved to be killed. He said: "*I'd have liked to see them dead I have no problems with that*". He later said this might have been extreme. He admitted to letting things build up which can explode later[55].

4.44 He said that if he was transferred to another ward as an informal patient he would most likely go home. He also said he was afraid he might get depressed again when he went home.

4.45 The recorded plan was to:

> *"Allow on leave to Lea Ward*
> *Decide on section on Monday (10 February 2003)."*

[54] P2-356
[55] P2-356

4.46 DR4 saw PT's father later that day[56]. He described PT as reclusive. He said he used to get depressed a lot and was not an open person. He asked for PT to receive counselling. He also suggested that he did not believe PT would be a danger if discharged.

Comment

On 7 February 2003 PT made a number of comments that should have signalled a continuing high risk to others. However, this does not appear to have been recognised and the risk assessment form was not updated to reflect the changing risk.

Monday 10 February 2003

4.47 A ward round took place with PSY1 and DR4.[57] Nursing staff said PT's leave to visit the open ward went satisfactorily. He was thought stable enough to be on an open ward.

4.48 The plan was to:

"Discharge to Lea Ward today."

4.49 A later entry in the notes was made by an unknown member of staff[58] (*possibly a nurse or a doctor from an unspecified open ward)*. PT was transferred from Haringey ward to Finsbury ward that afternoon. At 4.00pm banging noises were heard from the laundry room on Finsbury ward. It was discovered that PT had climbed over a washing machine to try to kick through a window to escape. He was given PRN Haloperidol 10mg and Lorazepam 2mg orally[59] and placed in seclusion. The only seclusion room was in the PICU. PT was later reviewed by the duty SHO[60] (entry in notes made at 7.15pm) who said PT had 'started trying to smash things in TV room'. He said he could not 'handle' the people on the ward and not being

[56] P2-357
[57] P2-357
[58] P2-358
[59] P2-284 PRN medication is to be given 'as required' and is written separately to regular medication on the inpatient prescription chart. The use of Haloperidol and lorazepam in the dosages prescribed was common practice at the time and formed part of many trusts' 'rapid tranquillisation' policies for managing disturbed behaviour on the ward.
[60] P2-357

allowed in his room. PT said he preferred it on Haringey ward. The duty doctor noted there had been no problem in the preceding three-and-a-half weeks. He ended PT's seclusion after discussion with nursing staff. PT had been told he could now remain on the PICU. He appeared calm and rational with no evidence of psychotic phenomena.[61]

Comment

PT was given leave to Lea ward but was then moved to Finsbury ward. These are both open wards but it seems unusual to familiarise a patient with one ward, to reduce anxiety and test their response to a less secure environment, then transfer them to a different ward. It was explained to us M1 that this was due to pressure on bed availability. However, staff did not seem to appreciate[62] the unsettling effect of moving PT to a new and unfamiliar ward, even if he later denied it made any difference (see under 14 February 2003 below).

Tuesday 11 February 2003

4.50 PT was seen by PSY1 for a Mental Health Act assessment[63] (see chapter 8).

Comment

As a consequence of events on 10 February 2003, PT was assessed and placed on section 3 MHA. PICU staff contacted the CMHT to arrange for an ASW to make the application. These contacts between Haringey ward and CMHT staff provided further opportunities for his assessment by the CMHT and for the allocation of a care coordinator. However, they were simply dealt with as requests to organise a MHA assessment and no further action was taken. We were told this was standard practice for the CMHT at the time. They would have waited for a formal written referral before assessing PT with a view to taking his case on and allocating a care coordinator.

[61] P2-359
[62] M1transcript page 8
[63] P2-358, 360

Two members of staff from the duty team at the Canning Crescent Centre organised the assessment and made the application. They both came from the Hornsey and Highgate CMHT but they worked in the same building as, and sent paperwork to, the Wood Green CMHT. When the Wood Green CMHT knew PT was detained under section 3 MHA it would have been logical for staff to assume that a care coordinator would need to be appointed. This was not done and, like their PICU colleagues, CMHT staff appear to have assumed it could be delayed until PT moved to an open ward. This inflexible approach created a barrier to the smooth transition of care for a patient from the inpatient unit into the community.

Friday 14 February 2003

4.51 PSY1 was not present[64] at this ward round[65]. PT said:

> *"I didn't like Finsbury ward and wanted to escape…I was trying to open the window."*

4.52 He repeated that he felt he would go mad if he had to stay there. He said he had never been to Finsbury ward before but did not think that would have made a difference. He said Haringey ward stopped him being depressed and that he did not:

> *"…want to go back and forth. Want to be either here (Haringey Ward) or outside."*

4.53 He made clear that he felt fine on Haringey ward and that he refused to go to an open ward. He said he would try to escape or go on hunger strike if this was tried. Staff told PT he could not 'be discharged from here' (Haringey ward).

4.54 The plan was to:

> *"Continue medication*
> *Discuss leave for one hour every day again in a few days."*

[64] P2-100
[65] P2-361

Friday 21 February 2003

4.55 PT and his father attended a ward round with PSY1[66].

4.56 Staff discussed having a further CPA meeting involving PSY4 (Wood Green CMHT consultant).

4.57 PT was told his behaviour before admission was a cause for concern and that was why they wanted him to be assessed by a psychologist. He was advised to continue the antidepressant. PT denied having strange beliefs or hearing voices so there was thought to be no need for antipsychotic medication.

4.58 PT still refused to go to an open ward. He asked if he could go home and attend a day centre every day.

4.59 The plan was:

> *"Visit to therapy centre* (OT Centre at St Ann's Hospital[67])
> *Walks around the campus*
> *Psychological assessment referral*
> *CPA meeting with PSY4 ASAP*
> *Refer to Canning Crescent Day Hospital."*

4.60 The recorded clinical impression was:

> Axis I - Severe Depression with psychotic features
> Axis II – Schizoid/Paranoid traits

4.61 On the same day, there was an entry by PSY1 headed 'referral'. *This presumably relates to a referral to the day hospital and seems to list the required paperwork requested by the day hospital, that is:*

- *referral form (tick Haringey)*

[66] P2-361
[67] P2-19

- *risk assessment*
- *CPA form*
- *part I summary*

4.62 DR2, SpR to PSY1, made a referral to the Day Hospital later that day.[68] This referral was later rejected. An undated memorandum sent to DR2 from M4[69], Day Hospital Manager, asked him to re-refer PT 'when he is ready' [for discharge])[70].

Comment

PT's refusal to move to an open ward forced the clinical team to think of different community treatment options. The day hospital referral was an alternative to PT going onto an open ward. The referral was initially refused because it was an unusual request to receive from a PICU. PSY1 re-referred after speaking to the day hospital manager[71]. The day hospital option might have allowed for more intensive monitoring of PT's mental health than just follow-up by the CMHT. However, it would have led to PT's return home with no assessment of the continuing risks he presented to others and no link yet established with a care co-ordinator in the CMHT.

The plan to organise a CPA meeting with PSY4 'ASAP' was not carried out. However, the vital step to ensure continuity of care for PT was referral to the CMHT not the organisation of a meeting with PSY4. If the referral that DR3 should have made in January had taken place then PSY4, or another CMHT member, could have been invited to a CPA meeting. DR3's uncertainty about the process to follow was coupled with the uncertainty we discuss elsewhere (see chapter 7) about the responsibility of the nursing staff on Haringey Ward to liaise with the community team.

[68] P2-402
[69] P2-48
[70] P2-399
[71] PSY1 transcript (2) pages 2-3

Tuesday 25 February 2003

4.63 PSY6[72], clinical attaché[73] to PSY1, sent a referral letter to the Halliwick psychotherapy centre at St Ann's Hospital. It requested psychological assessment stating 'we would be grateful for your opinion, particularly regarding the diagnosis'.

4.64 PT was advised of his rights after being detained under section 3 MHA on 12 February 2003.[74]

Friday 28 February 2003

4.65 A ward round[75] took place with DR2 and DR6. PSY1 was not present. Nursing staff said PT was still isolating himself.

4.66 PT said he was worried that if he went home he might become depressed again.

4.67 He said he did not feel as angry with the local children. He used to get angry and frustrated before but he was more hopeful now.

4.68 DR2 explained to him that if he became unwell on discharge he could come back to hospital voluntarily. He would be seen in the outpatient clinic regularly and would be followed up by a CPN in the community.

4.69 PT said he was interested in going on a computer maintenance course. He said his sleep was okay, he was eating well and was not suffering any side effects from the medication. He said he wanted to comply with medication on discharge.

4.70 The plan was:

"Continue same medication

[72] P2-382
[73] We assume a clinical attaché refers to a doctor gaining experience of NHS work.
[74] P2-294
[75] P2-362-364

To move to an open ward soon."

Monday 3 March 2003

4.71 A letter from MO1[76], referrals coordinator/medical records officer at Camlet Lodge (North London Forensic Service), addressed to DR3 (who had left by then), confirmed the receipt of a forensic referral and said PSY2 would make contact 'in due course'.

Wednesday 12 March 2003

4.72 Forensic consultant psychiatrist PSY2[77] saw PT (see chapter 10).

Friday 14 March 2003

4.73 PSY1, DR2, DR4, a staff nurse and PT's father attended a ward round.[78]

4.74 Nurses said PT had been stable on the ward.

4.75 PT said his moods had been more stable. He did not feel depressed, he felt more hopeful about life, was able to enjoy himself, concentrate and motivate himself. He had no more suicidal thoughts.

4.76 He said he was no longer angry with his neighbour because he had repaired the damage. PT said his reaction to the neighbour had been excessive and that he should have tried to talk or perhaps used a stone to break the windows, rather than a meat cleaver, because he could have hurt him.

4.77 He felt he should be discharged to the day centre. He was told of the difficulty of being referred there from the PICU. He agreed to go to an open ward and stay in during the day. He was said to be happy to continue with medication.

4.78 The plan was:

[76] P2-381
[77] P2-377
[78] P2-364

1. "*To transfer to open ward today*
2. *Continue meds".*

4.79 Later the same day PT absconded from the hospital grounds while being escorted to an open ward[79] (see chapter 8).

Conclusions

4.80 The medical management of PT's case was of a reasonable standard until this date. The main failure was that he was not successfully referred to the CMHT for allocation of a care coordinator (see chapter 7). There was significant contact with PT's parents, particularly his father. This contact did not lead to accurate information shaping a risk management plan or identify the need for a carer's assessment. Communication between nursing staff and the community team worked well when the need for 'statutory' input, arranging the MHA sectioning process, was identified. The problem was the inability of nursing and medical staff to establish effective communication with community staff so a care plan for PT could be developed.

[79] P4-413-415,421

5. PT's care and treatment from March to June 2003

Introduction

5.1 This chapter covers the period from 21 March 2003, when PSY1 ended PT's section 3 MHA, to 25 July 2003 when PSY1's referral to the CMHT was received and acted upon. (See chapter 6 for discussion about the decision to end the section 3 MHA).

The CPA meeting on 24 March 2003

5.2 The last time mental health professionals had contact with PT before his arrest for killing SB in 2004 was a meeting on Haringey ward on 24 March 2003. This was described as a CPA meeting. It was minuted that PT had 'leave until 25 March Tuesday pm'.

Comment

It is common for time off the ward for all patients, formal and informal, to be referred to as 'leave' because it would be long-winded to write anything else. It does not mean there was some formality about PT's leave status after the section 3 MHA ended.

PICU ward meetings in March and April

5.3 PT failed to return to the ward on 25 March 2003. He did not attend the ward round on 31 March 2003. We do not know in the absence of contemporaneous records if this was followed up or if PT was invited to attend the ward round. The staff we interviewed could not remember.

5.4 Nursing staff seemed unsure of their role in this unusual situation. PT was no longer detained under the MHA, but was still said to be 'on the PICU books'. N1 (PT's named nurse) told us:

"Obviously once a patient is discharged from a section, from the PICU, it means there is little further input that the nurses need to continue to give from that point in time. The consultant has just handed over to the community RMO, who most probably could have been in the last CPA meeting. So most of the meetings are now with them and the consultant.

I think the obvious thing would be concern, that this guy is no longer on a section but is still on the PICU books, which puts everyone in a sort of limbo.

I think if there was any follow-up it would have been between PSY1 and if not, then referral down to the CMHT, but we as the nurses on the ward would not have done much, as he is not on a section. If he was still on a section and in the community, then we as nurses would have protested and said this cannot happen, but if he is not on a section, what do you do?"[80]

Comment

We do not consider the fact that PT was no longer liable to be detained under the MHA removed from nursing staff the responsibility for ensuring that arrangements for his future care in the community were in place. Nursing staff should have recognised that he was an enhanced CPA patient and entitled to section 117 MHA aftercare.

Monday 31 March 2003

5.5 PSY1, DR4 and a staff nurse attended a ward round[81]. PT did not attend. PT was said to have been due for ward review the previous week (25 March 2003) but did not attend. It was noted that PT was 'presently informal'.

5.6 The plan was:

1. Consultant to contact PSY5

[80] N1transcript pages 16-17
[81] P2-368

2. Refer to forensic psychiatrists. *(This entry was incorrectly made: PT had in fact already been seen by PSY2 but the report had not been received).*

5.7 M4, the Day Hospital Manager, wrote to PT at home confirming his appointment on 3 April 2003 at 1.00pm.[82]

Friday 4 April 2003

5.8 PSY1[83] recorded that PT had failed to attend his appointment with the day hospital and questioned what action should be taken. He suggested PT be invited to attend the ward on 8 April 2003 and, if he failed to attend, he should be referred to the duty team at Canning Crescent. We have seen no record of an invitation being sent.

Comment

PSY1 stated in the risk management plan:[84] 'RMO to contact carer/relatives by telephone' if PT failed to attend or meet other commitments. However, when PT did not attend his appointments there is no record of PSY1 having made contact with his parents either directly or by instructing another staff member to do so. However, PSY1 says he remembers asking the nursing staff to do so[85].

The plan to refer PT to the duty team at Canning Crescent if he failed to attend on 8 April 2003 should have been unnecessary since he should already have been referred. The need to refer PT was first mentioned on the day of admission and repeated in the recorded plans on 21 March and 24 March. It remained unclear who was responsible for making such a referral. No such referral was made when PT was an inpatient.

[82] P2-398
[83] P2-368
[84] P2-324
[85] PSY1 letter dated 22/10/08

Tuesday 8 April 2003

5.9 The planned meeting did not take place because neither PT nor his family attended. PSY1 recalls discussing the case with PSY5[86], but PSY5 suggested this could have taken place on 29 May 2003, not 8 April 2003[87].

5.10 PSY1 recalls that he wrote a memo to DR4[88] on this date asking the SHO to make an entry in the notes that the discharge summary should be used to refer PT to the Canning Crescent Duty Team[89]. There is no entry in the medical notes on this date.

Comment

The precise events of this day are still uncertain. It is clear that neither PT nor his parents attended a planned review on the PICU and PSY1 again decided PT should be referred to the Canning Crescent Duty Team. It remains unclear whether the SHO was specifically asked to make the referral on this date as the memo PSY1 refers to is undated.

Activity in May and June 2003

5.11 The recorded activity in the clinical notes is sparse after the failed 8 April 2003 meeting. As PT was still on the PICU 'books' some clinical activity continued. The records tell us:

Thursday 29 May 2003

5.12 A ward round took place where PSY1[90]was present. He wrote:

> *"Still not referred"*
> *"Asked DR4 to write discharge summary (as I had done 3/52 earlier) and refer to Canning Crescent CMHT".*

[86] P2-103
[87] P2-94
[88] P2-103, 370
[89] P2-103
[90] P2-103, P2-369

Tuesday 3 June 2003

5.13 PSY1[91] signed and wrote an entry:

"No referral letter
No discharge summary?? (sic)"

5.14 In his statement to the SUI Investigation, PSY1 said he asked his secretary to check when he could not find evidence of the discharge summary or referral. She confirmed that DR4 had not written it.[92]

Monday 16 June 2003

5.15 PT did not attend a psychology appointment[93]. He was asked to contact the department by 27 June 2003 or they would assume he did not want to pursue the referral.

Tuesday 17 June 2003

5.16 PSY1[94] signed and wrote an entry:

"Dictated" (we assume this refers to the discharge summary)

Wednesday 18 June 2003

5.17 The discharge summary was typed[95]. It confirms that PT was discharged on 17 June 2003 and the plan was to continue escitalopram 10mg a day.

Comment

From 8 April 2003 it is unclear what plans existed for PT and who, if anyone tried to contact him or his family. N1 (staff nurse) told us:

[91] P2-369
[92] P2-102
[93] P2-86
[94] P2-369
[95] P2-373

"I think I could have made a few 'phone calls, but whatever I did could be in the missing notes."[96]

M1 (Ward manager Haringey ward) said:

"When he came back for review he was told to come back on other dates, he was given the dates to come back. When he didn't turn up, I don't know whether it was the parents that called or the nurses that called his family, and we were told that he's gone on holiday to Cyprus. That was the last conversation I remember having about him. I don't remember whether we had more discussions or what happened."[97]

There is no evidence that anyone from the PICU tried to contact the GP to check whether PT's prescription had been continued and no one contacted the CMHT.

PSY1 explained this lack of contact with PT by saying:

"Certainly from the point that I thought that he was discharged to the Community Team (i.e. 8 April 2003) until 29 May, he was more or less off the radar, yes, for me. Then he came back, and he was on the radar…"[98]

He came back 'on the radar' because PSY1 realised his SHO had not, as asked, made the referral to the CMHT. Apparently DR4 left his SHO post on the PICU at the end of May[99]. This would have been unusual as SHOs normally rotate to different training posts in February and August each year. PSY1 could not remember exactly when or why he left early.[100] He recalled that a locum SHO with no direct knowledge of PT replaced DR4. He told the panel inquiry:

"…that on 8 June he undertook to carry out the necessary discharge procedures for PT himself. The reasons why he did this work was

[96] N1transcript page 18
[97] M1transcript page 13
[98] PSY1 transcript 2 page 26
[99] panel inquiry Report, P2-12
[100] PSY1 transcript 2 page 27

because the previous SHO had now left and the new SHO did not know the case. PSY1 therefore felt it would be unfair to ask a new SHO to do this work. In addition he wanted to make sure the discharge was done."[101]

Activity in June and July 2003

5.18 The discharge summary was not completed until 18 June 2003 and the CMHT did not receive the referral until 25 July 2003. PSY1 told the panel inquiry that he telephoned the Canning Crescent Duty Team[102] at some point after 18 June 2003 to request information on how to make a referral, but there is no record in the CMHT file of this or any other contact. PSY1 told us that he:

"…waited for the form to come, and it didn't come. I may have 'phoned again, but I can't remember. That didn't come, and then indeed after four or five weeks I thought, 'Right', I think I went to one of the wards and got the form and was then informed, 'Yes, this is the right form' and then I sent it off to the CMHT."[103]

5.19 He explained that the referral was sent by post on 16 July 2003. Fax was not used, which may explain why the CMHT did not receive it until 25 July 2003.[104]

The discharge summary

5.20 The discharge summary PSY1[105] prepared contained several factual errors. It listed PSY4 as 'CRMO' (community responsible medical officer) and said the plans on discharge included referral to PSY5's outpatients' clinic in the Wood Green CMHT. DR1 was cited as the SpR and DR7 as the SHO. However, we understand both these junior doctors worked for PSY4 as they are referred to in the CMHT file. The report header also stated that PT was detained under section 2 MHA although detention under section 3 MHA is mentioned in the text.

[101] 1-776
[102] P2-103
[103] PSY1 transcript 2 page 26
[104] P2-434 and 434a
[105] P2-373-374

5.21 PSY1 accepted there were errors in the report and told us:

> *"I think that is because the secretary who did it would have taken the headings off the admission summary and…when I signed that copy did not look at it."*[106]

5.22 The discharge summary does not mention that PT attacked his neighbours' home and cars with a meat cleaver, although PSY2's forensic report is referred to and the following quotation from it is included in PSY1's discharge letter:

> *"His low self worth and associated depressive symptoms could well progress to angry blame directed towards others and in these terms I think it could be said that he shows a worrying potential for renewed aggressive outbursts in the future."*

5.23 PSY1 repeated PSY2's recommendation that PT should be reviewed 'on a regular basis as an outpatient'.

Comment

We have the impression that PSY1 felt pressured to produce the summary quickly when he discovered in June that his junior doctor had not done so in April. This probably contributed to the inadequate information and factual errors, which PSY1 failed to notice, in the summary. We think the discharge summary, read on its own, significantly understates the risks PT posed to himself and others. It relies heavily on the admission summary and limited CPA documentation being available to highlight those risks.

Inadequate and incorrect information about PT and his family

5.24 Throughout PT's care and treatment there seemed to be confusion over the family's ethnic origin and, more importantly, where members of the family lived at various times of the year.

[106] PSY1 transcript 2 page 28

5.25 SW2's ASW report on 17 January 2003 states PT's ethnic origin as 'Greek Cypriot'[107]. DR3's admission summary said PT's 'parents are Greek and speak good English'[108]. PSY2's forensic report said PT told him that others referred 'to the fact I'm Greek'[109]. PSY1's referral to the CMHT states that PT's ethnic origin is 'Greek (Cypriot??)'[110].

5.26 PT's parents were seen without PT being present during the CPA meeting on 3 February 2003. It is not recorded in the medical notes which professionals were at this meeting. It was recorded that they were:

> *"…with* [PT] *only 2-3/12* [2-3 months]. *Rest of the year they are in Greece."*[111]

5.27 However, after PT returned home in April staff began to think he might spend time in Greece or Cyprus with his family. PSY1 wrote in the referral to the Wood Green CMHT that:

> *"We were told that he had gone for an extended visit to Greece."*

5.28 PSY1 could not clearly remember where that information came from. He told us:

> *"I think I presume from nursing staff. Where the nursing staff had got that information from I don't know. Presumably from the parents, but I am presuming, I don't know."*[112]

5.29 M1 said:

> *"We were told that he's gone on holiday to Cyprus. That was the last conversation I remember having about him."*[113]

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[107] P2-460
[108] P2-386
[109] P2-442
[110] P2-393
[111] P2-355
[112] PSY1 transcript 2 page 29
[113] M1transcript page 13

5.30 In April 2004 PT's father gave a statement to the police which made clear that he and PT's mother were born in Cyprus, came to England in the 1950's as young adults and married here in 1968. Their children were all born in England. They also told police that since 1999 or 2000 they had been spending 'some months of the year in Crete where we have our own house'. They said PT had visited the house but only for two periods of one week and that it suited PT to be left on his own[114].

Comment

We are confident that PT's parents would given details of how long they spent in England if the PICU team had asked them. If this information had been available in 2003 then the inaccurate information about the parents whereabouts would not have had the consequences it did. For example, it was recorded that inpatient staff: 'were told that he (PT) had gone for an extended visit to Greece' in the referral letter to the CMHT. This, in turn, had a significant effect on how the CMHT responded to his referral, especially after one failed attempt to visit PT at home.

Conclusions

5.31 The referral was sent to the CMHT more than six months after PT was first admitted to hospital and three months after he left the PICU and returned home. There were no known problems in that time other than his failure to comply with appointments. We assumed the delay in relaying information to the CMHT would have significantly affected the way they responded to the referral; in fact the CMHT responded promptly. The team's problem was that they apparently did not receive any more than PSY1's referral form. They then failed to elicit further information.

5.32 The delay in referring PT to the CMHT contributed to the assessment of the risk that PT presented to others being dissipated. When PT was admitted he was regarded as a 'threat to the general public.' For the duration of his admission he was treated only on the PICU, the function of which is to provide care and

[114] P3-54-56

treatment to patients who present some sort of management problem, usually violence or aggression.[115] PSY1 was forced, through lack of effective support, to make the referral himself. By that time the acuity in assessing risk he demonstrated when arranging the forensic assessment in February had been lost. This led to inaccurate information on the discharge summary and the referral form. It also meant the impetus was lost to follow up assertively the referral to the CMHT.

[115] These were words used by N1 in describing the environment in which he worked. Evidence to the Internal Investigation 1-767

6. Case management from July 2003

Introduction

6.1 This chapter follows the management of PT's case from 16 July 2003 when he was referred to the Wood Green CMHT to 28 October 2003 which was the last dealing the team had with PT's case before his arrest for the unlawful killing in 2004. The last time a mental health professional saw PT was on 24 March 2003.

6.2 The Wood Green CMHT was based in the Canning Crescent Centre, 276-292 High Road, Wood Green, N22 8JT. In 2003 it shared the building with the Hornsey and Highgate CMHT. Staff were drawn from both teams on a rota basis to operate the duty team. The duty team handled all new referrals or enquiries on a Monday to Friday, nine to five basis. A borough-wide out-of-hours service (based elsewhere) covered enquiries and urgent referrals at other times.

6.3 The Wood Green CMHT was jointly managed by M2 who had a nursing background and M3 who had a social work background. There was no overall manager. The team consisted of: ten CPNs; five full-time social workers; one part-time social worker; one OT; one psychologist, PSYO1, and two consultants, PSY5 and PSY4[116]. A SpR, DR1, was supervised by PSY4 and each of the consultants had an SHO.

Referral process

6.4 The trust duty service operational policy[117] current in 2003 identified the responsibility of the duty workers to 'collaboratively engage in the acquisition and analysis of clinical information'. It said:

> *"When the referral does not contain an assessment of risk and/or necessary information to inform a clinical the [sic] judgement, the Duty Workers will contact the Referrer and request the relevant information."* [118]

[116] M3 transcript page 2
[117] Barnet, Enfield and Haringey Mental Health NHS Trust and Haringey Council. Hornsey/Highgate and Wood Green Duty Service Operational Policy April 2002
[118] Ibid paragraph 8.3

6.5 M3 described the role of the duty workers: 'If there was insufficient information they would contact the referrer for more information.'[119] The information would be screened by the duty workers. M3 was unhappy that there was no managerial oversight of the system[120]. She had brought the absence of a fail-safe system to management attention but had, in her words, been overruled. She said she and M2 would try and go through new referrals before meetings:

> *"If I was chairing I would try to do the screening the day before the meeting, so that if there were referrals that were considered inappropriate they could be sent back to the referrer with an accompanying letter to say why we felt it was inappropriate."*[121]

She accepted that if she was short of time, her screening might have been confined to evaluating whether a patient was eligible.

Comment

The referral of PT by PSY1 would have been considered a non-urgent appropriate referral according to the policy at the time. (This can be contrasted with the urgent referrals that took place earlier in the year. These referrals required assessments by doctors, with ASWs making the applications for detention under the MHA. These were speedily completed.) The information contained in the form completed by PSY1 was thought sufficient to allow the referral to be processed without the duty workers asking for more.[122]

Referral meetings at Canning Crescent

6.6 PSY1 wanted PT to be referred to the CMHT on 17 January 2003. This did not happen and the failure to refer was not pursued while PT was an inpatient. PT was eventually referred to the CMHT at Canning Crescent by PSY1 on 16 July 2003.

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[119] M3 transcript page 6
[120] M3 transcript page 6
[121] M2 transcript page 4
[122] 'When the referral does not contain an assessment of risk and/or necessary information to inform a clinical the [sic] judgement, the Duty Workers will contact the Referrer and request the relevant information.' Hornsey/Highgate and Wood Green Duty Service Operational Policy April 2002 paragraph 8.3

The CMHT received the referral on 25 July 2003. The case was first considered at a referral meeting on 30 July 2003. Cases were allocated for assessment and care co-ordination at these meetings.[123] The sequence of referral meetings that considered PT's case are listed in the table below. The 'Present' column only includes those involved in PT's case even though others may have been present. This information is taken from the minutes of the meetings. (The minutes are in summary form and only record key decisions). The decision taken on 30 July 2003 was that N2 (CPN) and DR1 (SpR) would assess PT on 15 August 2003.

Date	Present	Activity
30 July 2003	PSY5 DR1 M2 N2	Listed as a new referral received 25 July 2007 from PSY1. Action: DR1 and N2 to assess on 15 August 2003 at 10.30am and PSYO1 to see if he attended his Psychology appointment.
6 August 2003	DR1 N2 M2	Listed as feedback from previous meeting and same entry as above.
13 August 2003	PSY5 DR1 M3 N2	Listed as feedback from meeting 30 July 2003. Entry amended to read DR1 and N2 assessed on 15 August 2003.[124]
20 August 2003	DR1 M3	DR1 and N2 assessed on 15 August 2003 and PSYO1 has received no reply from client so will probably close case. DR1 to offer an OPA.

The information available at the referral meeting

6.7 We asked M3 what information would be available to the referral meeting about a new case. She said:

> *"You would expect there to be a CPA, you would expect there to be a risk assessment. There would obviously be a referral form because it would have come through duty. You would hope that there would be either a history or, with a case like this, there would be a forensic history and/or a part 1 or a part 2 summary. That would be the normal thing that you would get and you may get either reports from probation or other people involved."*[125]

[123] M3 transcript page 2
[124] The entry is inaccurate. The explanation for this is unclear. It may reflect the fact that the minutes were prepared after 13 August 2008 and probably after the assessment on 15 August 2008.
[125] M3 transcript page 5

6.8 M2 remembers a referral form was received but does not recall the CMHT receiving much more documentation in PT's case[126]. The referral form concerning PT, completed by PSY1,[127] contained basic details such as the patient's name and RMO's name and the following information:

Reason for referral Patient was admitted with most likely psychotic symptoms in the context of depression. He had been threatening others and damaged property.			
Medicines (prescribed and non-prescribed) **Name** **Dose** **When commenced** **Where prescribed if applicable** Escitalopram 10 mg mane Compliance doubtful			
Additional information: (attach Discharge Summaries/other information if available) (Past psychiatric history, current mental state, indication of urgency, housing situation, who does client live with, any dependants, etc) He has been seen by forensic psychiatric team, who recommended follow up in the outpatient department. We were told in May that he had gone for an extended visit to Greece. He should have returned now. My apologies for the late referral. It should have been actioned by my SHO some while ago. (I am trying to send the full set of notes to Canning Crescent)			
Name of person completing referral form: PSY1			
Title: Consultant psychiatrist	**Date:** 16 July 2003	**Signature of Worker:**	

6.9 The documents that PSY1 intended to accompany this form were:

> *"…the Admission Summary, Discharge Summary, Forensic opinion, CPA and Risk Assessment Forms"*[128]

[126] M2 statement page 3 paragraph 10
[127] An issue was raised that staff might not have known that PSY1 was working in the PICU when he made the referral. PICU is mentioned in the box 'consultant psychiatrist' signed by PSY1. See P2-393 as it is partially obscured on P2-434
[128] PSY1's letter to M5 15.9.04 page 8 (2-128)

Comment

It seems likely that only PSY1's referral form was available at the referral meeting. We consider it unlikely that the other documentation PSY1 intended to accompany the form was available. We find it difficult to understand why the information in the referral form was considered sufficient to allow the referral to proceed beyond the duty workers or M2's initial screening. There should have been a request to the referrer (PSY1) for additional information. We also consider it unlikely that existing information on the CMHT file relating to PT's previous MHA assessments was considered.

M2 told us that in referred cases where the section 117 MHA eligibility of a patient is clear a care coordinator would be allocated at the outset. M3 said if a patient is on enhanced CPA there is a requirement to both assess and allocate.[129] Their evidence indicates that if PT's section 117 MHA or CPA status had been known at the referral meeting then a decision to allocate a care coordinator would have been made immediately. Because of the inadequacy of the pre-referral screening, PT's CPA eligibility and his section 117 MHA status was never verified and the case proceeded to assessment rather than allocation.

The information PSY1 gave on the referral form was incomplete. We accept that PSY1 expected the form to be read alongside other documentation but the purpose of the form was to accurately summarise key information. This should have included a summary of the risk PT presented to others and the fact that he had been detained under both sections 2 and 3 of the MHA in the PICU for about nine weeks. The form contained incorrect information: 'we were told in May that he had gone for an extended visit to Greece'. The replication, without comment, of PSY2's recommendation: 'follow up via the outpatient department' served to downplay the risk that PT presented. It potentially sent a message to the assessors, DR1 and N2, that the appointment of a care coordinator was not required.

[129] M3 transcript page 11

The information available to the assessors

6.10 PSY1's referral. This was available and was likely to have been seen.

6.11 PSY2's assessment. DR1 was clear that the forensic report was not available.[130] M3 told us that home visits would not normally be arranged for people regarded as 'high risk'. If PSY2's assessment had been seen by the assessors then a home visit would not have taken place. M2 was 'fairly clear' after the failed attempt to assess PT that the report had not been seen, otherwise the case would have been referred to PSY1 before it was closed.[131]

6.12 The documents sent by PSY1 - the admission summary, discharge summary, forensic opinion, CPA and risk assessment forms. We have concluded that these additional documents were not seen by the duty workers, M2 or the assessors, N2 and DR1. DR1 was adamant he had not seen a discharge summary. If these documents had been scrutinised then both the referral and subsequent assessment were likely to have taken a different course. It is also unclear whether the documents were ever read after the failed attempt to meet PT in August 2003.[132]

6.13 The ASW reports. We have considered what other documents could have been accessed by the duty workers, their managers or the assessors. The documents that would have been on the CMHT files were compiled by the ASWs as a result of the MHA assessments in January and February 2003[133].

The ASW reports

Both ASW reports for the MHA assessments on 17 January 2003 and 13 February 2003 were copied to the CMHT. In addition, the referral initiated by M1 (acting manager of the PICU) on 12 February 2003 was in the CMHT file. The information contained within these documents can be summarised thus:

ASW Report 17 January 2003[134]

[130] DR1transcript page 8
[131] M2 statement page 6 paragraph 23
[132] Our task as investigators has not been made any easier by the fact that we have only copies of the of the CMHT 'file' supplied to our investigation managers. Without being able to refer to the original file we do not know when papers were received by the CMHT.
[133] M2 transcript page 15
[134] P2-459-467

PT: '…was arrested yesterday after he damaged a neighbours car and front door with a meat clever[sic]…'

'…told the FME that he was suicidal, that he wanted to kill children who were playing outside his door and that he would have killed the neighbour if he had come out of the house when he was vandalising his property…'

He was described as showing no remorse and repeated that he would have killed his neighbour if he had walked out of the house at the time (of breaking the windows). He also repeated that he often felt suicidal and feels like harming others when he becomes angry. The assessment summary concluded:

'He was considered to be very dangerous, had no remorse. Placed on Haringey ward.'

Under 'Risks', the ASW wrote:

'Prone to violent outburst.'

ASW Report 18 February 2003[135] (which relates to the MHA assessment on 13 February)

This makes it clear that PT was on Haringey ward at the time of the assessment.

PT described extreme swings of mood since teenage, alternating between having lots of energy, when he thought of harming people and feeling very low, hopeless and suicidal. The report describes the incident of PT smashing his neighbours windows in January, but stated he had used a kitchen knife rather than a meat cleaver. It also records PT's threats to kill children playing outside his home and the threats to kill the neighbour had he come out at the time PT was smashing the windows.

The ASW stated that PT:

'…was not able to reassure us that he would not confront his neighbour or their children.'

Referral form completed by SW3, senior practitioner (duty team Canning Crescent Centre) 12 February 2003[136]

This again makes it clear that PT was an inpatient on Haringey ward. It also states that he has felt suicidal in the past, that he damaged his neighbours' property with a meat cleaver in January and that he had made threats to kill children.

Current and past history of risk included 'serious violence/harm to others' and 'to children'.

[135] P2-449-454
[136] P2-456-457

Comment

A cursory look at the CMHT records would have informed anyone that PT had been on both section 2 and 3 of the MHA. The records would also have highlighted the risks he presented in January and February 2003.

We consider it unlikely that in July and August the assessors had adequate up-to-date information about PT. That would have included the ASW reports and the documentation that PSY1 intended should be sent: the admission and discharge summaries, the forensic assessment and CPA documents. The information that should have been on the CMHT file would have raised concern about the risks PT might pose even without the information PSY1 intended to send, especially as a home visit was intended. It would have been reasonable for the assessors to request the documents urgently from the inpatient team at St Ann's Hospital if they had not already been sent. They had 14 days to do this.

The assessment arrangements

6.14 At the CMHT referral meeting on 30 July 2003 N2 and DR1 were asked to assess PT. The date of the assessment was 15 August 2003. N2 was a CPN. He has since retired. DR1 was a specialist registrar. DR1 organised his work commitments to allow two to three sessions a week to the CMHT (out of 10 sessions a week).

6.15 N2 regarded DR1 as the lead assessor who would have accessed the relevant information about PT. At the referral meeting he recalls there was no information about PT. ('Generally we would have a full history, the background and everything'[137]). He assumed that DR1 had the full information.

6.16 However, DR1 assumed that N2 was the 'evidence provider.'[138] He regarded his own function as providing clinical service provision for the team. He described this role as 'quite limited'.[139]

[137] N2transcript page 9
[138] DR1transcript page 10
[139] DR1transcript page 4

6.17 DR1 analysed responsibility for gathering information as follows: the duty team as gatekeepers and then:

> *"The additional gathering would go to one of the permanent team members, who would either be care coordinating the case or, if they weren't, they'd be allocated to it."*[140]

6.18 DR1 reflected on the failures in passing information from the hospital to the community team.[141] He identified the points at which there should have been checks to ensure adequate communication: the point of entry to the team, the team meeting, the team member(s) being allocated the assessment and the meeting with the patient.

Comment

We are critical of the actions of DR1 and N2. At the very least their task was to assess a patient they should have known to be a PICU inpatient who had been assessed by the forensic service. This information was contained in PSY1's referral form. We are satisfied this was received. This information could and should have allowed them to access the CMHT file. The file would have provided information about PT's risk profile and told them he had been a detained patient. This information was in the ASW reports even if the medical recommendation forms had not been copied to the CMHT. A telephone call to the PICU would have allowed them to speak to a nurse or doctor with knowledge of PT's case. The other documents PSY1 had prepared to accompany his referral would then have been accessed from the inpatient notes. They had time to gather this information. They were both at the original referral meeting on 30 July 2003 and the next two meetings on 6 August and 13 August. The decision to make a home visit with inadequate information could have put them at risk. This was not considered at the time either by the assessors or their managers. Following the failed assessment on 15 August DR1 was at the final meeting, on 20 August, when PT was offered an outpatient appointment.

[140] DR1transcript page 7
[141] DR1transcript page 15

To put our criticism in context: the process of screening new referrals for eligibility or sufficiency of information was fragile. There was no proper oversight by duty workers and the volume of cases at referral meetings prevented detailed managerial review. Although the responsibility for gathering information was unclear we consider both assessors were experienced enough to have identified the need for further information at any stage. N2 was an experienced CPN and DR1 was a reasonably experienced trainee psychiatrist. He became a member of the RCPsych in 2001 and started his higher training in May 2002.

The abortive assessment on 15 August 2003

6.19 N2 described the attempt to assess PT.[142] The questions were asked by DR8:

> ***Q.*** *After the referral meeting, when you and DR1 had been allocated the task to go and see him a couple of weeks later, what do you recall doing?*
> ***A.*** *I was asked to write a letter to let him know we would be visiting and asking him to let us know whether it was convenient. We didn't get any response and so on the day we went to visit him.*
>
> ***Q.*** *In those two weeks can you recall looking through a file, making any contact with the GP?*
> ***A.*** *My impression was that the SpR had the full information – the notes and his forensic history and so on. Actually forensic wasn't mentioned at all at that time. We didn't discuss it before the visit, but on the day I asked about the history and he told me as much as I knew, that the patient missed the appointment and this was just an initial exploratory visit to see why he didn't attend.*
>
> ***Q.*** *At the time of walking round [to PT's house] it sounds as if you didn't have much information about PT at all?*
> ***A.*** *That's true, yes.*

[142] N2 transcript pages 9 and 10

Q. *Was that usual as well? To me, knocking on somebody's door is potentially risky, made riskier with no information.*
A. *Looking back I don't know why we didn't have any information and didn't know anything. I think that PSY4 or PSY1 thought that the patient hadn't turned up and needed to be seen. Generally we should have all the information before we visit someone at home.*

Q. *I assume you walked, because we've been to both [PT's house] and the CMHT base and we are aware that it's not very far away. Am I right?*
A. *We drove actually. I had a few patients down there and I wanted to carry on a bit further to visit more of them.*

Q. *So you used the car?*
A. *Yes.*

Q. *Did you and DR1 go together in the same car?*
A. *Yes.*

Q. *Do you recall what happened on that day when you tried to visit him?*
A. *Yes. There was no response whatsoever. We stood there; we looked through the letterbox and saw that there was some mail that hadn't been picked up. It was mentioned at the meeting that he was a Greek Cypriot and that his family went to Cyprus quite often. We started to think that perhaps they might be on holiday because it looked as though no one had been there. The mail was still there. Generally we see neighbours to ask if they have seen the patient, but we couldn't see anybody around at the time. We dropped a note to say that we had been to see him and asked him to get in touch with us.*

Q. *So you left and went on to do other things I guess for the rest of that day?*
A. *Yes.*

Q. *What did you do subsequently about trying to see him again?*

A. *I think I rang his GP to ask when he was seen last. When we came back to the next meeting we gave our feedback and at that time it was decided that he should be offered another outpatient appointment with the SpR.*

Q. *Do you remember anything about that and what led to that decision? It was one of many possibilities, wasn't it? You could have decided to try and see him again at home or written to him and asked him to come to the CMHT base. I just wondered why it was decided to offer him an outpatient appointment.*

A. *I can't think to be honest. The general policy is that we try to make three attempts to contact and if somebody doesn't respond then we either discharge or write to say we have tried, unless the case is quite complex and needs further involvement from any professional.*

Q. *By the time that the second discussion had happened and the decision in that meeting was to offer an outpatient appointment, what kind of information can you recall getting about PT? You said that to begin with you didn't have much, but by the time of the second meeting, can you recall any more information being available?*

A. *No.*

Case closure

6.20 PT's case was discussed at the referral meeting on 20 August 2003. It was decided that DR1 would offer PT an outpatient appointment.[143] In the CMHT records for 27 August 2003 N2 noted that the GP practice had no contact with PT since 13 February 2003.[144] The case was discussed at the Wood Green referral meeting on this date. It was decided to offer an outpatient appointment with DR1 and 'if no response – then close the case'. N2 also noted that PT had been offered an appointment with the team's psychologist, PSYO1, but there had been no reply. M3 said the case was closed on this date[145]. M2 agreed and said an outpatient appointment was booked for 24 October 2003[146].

[143] P2-88
[144] This information is incorrect. The GP records record the last date that PT was seen (?by a nurse) was 13/06/02. The last time he had seen a doctor was on 03/10/01. (P3-10)
[145] P2-83
[146] P2-88

Comment

We believe the decision to close PT's case to the CMHT after one failed attempt to see him and with inadequate background information was a serious error. There can be no justifiable reason for CMHT staff failing to ensure they had all available information from PSY1 or PICU staff. If they had we think PT would have been allocated a care coordinator and there would have been further attempts to see him either at home or at the CMHT base. His status as a former section 3 MHA patient entitled to section 117 MHA aftercare would have been identified. An assessment would then have taken place to identify his need for after-care services (see chapter 8).

If PT had continued to evade contact with the CMHT the care coordinator could have made further enquiries. For example, making contact with PT's parents to find out if they had any concerns about his behaviour. His GP should, as a matter of routine, have again been contacted. Contact with the neighbours should also have been considered. We accept this would have raised potential difficulties regarding patient confidentiality but we think an experienced CMHT professional should have been able to discretely seek information from third parties without divulging clinically sensitive information. The care coordinator could also have contacted PSY1 for his opinion on how PT should be managed. The use of section 135 MHA (warrant to search for and remove patients) could have been considered to access PT's home address with the help of the police to conduct a further MHA assessment.

Outpatients

6.21 The CMHT referrals meeting on 27 August 2003 decided to refer PT to DR1's outpatient clinic but this did not happen. PT was instead allocated to the clinic of a locum SHO to PSY4 rather than a more senior member of the medical team. In any event the doctor would have had no knowledge of PT and been reliant on information contained in the clinical file. When PT failed to attend the 24 October 2003 appointment the SHO (DR7) did not, to the best of our knowledge, discuss his non-attendance with a more senior colleague. He wrote to PT's GP suggesting he be

offered a further appointment in three months[147]. However, that appointment was never made.

Comment

The SHO recorded PT's non-attendance at the outpatient clinic in the inpatient medical file. This would suggest he had access to all the information from PT's admission including the admission and discharge summaries, PSY1's referral to the CMHT, CPA documentation (including the risk assessment and risk management forms) and the forensic report. This was therefore a further opportunity to reconsider PT's management in the community even if he failed to attend. It would seem likely that the SHO did not read this information.

The SUI investigation[148] and the panel inquiry[149] commented on the failure to adequately supervise SHO outpatient clinics. We agree with those comments and suggest that a thorough discussion should always take place with a consultant psychiatrist before a plan is made for following up a patient who does not attend an outpatient appointment.

The SHO recorded in the medical notes and in his letter to the GP that PT should be offered a further outpatient appointment in three months time. No such appointment was ever made and it is unclear why this administrative error occurred. This was not commented on in the SUI investigation or the panel inquiry but we consider this was a further flaw in the systems operated by the trust at this time. Had an outpatient appointment with PT been made for January 2004, even if he had failed to attend, it would have given another opportunity for a doctor to read through his file and reconsider his management. This was three months before PT killed SB.

The trust suggested in its response to our draft report that staff in the outpatients department or the CMHT might subsequently have decided that the SHO should not have offered another appointment in view of the decision made by the CMHT on 27 August 2003 to 'offer OPA (an outpatient

[147] P2-391
[148] P2-74
[149] P1-1009

appointment) with DR1 (and) if no response – then close the case'[150]. We consider this does not alter the fact that there was a flaw in the system operated by the trust at the time. If the SHO was thought to have made an error and PT should have been discharged, the case should have been discussed with a consultant psychiatrist. If they had agreed to discharge a further letter should have been sent to the GP to explain this.

R1 The current system of offering outpatient appointments should be thoroughly scrutinised through audit. Appointments should be made and letters of confirmation should be sent to all patients offered outpatient appointments.

R2 The current trust non-attendance policy should be critically reviewed in the light of our findings. The trusts should ensure that, where necessary, it is strengthened to ensure non-attendance is discussed with a named senior clinician and that nominated individuals are identified to carry out the agreed action plan which should be compatible with the risk management plan.

System issues

6.22 When we completed the first draft of this report we were uncertain how far M2 and M3, as joint managers of the CMHT, should be held responsible for the mistakes that were made in the assessment of PT's case. We sent them a copy of the draft and they provided written comments. We took their views into account in the following analysis of the relevant system issues:

System issues	Comments
1. Non urgent cases - assessment by the team prior to allocation	If PT's legal status had been recognised (he had been detained on section 3 MHA and was section 117 MHA entitled) then although an assessment of current need was necessary there should have been no doubt that a care coordinator had to be appointed.
2. Provision of adequate information to the CMHT by the in-patient team	Only PSY1's referral form was available at the referral meeting. All the other information about PT that was contained in nursing and medical records was not sent to the CMHT, or mislaid following receipt. There was no further communication between the in-patient and community mental health teams to remedy this problem.
3. Screening of the referral by the duty worker	M3 identified the absence of managerial oversight of the referral process as a potential weakness. One of the checks that should have remedied the absence of information from the in-patient team failed.
4. Screening the	M2 informed us in correspondence that PT's case 'was one of no less

[150] P2-432

referral by the chair of the referral meeting	than 16 new cases on 30th July and it would not have been practical for me to have gone through this in great detail before the meeting.' (M2 letter to Verita 16 October 2008.) A further check on the sufficiency of information was therefore not available.
5. Designation of lead assessor	M2 told us that the decision of who was to lead the assessment would be agreed between the professionals allocated to conduct the assessment. We reflected as to whether the absence of a protocol/policy in relation to the designation of the lead assessor reflected a system failure. We have concluded that it would be unnecessarily bureaucratic to nominate a lead professional in every case requiring an assessment; there has to be reliance on the ability of the two professionals involved to share the gathering of the information and to work collaboratively.
6. The responsibility of the assessors to obtain information	Following from 5. above we agree with M2 that the onus must be on the professionals allocated to assess to obtain further information. This should have involved (at minimum) making contact with the PICU and reading the CMHT file. This would have provided a further safeguard in the case.
7. Case closure decision	'Once a case had been initially discussed in the Team meeting, it would not subsequently have been re-scrutinised in a later meeting as if it were a new referral. The sheer volume of work passing through the Team would make it impracticable do otherwise.' (M3 letter to Verita 14 October 2008)

With the exception of point 5 above, we have identified a number of system errors. The initial mistake was not to provide full and accurate information (stage 2). There were then four stages (3, 4, 6 and 7) where the absence of proper information about PT could have been remedied. The screening process (stage 3) was not working properly and managerial input at stages 4 and 7 was cosmetic because of the volume of work passing through the CMHT. Stage 6 relied on the professional skills of the practitioners involved.

Comment

We have concluded that M2 and M3 were no more responsible than any other managers for the systemic difficulties we have identified. We think the individual professionals responsible for the assessment made errors. However, our criticisms of DR1 and N2 should be seen in the context of the system errors we have analysed.

Conclusions

6.23 There was a six-month delay in referring PT's case to the CMHT. Inadequate and inaccurate information was then sent to the CMHT. The available information about PT's case on the CMHT's file was not properly evaluated. The assessors failed to remedy the absence of information after the allocation of the case. The attempt to assess PT therefore took place with little, if any, of the information that should have been available. Following the failed attempt to assess PT in the community his case was closed. This decision was incorrect and was made without a scrutiny of any of the information that should have been available

7. The care programme approach (CPA)

Introduction

7.1 The terms of reference of this investigation require us to:

> *"Review the extent to which trust services adhered to statutory obligations, relevant national guidance and local operational policies."*

7.2 The national guidance and local operational policies at the centre of any investigation of this nature relate to the Care Programme Approach (the CPA). This chapter is in two parts. The first part outlines the CPA policies that were likely to have been current in 2003. The second part deals with the application of those policies to events during PT's care and treatment.

Part 1

The CPA framework

7.3 The delivery of all mental health services is framed in the CPA set out in circular HC(90)23/LASSL(90)11 and in the Welsh Office Mental Illness Strategy (WHC(95)40) national guidance. This circular was published by the Department of Health in 1990 and was effective from 1 April 1991. Building Bridges, published in 1995, says the CPA is the cornerstone of the government's mental health policy[151] and provides guidance about its operation. Some requirements of the CPA were modified in 1999. These modifications are contained in a booklet called Effective Care Co-ordination in Mental Health Services - Modernising the CPA.[152] The CPA has recently been further modified.[153] The CPA applies to everyone under the care of the secondary mental health service (health and social care) regardless of setting. It is a model for good practice for the delivery of mental health services which remains applicable today despite changes to guidance over the years.

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[151] Para 3.0.3 Building Bridges – a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people. DofH 1995

[152] Effective Care Co-ordination in Mental Health Services - Modernising the Care Programme Approach DofH 2001

[153] Refocusing the Care Programme Approach DofH 2008'

Which Barnet, Enfield and Haringey Mental Health NHS Trust CPA policy was operational in 2003?

7.4 We found it impossible to identify which CPA policy was operational in 2003. We were given the following documents:

1. Enfield and Haringey Health Agency Joint Care Programme Approach Policy March 1996
2. Barnet, Enfield and Haringey Mental Health NHS Trust Care Programme Approach Draft 6 Undated
3. Barnet, Enfield and Haringey Mental Health NHS Trust Policy on the Care Programme Approach, Care Management and Risk Assessment and Management December 2003
4. Barnet, Enfield and Haringey Mental Health NHS Trust Care Programme Approach Policy November 2005
5. Barnet, Enfield and Haringey Mental Health NHS Trust Care Programme Approach Policy 2008

7.5 Number 1. was out of date as it used terms such as 'keyworker' which was superseded in 2003 by 'care coordinator'. Number 2. was marked draft and so its application was uncertain. Number 3. post-dated the focus of our investigation although we were told it had been circulated as a draft 'so people were probably working from the draft.'[154] Number 4. is the current policy. Number 5. is an undated draft policy. (See chapter 14 for a discussion on the adequacies of the 2005 and 2008 policies).

Comment

It became clear to us during our investigation that staff throughout the trust, at all levels of seniority, were uncertain which CPA policy was in operation in 2003.[155] This uncertainty was a disadvantage for our witnesses. As the CPA has been the cornerstone of government attempts to reform the delivery of mental health care and treatment in the community since 1990 this is remarkable.

[154] M6transcript page 16
[155] When PSY1 gave evidence to the 2005 internal investigation he felt that the CPA policy was not easily accessible. (1-778)

The main elements to the CPA

7.6 We decided to identify the main features of any policy that would have been current at that time and use them as a framework to evaluate CPA application in PT's case. We consider it reasonable to do this as the main features would not have been subject to significant local variation and there was uncertainty about which particular local policies applied at the time. In 2003 there was a division between standard and enhanced CPA. The criteria for enhanced CPA included a high level of assessed risk and an identification of complex needs. The criteria also included any patient, like PT, who was entitled to section 117 MHA aftercare (see chapter 8). PT therefore met the criteria for enhanced CPA.

7.7 The main elements of the CPA are outlined below.

- Assessment of the needs of all mental health service users. (The 1999 policy stated that the CPA applied 'to all people referred to and accepted by specialist mental health services, and all psychiatric patients considered for discharge from hospital.'[156] By 2005 those eligible had been more precisely defined: that is any person 'accepted, and being treated by, specialist psychiatric services and mental health service users being considered for discharge from hospital and including those with dual diagnoses'[157]). Central to the assessment of need is the requirement to fully assess risk.

- The appointment of a care coordinator who will be a mental health professional. The term mental health professional includes psychiatrists, psychologists, mental health nurses, social workers and occupational therapists.

- The formulation of a care plan to identify the health and social care needs of the service user. There should also be a crisis plan for all mental health service users on Enhanced CPA.

[156]Enfield and Haringey Health Agency Joint Care Programme Approach Policy March 1996 page 3
[157] Barnet, Enfield and Haringey Mental Health NHS Trust Care Programme Approach Policy November 2005 page 3

- Regular review and, where necessary, agreed changes to the care plan.

Carers assessments

7.8 By 2003 the statutory entitlement for carers to be assessed[158] was routinely incorporated in CPA policies.[159] PT's mother and father were therefore entitled, as carers for their son, to an assessment. The National Service Framework for Mental Health[160] sets as a key standard (which was expected to be delivered by April 2000) the following:

> *"All individuals who provide regular and substantial care for a person on CPA should have an annual assessment of their caring, physical and mental health needs; and have their own written care plan, which is given to them and implemented in discussion with them."*

7.9 PSY1 saw both PT's parents on three occasions and his father a further three times. (20 January 2003[161], 31 January 2003[162], 3 February 2003[163], 7 February 2003[164], 21 February 2003[165] and 14 March 2003[166].)

7.10 HD1 (assistant director community services) reflected on the importance of assessing the carers in relation to the CPA:

> *"The other thing that I came across at that time was around carer's assessments. It strikes me from the panel and from M5's report that there was a lot of information around the family, but it didn't seem to be at the centre of the care planning, so there was information there that his brother had left the country because he was frightened of him. There was*

[158] Disabled Persons (Services, Consultation and Representation) Act 1986 and the Carers Recognition and Services) Act 1995
[159] Barnet, Enfield and Haringey Mental Health NHS Trust Policy on the Care Programme Approach, Care Management and Risk Assessment and Management December 2003 page 5
[160] NSF Standard 6 Caring about Carers page 69 National Service Framework for Mental Health DofH 1999
[161] P2-343
[162] P2-353
[163] P2-354
[164] P2-357 It is not absolutely clear whether PSY1 was present when DR4 met PT's father on this date. The fact that it was PT's father on his own after 3 February 2003 suggests that this was the time that PT's mother and his brother went to Crete. This fits with his father's statement (see chapter 3) and should have provided further information to staff about the family spending time in Crete.
[165] P2-361
[166] P2-364

information that, I believe, the family went home to Greece for a couple of months each year, so there were things that would have helped people."[167]

What were the responsibilities of the named nurse under the CPA?

7.11 PT was not known to specialist mental health services before his admission to the PICU in January 2003, so he had to be assessed and a care coordinator appointed. There were several assessments, some of which we describe in this chapter, and his status as an enhanced CPA patient was not disputed. The fault in the CPA management of his case was the failure to appoint a care coordinator.

7.12 One of the reasons a care coordinator was not appointed was the absence of clear polices at that time about the responsibilities of the named nurse.

7.13 The 1996 policy says:

"…the named nurse, inpatient services, will remain key worker [the previous term for care coordinator] until a community key worker has been appointed."[168]

The 2003 policy says:

"…where the service user has not been previously known to the services or is not on the CPA then the assessment and development of the care plan should be co-ordinated by the primary nurse…The primary nurse should consult with service user, and if appropriate their carers, and liaise as early as possible with members of the CMHT to identify a potential Care Coordinator."[169]

[167] HD1 transcript page 5
[168] Enfield and Haringey Health Agency Joint Care Programme Approach Policy March 1996 page 11
[169] Barnet, Enfield and Haringey Mental Health NHS Trust Policy on the Care Programme Approach, Care Management and Risk Assessment and Management December 2003 page 11

7.14 N1 was PT's named nurse although he was on leave from 3 February to 3 March 2003[170]. He is a RMN (registered mental nurse). At the time he worked with PT he was an E grade staff nurse[171] sometimes acting as a charge nurse. At the time we interviewed him he was still working on the PICU. He said the responsibilities of the named nurse were drafting nursing assessments, which he described as care plans, and getting information from the patient and their family. In relation to 'CPAs' he regarded it as the named nurse's responsibility to invite relevant people such as family and 'the community', by which we assume he meant a member of the CMHT, to CPA meetings.[172]

7.15 He summarised the responsibilities of the named nurse under the CPA as follows:

> *"…when it comes to the CPAs, the primary nurse or whichever nurse had attended the ward review had the responsibility of inviting the interested parties, such as the family, the community or whoever is identified to be pertinent to the care of this particular client."*[173]

7.16 He regarded care coordination as generally the responsibility of social workers and assumed that because a request to assess PT for a section 2 MHA had been made to the CMHT this constituted a referral. He also remarked on a referral that was sent back to the PICU. (We think this was probably the refusal of the day centre to accept a referral[174].) He considered that the likely response from the community team to any referral from the PICU would be:

> *"…'We don't deal directly with patients on the PICU', because they figure that if they are on the PICU they are not ready for the community input."*[175]

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[170] P1-768
[171] An E Grade nurse (the equivalent of a Band 5 nurse today) is an experienced and relatively senior member of the inpatient nursing team with responsibilities for co-ordinating shifts, delegating tasks to other nurses and acting as primary nurse for an allocated group of patients.
[172] N1transcript 6
[173] N1transcript 5
[174] N1transcript 7 to 8
[175] N1transcript 7

7.17 He said he had learnt from his experience on the PT case. He described how he would now respond in the case of a patient not known to mental health services:

> *"So as soon as the client comes onto my ward and I am on duty, I make sure all the nursing information is displayed and sent to the appropriate community team, just in case things happen the way they usually happen like you are saying. [N1 was responding to the example of a patient on the ICU not known to community services having been discharged by a Mental Health Review Tribunal.]"*[176]

7.18 M6 (PICU manager/Lead Nurse Haringey Mental Health Services) was clear about the named nurse responsibilities:[177]

> *"The responsibility of the named nurse would be formulation of the care plan with the MDT, ongoing review of the person's care plan, the link, interface with other agencies and the multidisciplinary team, engagement with the service user just to establish the needs of the service user; that person's role is really coordinating all the care whilst the person is within the inpatient service, liaison with other agencies, the link person. We also had an associate nurse, but the named nurse is the lead nurse. If the person is not there, then the associate nurse would take responsibility."*

7.19 She agreed that in 2003 the role of the named nurse was as identified in the 1996 CPA policy saying:

> *"The person selected as care coordinator must be involved in accepting the responsibilities of being the care coordinator. The named nurse inpatient services will remain care coordinator until a community care coordinator has been appointed."*[178]

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[176] N1transcript 18
[177] M6transcript 11
[178] M6 transcript 17. The 1996 policy refers to keyworkers rather than care coordinators – their function is the same.

7.20 HD1 was also clear that it was part of the named nurse's role to ensure the appointment of a care coordinator.[179]

Comment

N1 and his nursing colleagues effectively followed some of the guidance in the 2003 CPA policy, particularly in consulting with PT's parents. However, they did not successfully liaise with the CMHT. N1's assumptions about links between the PICU and the community teams were not always clear. He assumed that the involvement of the CMHT in providing an ASW who co-ordinated a mental health assessment would constitute a referral to the team. He assumed that 'being on PICU means you are not ready for other interventions or community services'.[180] He assumed that when PT was discharged his care was handed over to a community RMO. He regarded this as the community referral.

We think there was logic in N1's assumption that the CMHT must have received a referral since it already knew about PT's case. We also recognise that PICU nursing staff would not know as much about the workings of community teams as staff on other inpatient wards. However, lack of clarity about the named nurse's role and the fact that PICU nursing staff were not used to liaising with community services both contributed to the failure to make sure the CMHT had accepted responsibility for PT's case. We think N1 could have acted more proactively given his experience and taking into account his candid acknowledgment that he would deal with a similar situation differently today. In particular he could have taken responsibility to pursue the referral of PT to the CMHT when there was no response by late March 2003.

We also think N1's manager, M1, could and should have more actively overseen the management of PT's case. She knew about PT's unusual circumstances. He was 'on the books' even after his discharge and there were only 12 patients on the PICU. If the nurses had concerns they could have raised them with PSY1. We agree with HD1 that she should have ensured N1 referred PT's case to the CMHT and a care coordinator was appointed.

[179] HD1 transcript page 11
[180] N1transcript 15

The CPA and the PICU

7.21 The PICU operational policy[181] contains guidance under the heading Care Programme Approach:

1. Early involvement/liaison between Haringey Ward and patient's Community Team is regarded as essential so as to provide high standards of care.

2. CPA meetings will therefore be arranged for patients at the earliest opportunity, if possible within the first two weeks of admission.

3. Social work and community mental health nurse involvement will be sought via the Sector Manager, if there is no allocated key worker.

Comment

Although the wording of the policy is dated (for example, the term care coordinator replaced the term key worker) the policy was current in 2003. It underlines the importance of speedy CPA planning, intervention and the appointment of a care coordinator. Apart from a CPA meeting taking place on 3 February 2003, the policy was not complied with.

Who could have made the referral to the CMHT?

7.22 M6's view was:

> *"It would be discussed in ward round and agreed, and the named nurse or the SHO could have done it, any of them could have done that."*[182]

7.23 M3 thought it could either be the named nurse or the psychiatrist in charge of the patient's treatment.[183]

7.24 M1 (ward manager PICU), said the primary nurse on the ward was the person to make the necessary arrangements for the patient to have a care

[181] Haringey Healthcare NHS Trust Mental Health Directorate Haringey Ward Operational Policy SAH58 January 1999 paragraph 9
[182] M6 transcript 14
[183] M3 transcript page 14

coordinator. She went on to explain that if there was no care coordinator then the primary nurse would act as one until a care coordinator could be appointed.[184]

7.25 PSY1 thought it was the responsibility of the named nurse to liaise with community services.[185] He said it was not normal practice for CMHTs to become involved with the ICU patients. He told us it was the responsibility of the nursing staff to make a referral to the community team[186].

7.26 The first point of contact with community services, according to PSY1, was attendance by a member of the community team at a patient's CPA meeting. However he thought it was common for the community teams not to attend CPA meetings, particularly for a PICU patient.

Comment

N1's view of the function of the named nurse differed from some of his managers. Given the lack of clarity about CPA policies at the time this is hardly surprising. PSY1 thought it was the nurse's responsibility to make the referral. In January 2003 DR3 thought she had been asked to make the referral. When PSY1 realised the referral had not taken place he eventually made it himself. More than one witness also identified the problem of arranging for anybody from the CMHT to attend CPA meetings particularly on the PICU.

Part 2

The application of the CPA

Risk assessment

7.27 On 17 January 2003 DR2, a SpR working with PSY1, completed a risk assessment and risk management exercise for PT. The completion of a risk assessment is an essential part of the CPA. He recorded an identified 'medium' risk of self harm and harm to others, associated with a provisional diagnosis of

[184] M1 transcript 5
[185] PSY1 transcript(1) page 17 and 20
[186] PSY1 transcript 20

depression with psychotic features. A history of past self harm and serious violence/harm to others was recorded. An identified current risk of self harm, attempted suicide and serious violence/harm to others was also recorded.

7.28 Specific events listed in the risk assessment were:

This episode:

"Smashed neighbours window with meat cleaver
Held Stanley knife against his throat
Threats to kill children in street (or anyone who annoys him) in October 2002"

Past:

"Kicked in neighbour's door
Thoughts of carrying knife to revenge being called 'kebab man'
Intention to kill children who put firework through letterbox (Halloween Trick or Treats)
December 1999 - Punched someone who was shining a light in his eye
Has hit brothers".

7.29 Factors thought to increase risk were :

"Getting depressed or despondent."

7.30 Factors thought to decrease risk were :

"Taking medication
Regular outpatient appointments".

PSY1 probably added these comments to the CPA risk assessment form on 24 March 2003 during a CPA meeting[187] but this is not made clear because the same form was used on more than one occasion.

[187] P2-324

Comment

The risks PT posed to himself and others were quickly and accurately identified and recorded when he was admitted. However, there was a difference of opinion between PSY1 and DR2 regarding the level of risk. PSY1 rated the risk as 'high' whereas DR2 rated the risk as 'medium'. We agree with PSY1's assessment, based on the recorded information, but it was DR2' assessment that was recorded on the risk assessment form. This was not amended at any stage during the admission. It was part of the information that it was planned to send to the CMHT. The risk assessment should have been reviewed, and if necessary modified, when PT absconded from the ward on 14 March 2003 (see chapter 10). It should also have been reviewed when PT was discharged.

CPA meeting 3 February 2003

7.31 PT's parents attended the meeting[188] on the ward at the PICU. There was no representative from the CMHT or an open ward. His mother said she was worried about PT's lack of leave to go for walks. Staff discussed the possibility of visits to one of the open wards. His father thought PT would not mind these but would not want visits home. His mother thought PT might want to live away from his parents. PT had met with them on Saturday (1 February 2003) and told them to sell their house and enjoy themselves. He asked them not to visit him.

7.32 His parents said that six to eight years previously PT had bought a studio flat, paid the mortgage for a year and then left. PT was seen alone and said he did not want to see his parents again. He felt guilty about burdening his parents. Leave to an open ward was discussed and PT seemed happy to go along with that. He said that on medication his 'highs' were not extreme, his appetite had come back and his sleep was normal. He told staff his parents only lived at home with him for two to three months and spent the rest of the year in Greece. He said he was financially okay and had savings. Staff told him that he could speak to a benefits advisor when he moved to an open ward. He talked about learning a new skill such as computer maintenance if he could avoid depression. Staff also discussed a psychological assessment.

[188] P2-354, 326-328

7.33 The plan was:

1. *"Continue antidepressants*
2. *Consider leave to open ward and subsequent transfer*
3. *Psychological assessment referral"*

Comment

The CPA meeting was arranged promptly as required by the PICU operational policy. PSY1 had made a decision to refer PT's case to the CMHT on 17 January 2003. DR3 accepted responsibility for making the referral but the referral did not take place because, it transpired, DR3 misunderstood her instructions. Unfortunately the community referral, the 'involvement' of the community team as outlined in the policy, was not followed up at this CPA meeting.

CPA meeting 24 March 2003

7.34 PSY1 made a record of this CPA meeting in the clinical notes[189]. PT had been discharged from section 3 MHA on 21 March 2003 and allowed home over the weekend. He arrived late for the review but was said to be well. His mood was normal and he denied experiencing any persecutory ideas.

7.35 He complained of occasionally feeling light-headed, 'like I've had a few drinks', but this was not thought to be a side effect of his medication which was escitalopram 10mg per day.

7.36 PSY1's clinical impression was that PT was 'well'.

7.37 The plan was:

1. *"See CPA form[190]*
2. *Re-refer to day Hospital (discussed with M4)*

[189] P2-367
[190] P2-326-329, P2-324

3. *Review by PSY5 Tuesday (?25th)*
4. *Refer to CMHT*
5. *Leave until 25/3 Tuesday pm".*

7.38 The CPA forms (entitled Enhanced Care Programme Approach) which were partially completed on 3 February 2003 were added to on 24 March 2003. PT was recorded as being well, with normal mood. He was said to be 'happy' living with his parents. It was also recorded that he had been referred to the day hospital. Under the heading 'Risk behaviour' it said: 'see risk assessment.' This was presumably a reference to the risk assessment completed by DR2 on 17 January 2003.

7.39 The care plan was:

1. *"Continue antidepressants (escitalopram 10mg od)*
2. *Refer to Halliwick for assessment (SHO). Re-refer 24/03/02 (PSY1)*
3. *To be seen by PSY5 25/03/03 15.00*
4. *Outpatient appointment with PSY5."*

Comment

Although this ward-based review was called a CPA meeting no members of the community team or, members of staff from outside the PICU were present. PT's parents were also not present. It is unusual for the RMO to have completed CPA forms and written in the medical notes. This suggests no junior doctor was at the meeting. We are unsure of the reasons for this. It is not clear who was invited to the meeting, and by whom, because there are no contemporaneous nursing records. We do not know if the primary nurse attended the CPA or why s/he did not complete the CPA forms if s/he did attend.

PSY1's decision to amend the original CPA paperwork (completed on 3 February 2003) rather than complete new forms was inappropriate and caused confusion.

PSY5 is mentioned several times in the 24 March 2003 care plan but she was not at the CPA meeting. It is unclear who was meant to take responsibility for referring PT to the day hospital or to the CMHT and who was going to arrange the review by PSY5 the next day.

PT failed to attend the ward on 25 March 2003 and the planned meeting between PSY5 and PSY1 never took place. She was therefore unaware of her proposed involvement in PT's care plan. Her memory of the case was advising PSY1 how to refer PT to the Wood Green Sector Team, after which:

> **"it could be arranged for two members of the team, probably including one of the doctors, to visit him at home and assess the situation."**[191]

7.40 The 'contingency plan' was:

> *'Contact PSY5 for an early outpatient appointment'.*

7.41 Under the heading 'crisis plan', 'early warning signs' were :

> *'More depressed'*

7.42 The 'out of hours response' was:

> *'Emergency Reception Centre St Ann's Hospital'.*

The risk assessment form completed by DR2 on 17 January 2003 was added to by PSY1 on 24 March 2003 as follows:

1. PT was diagnosed as suffering from *'depression with psychotic features'.*
2. Factors decreasing risk were said to be *'taking medication' and 'regular OPA' (outpatient appointments).*

7.43 The Risk Management Plan, completed in full by PSY1[192], included 'steps to be taken if patient fails to attend or meet other commitments':

[191] P2-94
[192] P2-324

'RMO to contact carer/relatives by telephone'.

'Action to be taken in the event of relapse /increased risk':

1. *Contact PSY5 [a telephone number was supplied]*
2. *Out of hours: Emergency Reception Centre St Ann's Hospital*

Comment

A CPA risk management plan was completed. There is no evidence it was followed when PT failed to attend his outpatient appointment. No updated risk assessment was completed. The CPA paperwork did not mention the identity of a care coordinator as no care coordinator had been appointed. This was the last day any mental health professionals saw PT before his arrest for killing SB.

Case closure

7.44 If PT's case had been properly dealt with the decision to close his case in August 2003 should have followed the CPA policy current at the time. The 1996 policy stated that:

> *"They [patients] may be discharged from CPA only when they no longer need specialist services; they refuse to co-operate with the Care Plan and are not considered, when the situation is reviewed by the multi-disciplinary team, to be at risk."*[193]

7.45 The 2003 policy states that a user can only be discharged from section 117 MHA after a review meeting has taken place.[194]

Comment

[193] Enfield and Haringey Health Agency Joint Care Programme Approach Policy March 1996 page 7
[194] Barnet, Enfield and Haringey Mental Health NHS Trust Policy on the Care Programme Approach, Care Management and Risk Assessment and Management December 2003 page 20

We have already commented that the decision to close his case was flawed. (See chapter 6.) Existing CPA policies required a multi-disciplinary review and this took place. However, decision-making at this meeting was based on inadequate information and the decision made at the meeting was therefore wrong.

Conclusions

7.46 The failure to appoint a care coordinator for PT was due to: the mistake made by DR3 in January, the lack of clarity about responsibility for following up whether the referral had been made and received, and the assumption that the community team would not become involved with a PICU patient.

7.47 The absence of clear CPA procedures requiring the appointment of a care coordinator for an enhanced CPA patient within a stated time also inhibited a request to the CMHT for further action.

7.48 If PT had been discharged in a planned way and tested on section 17 MHA leave there would have been a chance to develop a proper care plan.[195] This care plan could have contained the following key elements:

a. appointment of a care coordinator,
b. patient to meet care coordinator at specified times,
c. patient to meet psychiatrist in outpatients or ward rounds at specified times, and
d. a carers assessment.

7.49 This would have allowed PT's mental state and level of engagement with mental health services to be monitored. Any deterioration in his condition could

[195] M5 reflected on the purpose of such a care plan. 'There was something about monitoring his mental state following discharge and that was about it being regular. I think it was about being quite intensive early on. There was something about doing a carer's assessment as well as a care plan. There was something about his whole lifestyle being pretty unstructured, so I would be looking at the need for structured daytime activities. I would also be looking for an ongoing assessment as to whether he was accommodated in the most appropriate place. He was a mature man still living with his parents and in view of the dispute with the parents, should he have been offered supported accommodation and should he ever have gone back home? Work, employment and training should be part of structured daytime activities.' (M5 transcript page 18)

then have been identified. If his deterioration was marked, or he stopped meeting his care coordinator, then a re-assessment could have been arranged.

7.50 If a care coordinator had been appointed then a visit to PT's home while he was still liable to be detained under section 3 MHA would have provided a different perspective on PT's circumstances. For example, it would have confirmed that PT spent very little time in Crete. As his father said:

> *"PT has been to Crete with us on two occasions, for one week last summer and the year before that he had come for two weeks but had returned to England after the first week because he was suffering from sunburn.*[196]*"*

Information would also have been obtained about PT's highly routinised and isolated existence.

[196] On 20.04.04 PT's father gave a detailed statement to the police following his son's arrest for the killing of SB. 3-56

8. The Mental Health Act 1983

Introduction

8.1 Our terms of reference require us to evaluate compliance with statutory obligations. This includes the application and operation of the Mental Health Act 1983 (MHA). PT was admitted under section 4 MHA on 17 January 2003. This was converted to a section 2 MHA on 18 January 2003. On 13 February 2003 he was placed on section 3 MHA. He was discharged from section 3 MHA on 21 March 2003 and was then entitled to aftercare under section 117 MHA.

Section 4 MHA

8.2 On 17 January 2003 the police contacted duty ASW (SW2) at 1.12am[197]. She called duty psychiatrist (DR5, SpR)[198] before 2.00am. A Forensic Medical Examiner (FME) saw PT and recorded that he was 'behaving strangely' and 'talking about suicide[199]'.

8.3 DR5 initially recommended that PT be remanded in police custody overnight and referred to the court diversion scheme. However, the police advised that the 'circumstances were complicated' because the 'neighbour has dropped the charges'. Police said they could not hold PT and were concerned for the neighbour's safety. He recorded that a police inspector had requested a MHA assessment[200].

8.4 DR5 arrived at Hornsey Police Station before 4.00am[201]. He concluded that PT most likely had dissocial personality traits plus biological features of depression but there was a possibility he had a psychotic illness given his misconstrued ideas 'i.e. kebab man'. (The context of this remark is discussed in chapter 4. During his assessment at the police station, PT described an incident when he believed workmen had called him 'kebab man.') He decided that more information was needed and that the risks of future offending by PT were high, especially towards

[197] P2-309
[198] P2-331
[199] P2-331
[200] P2-332
[201] P2-332

his neighbour. He completed a section 4 MHA recommendation at 6.10am[202]. In it he said he thought the situation was an emergency and justified the use of a section 4 MHA because a section 2 MHA would cause a six hours delay which might result in harm to the patient, those caring for him and others. He gave the following reasons:

> *"[PT] has traits suggestive of a Dissocial Personality Disorder. On 14 January 2003 he caused criminal damage to a neighbours car with a meat cleaver. He has also expressed a wish to kill his neighbours and other members of the public should they annoy him. Further, he also has Depressive features and suicidal Ideation. I believe that Mr PT is a threat to the general public."*

8.5 ASW, SW2, records making the section 4 MHA application at 5.00am[203]. She faxed a copy of the ASW assessment form to Canning Crescent Centre at 7.39am[204].

Comment

The use of section 4 MHA is for emergencies. The duration of the section is 72 hours from the time the patient is admitted to hospital. The MHA Code states that to:

> **"…be satisfied that an emergency has arisen, there must be evidence of: an immediate and significant risk of mental or physical harm to the patient or to others…"[205]**

DR5 was under pressure from the police. He was told that PT could be released without charge (see chapter 10). It is understandable why a section 4 MHA was implemented.

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[202] P2-304
[203] P2-305, P2-311
[204] P2-459-466
[205] Mental Health Act 1983 Code of Practice Department of Health 1999 paragraph 6.3

Section 2 MHA

8.6 To 'convert' a section 4 MHA to a section 2 MHA a second medical recommendation must be completed within 72 hours from the date of the patient's admission. N1 (PT's named nurse on the PICU) telephoned Canning Crescent Duty Team at 10.25am[206] on 17 January 2003 to arrange for a doctor to conduct a section 2 MHA assessment. DR9 assessed PT and completed a medical recommendation for the section 2 MHA.[207] He recorded that PT:

> *"Has depressive symptoms with poor sleep and appetite and suicidal ideation. He is concrete in his thinking and appears to insist to be in hospital under section. He refuses medication and admission."*

8.7 On 18 January 2003 the MHA office received the section 2 MHA papers.[208] PT was 'advised of his rights.[209]'

Comment

The purpose of a section 2 MHA is to allow the assessment and treatment of a patient in hospital for a maximum of 28 days. During this time a patient can be treated without their consent. PT was identified as presenting a risk to others (by DR5) and was regarded as having a mental disorder but 'refusing medication and admission[210]' (by DR9) In these circumstances the use of section 2 MHA was appropriate.

Section 3 MHA

8.8 On 11 February 2003 PSY1 saw PT for a MHA assessment[211]. He explored PT's reasons for trying to abscond from the PICU. PT said all the people on the open ward looked depressed and it would have driven him mad to stay there.

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[206] P2-467
[207] P2-302
[208] P2-303, 317
[209] P2-306
[210] P2-302
[211] P2-358, 360

8.9 PT said he had remorse about the incident with his neighbour but was 'not really sure' if it would happen again. He said he did not know how he would feel if he went home.

8.10 PT told PSY1 that he would not stay on an open ward voluntarily.

8.11 PSY1's recorded impression was:

> *"Recovering from severe depression*
> *DD PD (differential diagnosis personality disorder)*
> *Risk to others/self high when unwell low when well."*

8.12 His plan was:

> *"Signed S3[212] to allow further treatment and gradual exposure to community and formulation of community treatment plan."*

8.13 PSY1's medical recommendation said:

> *"Patient has episode of severe depression. He had nihilistic ideas and delusions and ideas of persecution.*
>
> *He has as result of his mental illness come close to seriously harm himself and others. He is unwilling to stay voluntarily on an open ward."*

8.14 All three categories of risk (PT's health and safety and the protection of others) were thought to make detention under section 3 MHA necessary.

8.15 On 12 February 2003 the Canning Crescent Duty Service contacted DR10 (PT's GP) to ask if he would carry out a MHA assessment. They then informed Haringey ward that it had been arranged. ASW, SW4 (working in the CC Duty Team that day, but a member of the Hornsey/Highgate CMHT[213]) also contacted PT's father[214]. ASW and senior practitioner SW3 (working in the CC Duty Team that day,

[212] P2-300-301
[213] M3 transcript page 13
[214] P2-448

but also a member of the Hornsey/Highgate CMHT[215]), then completed a CMHT referral form[216] following or during a telephone conversation with M1, acting nurse manager on Haringey ward. On 13 February 2003 ASW SW4 and DR10 assessed PT under the MHA.

8.16 DR10[217] completed a medical recommendation which said:

> "*Probably long-standing depressive disorder with manic episodes of uncontrollable rage resulting in aggressive behaviour. He also has persistent suicidal ideation.*"

8.17 DR10, like PSY1, believed the risk criteria contained in section 3 MHA (the patient's health and safety and the protection of others) made PT's detention under section 3 MHA necessary.

8.18 The section 3 MHA application was later submitted to the hospital managers[218]. SW4 also completed a report.[219]

Comment

The section 2 MHA was due to expire on 14 February 2003. PSY1 acted promptly and appropriately to the situation after the failed attempt to move PT to an open ward. It is unfortunate that the plan he outlined was not adhered to when PT was discharged. SW4's contact with PT's father was to comply with the requirements contained in section 11(4) MHA to consult with the patient's nearest relative before an application for section 3 MHA. She recorded:

> **"He felt his son was still unwell – even though he appeared calm – not disagreeing with section."[220]**

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[215] M3 transcript page 14
[216] P2-456-457
[217] P2-299
[218] P2-295-299, 307-308
[219] The Mental Health Act Code of Practice recommends that an 'outline report' should be completed by the ASW 'giving reasons for the admission and any practical matters about the patient's circumstances which the hospital should know about..' The reports completed by the ASWs (discussed in chapter 4) were of a high quality and contained relevant information. Mental Health Act Code of Practice DofH 1999 paragraph 11.13.

We agree that the use of section 3 MHA was appropriate.

Responsible Medical Officer

8.19 Responsible Medical Officer (RMO) is defined in section 34(1) (a) MHA as 'the registered medical practitioner in charge of the treatment of a patient'. This definition only has application to patients detained under sections 2, 3, 4 and 25A MHA. (25A supervised aftercare has no application in PT's case.) PSY1 was PT's RMO throughout the time he was detained.

Comment

We discuss elsewhere PSY1's general responsibility for PT (chapter 13). Although RMO responsibility ends when a patient is no longer subject to the MHA, consultant responsibility may remain:

> **"with regard to the care of the most complex cases, and where inpatient care and/or care under the Mental Health Act is necessary, the consultant will take over care for as long as is necessary."**[221]

Ground leave

8.20 On 14 March 2003 PT absconded from the hospital grounds while he was being escorted to an open ward. At this time he had 'ground leave'. This is not a statutory term but reflects common usage:

> *"…no formal procedures are needed to allow a patient to go to different parts of the hospital or hospital grounds as part of the care programme."*[222]

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[220] P2- 315

[221] Roles and responsibilities of the consultant in general adult psychiatry. Royal College of Psychiatrists London Council Report CR140 August 2006 page 21. Although this guidance was published in 2006 we consider it reasonable to use it as a yardstick to evaluate good practice in the period under investigation. The guide describes approaches to practice that were well known and accepted in 2003.

[222] Mental Health Act 1983 Code of Practice Department of Health 1999 paragraph 20.1

Comment

A patient detained under the MHA can be granted leave. This is referred to as section 17 leave. RMO consent is required, which is a prerequisite for granting section 17 MHA leave. The local section 17 MHA policy current at the time said 'section 17 MHA leave is not required if the patient is to remain within the perimeter of the hospital grounds.'[223] This is consistent with current MHA Code of Practice guidance. It also appears to be consistent with Haringey Ward Ground Leave Policy[224]. This establishes a detailed protocol for granting leave. The policy states that:

> **"Before any patient is considered for escorted ground leave a detailed Risk Assessment will be completed as per the Risk Management Policy."**

We have seen no evidence that a risk assessment was carried out.

Absence without leave

8.21 We have no details of how PT absconded or the procedures followed by staff after he left the hospital because the nursing records are not available. The operational policy relating to missing patients contains guidance specific to PICU patients.[225] This includes the following:

> *"If the patient is not found, 'the nurse in charge of the ward should inform the Duty Medical Officer, the Police and the out of hours On Call Senior Manager…without delay.'*
>
> *Information that is given to the police 'should include a risk assessment regarding the patient's potential for violence and whether the patient is a danger to himself or others, or is a suicide risk. A description of the patient should also be given.'*

[223] Section 17 Leave of Absence Policy Haringey Healthcare NHS Trust Mental Health Directorate 1999 page 1
[224] Haringey Ward Ground Leave Policy Haringey Healthcare NHS Trust 1999 SAH 59
[225] Patients Missing From Inpatients Wards Policy Haringey Healthcare NHS Trust SAH 25 1997 pages 3-4

'The nurse in charge must inform the patient's designated Next of Kin as soon as it is established that the patient is missing.'

'The Service Manager, Acute Mental Health, must also be informed as soon as possible.'"

8.22 The general procedure to be followed for all missing patients detained under the MHA included:

"Informing the Nearest Relative…should be done before contacting the police to ascertain if they are aware of the patient's whereabouts."

"It should be noted that it is police policy that they cannot return patients who are absent without leave from hospital <u>unless</u> they are violent or potentially violent; or may be a danger to the public; or are likely to be an immediate danger to themselves."

8.23 M1 told us:

"I cannot remember specifically in his case what we did, but usually when a patient absconds we inform the police, we inform the relatives, and we inform the managers on call and everyone that this is what has happened. Then we wait for the police to bring the patient. That was the usual practice when a patient absconded."[226]

8.24 PSY1 told us:

"…it would be normal procedure that if a patient absconds that indeed the police are informed straight away. I think in the policy there is also something about, 'But the police will not take action automatically if the risk wasn't particularly high'. I don't know what the advice was that we gave the police about it.'[227]

[226] M1transcript page 9
[227] PSY1 transcript 2 page 4

I think my response was, and I think that is reasonable, is that we should try to get the gentleman back. That we should take the necessary steps to go out with the police and try to get him back… over the weekend. To be honest, as soon as possible."[228]

8.25 We asked PSY1 for his assessment of the risks PT posed at the time. He said:

"…the risk had been reduced because he was an awful lot better, his mood had improved, he was a different person. He had started to show remorse, all of that, but he was still on a section of the Mental Health Act, and so you would have quite a difficult decision to make with the police about how high of a risk he is."

Comment

There was no discussion of PT living anywhere other than with his parents during his time as an inpatient. So it was reasonable to assume he would return there after absconding from hospital. We think this should have raised concern for the neighbours' safety despite the seemingly reassuring comments PT made during the ward round that day. It should be remembered that on 11 February 2003 when he was asked about the incident in January he said he:

"…was 'not really sure' if it would happen again…" and

"…he didn't know how he would feel if he returned home…"[229]

On 28 February 2003 PT said he:

"…was worried that if he went home he might become depressed again."[230]

Staff should also have been aware that PSY2 had recently assessed PT for a forensic opinion. This had not been received by 14 March 2003. This should

[228] PSY1 transcript 2 page 5

[229] P2-360
[230] P2-363

have led to a cautious approach when PT went missing at least until the forensic opinion was reviewed.

DR2[231] completed a risk assessment on the day of PT's admission which indicated a risk to the general public. If this had been made available to the police we think it likely they would at least have visited PT's home address. PT's apparent calm and settled presentation on the PICU may have contributed to the PICU staff decision not to share the information with the police[232]. In the absence of the nursing records we cannot comment further about the sufficiency of the risk assessment provided to the police.

No member of staff seemed to appreciate the potential risks to his neighbours in the days after PT absconded. This is despite their knowledge of the circumstances that led to his admission and the subsequent comments he made about his neighbours, particularly SB, on the ward.

Staff should have been aware that PT had not received any trial leave. That meant his current response to his home environment had not been assessed and was potentially dangerous. The fact he had returned home in an unplanned way could only increase the risk involved and police should have been told.

PT's status under the Mental Health Act from 14 March 2003 to 21 March 2003

8.26 On 17 March 2003 an entry in the clinical notes records that PT:

> *"Has been in contact with ward via telephone. Father confirms that he's at home. Police aware."*[233]

8.27 PSY1 could not remember when he became aware that PT was at home, but said:

> *"In my mind I think it is certainly not to leave a patient…out in the community on a section of the Mental Health Act. I would not have been*

[231] P2-322-323
[232] PSY1transcript 1 page 28, N1transcript pages 15-16
[233] P2-365

happy with that decision. That is what I remember but whether I became involved in the discussion, or aware that this was the decision made, I don't know."[234]

8.28 M1 told us:

"I presume that when the phone call came in that he was at home, they [nursing staff] would have mentioned it to the consultant that this is what's happened, and maybe he would have advised on what to do. The nurses won't make that decision."[235]

Comment

Without the nursing notes it is impossible to be precise about the decisions made about PT during this eight-day period. PT was a detained patient. His RMO (PSY1) should have been notified when he absconded. He could have granted section 17 MHA leave or arranged for an immediate recall. We have not seen any completed section 17 MHA leave forms so we assume that route was not pursued. PT's legal status during this time was therefore ambiguous. No one in a senior position took control of the situation and PT was allowed to remain at home until 21 March 2003.

Staff seemed to think the police were unlikely to return PT to the ward as he had been quite settled.

N1 told us:

"One thing you should bear in mind is that the intention was to transfer him the previous week to the open ward. He was felt to be settled, and I think it was even felt then that he was unlikely to stay long on the open ward, but by chance he found himself in the community, and the family have just reassured the team that 'He is here with us'. Because I think what happens is when we ring the police to say 'This guy is at this place, go and pick him up', on quite a few occasions they have gone, they have

[234] PSY1 transcript 2 page 7
[235] M1transcript page 11

seen the client or the patient, and the person is very calm and they just advise them, 'Please go back to hospital', they do not take them forcibly, unless they are causing problems, they have experienced that before."[236]

The police may not have been involved but we are unclear why staff made no effort to return PT to the ward when they discovered he was at his parents' home. We repeat our previous comment that because PT had not received any trial leave staff should have known that his response to his home environment was unassessed and potentially dangerous. Returning home in an unplanned way increased the risk involved.

The meeting on 21 March 2003

8.29 PT was discussed in his absence by the multidisciplinary team on the PICU and then interviewed.[237] PSY1[238] wrote and signed an entry which said:

> *"PT had returned to the ward voluntarily with no problem in the community reported. He didn't want to stay on Finsbury (an open) ward, but was happy to return to the PICU.*
>
> *Prior to seeing PT, the stated plan was to:*
>
> *Review on PICU*
>
> *Review before discharge by CMHT – refer to CC* (Canning Crescent)"

8.30 PT said he had a nice week and enjoyed the weather. He said he had apologised to his neighbour and had regrets about what happened. He had experienced no angry outbursts and had no ideas of wanting to harm others.

8.31 PT's mental state examination showed no abnormality. He agreed that he had been depressed but was now better with medication, which he wanted to continue.

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[236] N1transcript pages 15-16
[237] PSY1 transcript 2 page 8
[238] P2-365

8.32 PSY1's clinical impression was:

> *"Well. Diagnosis depression with psychotic features now in remission. Risk to self/others reduced."*

8.33 His recorded plan was:

1. *Leave until Monday pm (24/03/03)*
2. *Sign of (sic) Section*
3. *Recommended but not happy to go to Finsbury ward – leave on "PICU books"*
4. *Medication from PICU*
5. *Return if becomes more depressed.*

8.34 He completed a section 23 MHA discharge form ending PT's detention under section 3[239] MHA on 21 March 2003.

Comment

One element of the plan was for PT to receive his medication from the PICU but it is unclear how this was to be arranged. There are no further details in the medical notes.

The decision to discharge the section 3 MHA

8.35 On 11 February 2003, when he signed the section 3 MHA medical recommendation, PSY1's plan was:

> *"…to allow further treatment and gradual exposure to community and formulation of community treatment plan."*[240]

We asked PSY1 what he meant by this:

[239] P2-316
[240] P2-300-301

Q. *When you said, 'Formulation of a community treatment plan', what kind of things did you have in mind?*

A. *I suppose allocation of community mental health worker, visit every few weeks by a community mental health worker, perhaps, outpatient appointments, perhaps engagement with the day hospital or some sort of structured day activities.*

Q. *At that time, can you remember thinking about your assessment of the likelihood of him engaging in that process?*

A. *I thought there would have been a fair chance of that happening, yes.*[241]

8.36 PSY1 said he decided to discharge PT from section 3 MHA on 21 March 2003 because:

> *"He had been on the psychiatric intensive care unit for two months. After four weeks he showed remorse, his mood started to pick up, he was also a loner. There was no evidence of psychosis, except for one or two remarks …the kebab man, he made a comment that he thought that his father had paid the neighbour off to drop the charges, and I think there was another comment, I can't remember, but no evidence for it [psychosis] during his stay on the ward.*
>
> *So I didn't find it the easiest decision to make in the first place to recommend the section 3 [MHA], when the section 2 [MHA] was coming to an end. I thought, 'Right, what is our evidence for recommending that this chap should stay in hospital with a diagnosis of depression, which has resolved, and having a schizoid personality disorder. So I found it was not the easiest decision, but certainly I think in view of the incident and so on, that needed to happen.*
>
> *So, certainly … I thought a fuller assessment and whilst he was exposed to the community would help…because my worry was, 'What is going to happen if he goes to the community, and he goes back to this neighbour? What is going to happen?'*

[241] PSY1 transcript (2) pages 9-10

So the next step would normally be to go into an open ward, to go through a period of different environments, different assessments, then periods of leave outside on the grounds, and then eventually you have to make a decision about him going to the open wards.

Well, that couldn't happen because he refused to go to an open ward, so he stayed on PICU. I suppose day in day out the same, ward round after ward round the same. Feedback is that he was a model patient, there are no symptoms of psychosis. So I had to think, 'Well, what next? He is not going to go to an open ward, what next? How are we going to advance this? and the sticking point was, of course, how is he going to be in the community? That is the anxiety, what is going to happen.

Then he absconded and he was in the community for a week, and it had gone well according to the report I got, what he told me, nothing had happened, he returned voluntarily, he had been a model patient. But a better thing was the leave in the community had gone well. Nothing had happened, and I certainly thought, and certainly the ward at that time felt that would there have been a tribunal he would have been discharged. I think the majority view was why is he still detained?

So when I saw him. I thought going through the test of being in the community and he passed it and I thought he was no longer detainable. I thought at that time if it had gone to a tribunal, in my mind anyway, they would have discharged him."[242]

Comment

We think PSY1's decisions on 21 March 2003 about the best plan for PT were based on inadequate information and misunderstandings about MHA application.

PT was reviewed on his own. His father was not present. His domestic circumstances were not understood. We do not know what attempts, if any, were made to verify his report that things had gone well during his week at

[242] PSY1 transcript 2 pages 8-9

home. PSY1 recalled he had been told that PT had apologised to his neighbour about the incident in January:

> **"From memory, I think that the nursing staff had reported to me that the father had spoken to them about this. There had been a meeting between PT and a neighbour."**[243]

However, PSY1 did not have direct contact with PT's parents or instruct either of his junior doctors to seek third party information to confirm what PT reported. PSY1 had not seen PSY2's report. He said he might have spoken to PSY2 but could not remember.[244]

PSY1's assumption that PT's risk, both to himself and to others, had diminished was based on incomplete and inadequate information. This assumption led PSY1 to question whether PT could still be legally detained under section 3 MHA. We do not consider PSY1's analysis of the law was correct as he did not differentiate between the nature and the degree of PT's mental disorder.

Continuing to detain a patient can be justified on the grounds of the nature or *degree of the patient's mental disorder. The MHA uses the term 'liability to detention' and this can apply if a patient is in hospital or living in the community on section 17 leave. The High Court considered the difference between nature and degree (our underlining):*

> **"The word <u>nature</u> refers to the particular mental disorder, its chronicity, its prognosis and the propensity of the patient to relapse; <u>degree</u> refers to the current manifestation of the illness."**[245]

PT's condition had proved difficult to diagnose with any certainty. Various possibilities had been considered. PSY1 made the reasonable assumption throughout PT's admission that he suffered from a depressive illness with

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[243] PSY1 transcript 2 page 8
[244] PSY1 transcript 28
[245] Popplewell J in R v the MHRT for the South Thames Region ex parte Smith (1999) C.O.D.148

psychotic features and schizoid or paranoid personality traits. PT was classified as suffering from mental illness. This is not defined in the MHA and does not correlate with any particular diagnostic category.

The symptoms of his illness diminished during his admission probably to the point of making the 'degree' insufficient to justify liability to detention under the MHA. However, PT's attitude towards continuing his medication and contacting mental health professionals in the community had not been established. He had recently absconded so there was evidence that he was not always a compliant patient. This would have been sufficient to establish that the 'nature' of his illness was still largely unknown and therefore needed testing or observing over time in conditions other than the PICU. There is little doubt that the risk criteria justifying continuing detention would have been met in PT's case. The risk to his own health and safety and the safety of others needed to be tested over time in the community.

By 2003 there had been two important judgements in mental health law which established the lawfulness of the continuing use of section 17 MHA leave as part of a patient's ongoing treatment plan.[246] We think a consultant psychiatrist with ongoing MHA responsibilities could reasonably be expected to know about these cases. If PSY1 had followed the principles set down in these cases he could have properly granted PT section 17 MHA leave to his parents' address. This would have allowed PT to go home, still under section 3 MHA. If he had subsequently missed appointments or there had been other causes for concern which justified recall he could have been asked to return to the PICU. If he failed to respond the police could have been asked to return him to hospital. There would therefore have been a 'safety net' in place to make sure PT was regularly reviewed. By discharging PT from section 3 MHA, this safety net was lost. That made it more likely that he would be lost to follow-up. It also meant that an opportunity to involve the CMHT in planning for his aftercare while he was on section 17 MHA leave was lost.

[246] R v Barking, Havering and Brentwood Community Healthcare NHS Trust ex p B [1999]1 FLR 106 CA and R (DR) v Mersey Care NHS Trust [2002] MHLR 386 Admin Ct

Section 117 MHA

8.37 This section of the MHA applies to patients detained under section 3 MHA and other forensic sections of the act. It imposes a duty on health and social service authorities:

> *"To provide in cooperation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the Primary Care Trust or Local Health Board and the local social services authority are satisfied that the person concerned is no longer in need of such services.*[247]*"*

8.38 This section places an enforceable duty on health bodies and the local authority to consider the after-care needs of each individual to whom the section applies. The CPA (see chapter 7) provides a mechanism for the delivery of these services to patients within its scope.

8.39 The duration of their responsibility should be based on individual need:

> *"The responsibility for providing after-care services under this section will last until the after-care bodies are satisfied that the patient no longer needs any after-care services for his or her mental health needs."*[248]

Comment

When PT was discharged there no care plan in place and the trust's statutory responsibilities to him were ignored. This failure was compounded when CMHT staff made the decision to 'close his case' without any assessment of his need for aftercare services (see chapter 6).

R3 The trust should establish a database (or modify existing databases) of all patients who are entitled to section 117 MHA aftercare. The database should

[247] Mental Health Act 1983 section 117(2)
[248] Mental Health Act Manual Richard Jones 10th edition Thomson Sweet & Maxwell 2006 page 455

contain, or link with, details of CPA aftercare plans as well as risk assessment and risk management information. One of the purposes of such a database would be to ensure that section 117 MHA/CPA activity could be routinely scrutinised.

Conclusions

8.40 The MHA was properly used to provide a statutory framework for the assessment and treatment of PT. Mistakes were made when it came to granting him section 17 MHA leave and discharging him from section. His statutory entitlement to aftercare was ignored. These mistakes contributed to PT being discharged from hospital without a proper risk assessment or community care plan.

9. The care and treatment of PT from April 2004 to the present

Introduction

9.1 This chapter focuses on the care and treatment PT has received since he killed his neighbour, SB, on 15 April 2004. He was arrested on 18 April 2004 in Hyde Park. We understand he went there after the killing. He was charged with murder and remanded in custody before being transferred to Broadmoor Hospital where he remains.

9.2 We decided to include this chapter as we think it contains vital information. This concerns the difficulties in accurately diagnosing PT's condition and in appreciating his personality structure. It also underlines that it was possible to obtain, both from him and from other sources, information that would have contributed to a more accurate assessment of the risk that he presented. This emphasises the vital role that community follow up should have played in the management of his case following his discharge in 2003.

19 April 2004

9.3 PT was assessed at Charing Cross police station by staff from the West End CMHT and two section 12 MHA approved doctors[249]. He had been arrested the previous evening in Hyde Park. The assessment says he assaulted a park warden in Hyde Park suggesting this was linked to paranoid beliefs. The park warden was 'in on it' and it was a 'set up' by the police. PT also thought 'a drink he had been given by the police might be poisoned'.

9.4 PT was found to be fit for police interview. A recommendation was made to keep him in the criminal justice system although he demonstrated evidence of mental illness. He was considered too high a risk to be detained under a part 2 section of the Mental Health Act (i.e. section 2 or 3 MHA). Staff from the West End CMHT gave their findings to the local court diversion scheme the next day.

20 April 2004

[249] P2-408-413

9.5 PT appeared at Horseferry Road Magistrates' Court and was remanded in custody to HMP Wandsworth. Staff from the court diversion team informed prison healthcare staff he was a potential risk to others if he shared a cell[250].

20 April 2004 to 26 July 2004

9.6 PT was kept in the healthcare wing of HMP Wandsworth. PSY2 (North London Forensic Service) assessed him on 3 May 2004 and referred him to Broadmoor Hospital on 12 May 2004.

9.7 PSY2's referral letter[251] provides important information about PT's personality and how his thoughts and beliefs about his neighbour gradually led to the stabbing on 15 April 2004. PT described his rigid daily routine at his parents' house which involved predominantly solitary activities. He told PSY2 he would go for a long walk every morning and then 'meditate' until lunch. He would do some 'light exercise' or listen to classical music. In the evenings he would 'relax…take a shower, watch TV till bedtime'.

9.8 PT said that from October 2003 he 'knew there would be trouble again' when his neighbour approached his parents about a proposal to build a loft extension. When work on this extension began in January 2004 PT said his 'meditation' time began to include thoughts about 'what I was going to do about him' (SB). By February 2004 he said he had 'pretty much decided I was going to kill him'.

9.9 PT was asked why killing his neighbour was necessary. He said: 'why should I allow someone to damage our property…he ignored us, what was I supposed to do…and he wanted to build on the ground floor as well…an extension from the kitchen, up to our fence…I couldn't see any other way, or he'd just carry on'. 'It wasn't just the roof, it was also the stuff he was throwing over…I just thought he was provoking me…I thought he was wanting to get me sectioned again so he could build what he liked'. He admitted to having thoughts about his neighbour 'driving

[250] P5-26-27
[251] P5-118-121

home and me running up to him and stabbing him' using 'a machete…or a knife or some other weapon'.

9.10 He said he decided to kill SB on 15 April 2003 because his parents were due to fly to Crete the next day. He said: 'I wanted to do it before my parents went so they wouldn't have to come back to it again'.

9.11 PT described to PSY2 possible psychotic phenomena he experienced after killing his neighbour. He said he felt he was under police surveillance in Hyde Park. He hit a park warden because he was singing 'I'm forever blowing bubbles' which PT thought was a reference to him being of Greek origin (Cockney rhyming slang for Greek is 'bubble and squeak'). PT believed this was a police 'set-up' to see how he would react. PT thought the police at Charing Cross station were poisoning his food and water and gassing him through the air vent in his cell. He also believed he was gassed in the security van that took him to prison to 'make me look mad…and make me say the truth and keep me weak'. When he arrived at HMP Wandsworth he felt other prisoners might be working for the police because of the questions they asked him. PSY2 concluded that PT had developed clear persecutory delusional beliefs after he killed his neighbour but was unclear if PT had been psychotic before the killing.

9.12 PSY7, consultant forensic psychiatrist from Broadmoor Hospital[252] assessed PT on 1 July 2004. PSY7 felt there was evidence of a decline in PT's personality in the last six to seven years which was 'consistent with the picture of an emerging psychotic illness'. He believed PT's 'recent reaction to his neighbours perceived actions resulting in homicide cannot be explained on the basis of personality disorder alone'. He said it 'would indicate a schizophrenic process, probably that of a paranoid schizophrenia which has unfolded in recent years with a prolonged preceding period of prodromal symptoms'. He recommended transfer to high security hospital although PT himself 'strongly believed that his offence warranted detention in prison, and that he would have no regrets being jailed and imprisoned for life as a result'.

[252] P5-131-146

27 July 2004 to 14 December 2004

9.13 PT was transferred to HMP Belmarsh after a court appearance. He was initially placed in the prison healthcare wing. In early September he was transferred to 'ordinary location' and shared a cell with two other inmates. He refused food and drank little for nine days as a protest before 'smashing his cell' on 15 September 2004 and being transferred back to the healthcare wing[253].

9.14 PSY8, consultant psychiatrist, wrote a report for the court dated 3 September 2004[254] which said 'clear psychotic symptoms are not readily apparent prior to the offence'. He concluded that PT was suffering from a personality disorder at the time of the offence. However, he noted the development of 'persecutory delusions' after the offence. In addition to those already described, he said PT told him his paternal uncle had died a few days before the offence and had said 'maybe his uncle had given him the strength to do it, adding that perhaps the dead could influence life on earth'.

9.15 On 26 August 2004, the admissions panel at Broadmoor initially rejected PT's referral. It recommended transfer to a medium secure unit to enable PT to be treated with antipsychotic medication against his will. This was successfully challenged by PSY2 on 12 October 2004 and PT was transferred to Broadmoor under section 48/49 of the Mental Health Act ('removal to hospital of a remand prisoner', subject to Home Office restrictions on discharge) on 14 December 2004.

14 December 2004 to present day (Broadmoor Hospital)

9.16 PT believed he was poisoned on the first day because he felt uneasy after having a meal and coffee[255]. His RMO (DR11) started a depot antipsychotic, Depixol (flupentixol decanoate) 25mg i.m. weekly, on 24 December 2004. The dosage of this medication was varied over time between 50mg weekly to 50mg fortnightly. It was changed to the oral atypical antipsychotic Quetiapine in July 2005 because PT complained of side effects from the injection.

[253] P5-95
[254] P5 151-163
[255] P5-183

9.17 On 27 May 2005 PT's plea of diminished responsibility was accepted by the court. He was persuaded to change his mind and enter this plea after months saying he would only plead guilty to murder as he wanted to go to prison not hospital.

9.18 On 22 November 2005 PT received a hospital order under sections 37/41 MHA without limit of time.

9.19 PT's diagnosis is now thought to be schizophrenia. There is still debate among the doctors who assessed him in prison and Broadmoor as to whether the symptoms of his illness began to appear before or after the homicide.

9.20 He seems to have responded to treatment with an antipsychotic (Quetiapine 400mg per day), but will not agree to an increased dosage as recommended by his current RMO DR12. His negative symptoms (or personality features) such as his rigid routines and social isolation continue. He refuses to participate in OT or engage with any psychotherapeutic approach to his management.

9.21 In March 2005 DR11 recommended that PT be transferred to a medium secure hospital[256]. This view continues to be held by some consultants at Broadmoor and was supported by an independent second opinion provided by PSY9 (South London and Maudsley NHS Trust Forensic Services) on 29 June 2006[257]. To date no medium secure unit has accepted PT.

9.22 On 16 February 2007 PSYO2, consultant clinical psychologist,[258] made a clinical risk assessment using the HCR-20. This is a generally accepted risk assessment tool in forensic psychiatry. It consists of 10 historical risk items, five clinical items and five risk management items each scored between 0 and 2 with a maximum total score of 40[259]. She scored PT at H 11, C 5 and R 9, with a total

[256] P5-207
[257] P5- 255-268
[258] P5-291-296
[259] P5-263-267. **H** items are: previous violence, young age at first violent incident, relationship instability, employment problems, substance misuse problems, major mental illness, psychopathy, early maladjustment, personality disorder and prior supervision failure. **C** items are: lack of insight, negative attitudes, active symptoms of major mental illness, impulsivity and unresponsive to treatment. **R** items are: plans lack feasibility, exposure to destabilisers, lack of personal support, non-compliance with remediation attempts and stress.

score of 25. The HCR has no agreed cut-off score to indicate high levels of risk. However she added the following:

> *"…his mental illness is currently well controlled on medication and in the low stress environment of a secure psychiatric service where he can maintain his isolated lifestyle and routines he is unlikely to relapse and pose a high level of risk.*
>
> *Situations that would be considered potentially destabilising would be non-compliance with medication and changes to his environment that take him out of his 'comfort zone'. In particular, anything he perceived as an emotional, physical or territorial intrusion could increase his level of stress. In the past, particularly in relation to his index offence, there has been a long build up to his violence and this would suggest that there should be opportunities to intervene in any developing process of rumination on perceived wrongs. However, in order to do this it will be necessary for the team managing him to make regular efforts to ask him about such potential stresses, rather than relying on him to identify them himself."*

Comment

There now seems to be a consensus that PT suffers from schizophrenia but no agreement on whether the psychotic symptoms developed before or after the homicide. The current majority opinion is that he was probably psychotic before the homicide, but exactly when his psychotic symptoms first emerged remains unclear.

PSY10, consultant psychiatrist, who wrote several reports for PT's defence lawyers before sentencing, concluded that PT's:

> **"…likely evolving psychosis in the period between his effective discharge from St Ann's Hospital in March 2003 and the homicide in April 2004 must be to some extent speculative (in the absence of any corroborating information from his family) because follow up arrangements by local**

mental health services were so delayed, tentative, few and unsuccessful."

"Since psychotic symptoms were not readily demonstrated in the January to March 2003 admission, it is I believe likely that there must have been some deterioration over the intervening year. It must be at least reasonably likely that such a deterioration could have been identified had community follow up been achieved. Whether such supervision would have prevented this tragic outcome must remain speculative, but it is in my view possible without the inadequacies in the management of [PT]'s care identified above, that this outcome could have been averted.[260]"

We agree with these comments especially when they are considered alongside those of PSYO2 above[261].

PSY2 decided to perform a retrospective HCR-20 risk assessment after PT killed his neighbour using the information that was available on 12 March 2003[262]. We accept that using retrospective data is problematic because it is difficult not to be influenced by subsequent events. However, PT's score of 21 'would have probably pointed to a future risk of violence by him in the boundary of low-moderate categories'[263] at that time. It is perhaps understandable that the clinical team on the PICU was reassured by PT's progress up to 12 March 2003 when he saw PSY2. Two days later, however, he absconded from hospital and did not co-operate with follow-up arrangements. He stopped taking medication. His care was not successfully transferred to the CMHT though he had returned home and may have experienced further problems with his neighbour.

[260] P5-185
[261] P5-291-296
[262] PSY2 transcript page 10
[263] PSY2 letter to investigation panel 9 June 2008

Conclusions

9.23 We accept that PSY2's assessment of risk was accurate at the time he saw him but think the risks would have risen significantly after this. If outpatient or CMHT staff had seen PT after his discharge from the PICU they might have appreciated the increasing risks to SB.

10. PT – the police, the courts and forensic services

Introduction

This chapter considers two separate but linked areas. Part one considers PT's involvement with the police and the courts in January 2003 after his arrest and charge for criminal damage. Part two considers PT's assessment by the forensic service while he was an inpatient on the PICU.

Part 1

The police and the courts

Arrest and charge

10.1 On 14 January 2003 PT was arrested for damaging property belonging to SB and DB. He was bailed to attend Hornsey Police Station on 16 January 2003. He did not attend. That evening the police arrested him at his home. He was asked why he did not answer to his bail and said 'I didn't feel like it.'[264] He was taken to the police station and assessed under the MHA. On the morning of 17 January 2003 he was charged with causing criminal damage and bailed to appear at Haringey Magistrates Court on 24 January 2003.

Entry to the PICU from the police station

10.2 On 17 January 2003 police contacted duty ASW SW2 at 1.12am[265]. She called duty psychiatrist DR5 (SpR)[266] before 2.00am. The FME (Forensic Medical Examiner) saw PT and recorded that he was 'behaving strangely' and 'talking about suicide'. At 6.10am DR5 completed an application to detain PT under the MHA. He subsequently discussed the case with PSY1. He told him the police had said they could not keep PT there saying: 'either he has to go home, we have no power to keep him in a police cell' or 'he needs to go to hospital.'[267]

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[264] 3-221
[265] P2-309
[266] P2-331
[267] PSY1transcript(1) page 12

Comment

We do not understand why the police apparently told DR5 they had no power to keep PT after he was charged. He had been charged with a criminal offence which required a decision about bail. If police bail had been refused PT would have appeared before magistrates where a decision would have been made about granting bail, if necessary with conditions, or remanding him in custody. We assume the police took the course of action they did because the offence was not regarded as sufficiently serious to warrant bail being refused.

This was unfortunate because a magistrate's court diversion scheme was in operation in the area at the time.[268] (The function of such a scheme is to divert mentally disordered offenders away from the criminal justice system into the health services, if necessary by using the MHA.) PT's diversion could have been considered. He would then have been seen by staff experienced in making forensic psychiatric assessments and liaising with the court and a range of local providers of secure psychiatric facilities. This would have increased the chance of a more considered decision being made about continuing the charges against PT and transferring him to an appropriate secure ward. This may have been Haringey ward but PSY1 would have taken part in the initial discussions about the suitability of the PICU and the value of continuing the charges.

Withdrawal of the charge

10.3 PT attended Haringey Magistrates Court on 24 January 2003 and the charge of criminal damage was withdrawn; although he had only been in the PICU for a week he was regarded as fit enough to attend court. On 17 February 2003 the Metropolitan Police Service wrote to SB. The letter told him, as the victim of the offence, the result of the case. The letter contained the following information:

> *"On the 24th January 2003 the defendant appeared at Haringey Magistrates Court charged with the following offence:-*

[268] The North London Forensic Service operated a diversion scheme from Tottenham Magistrates' Court. PT would have first been presented to Highgate Magistrates' Court from Hornsey Police Station, but could have been remanded in custody to Tottenham for assessment.

CRIMINAL DAMAGE:-
CASE WITHDRAWN DEFENDANT IS SUBJECT TO A HOSPITAL ORDER"

Comment

We asked the Metropolitan Police Service lawyers the following questions:

1. ***What guidance was available to prosecutors in 2003 regarding diversion***
2. ***What does the guidance say (if anything) about relevant information being obtained about a defendant's mental illness before a decision to withdraw a charge?***
3. ***Would it have been normal practice to obtain a psychiatric report before withdrawing a charge?***
4. ***Would the prosecutor have sought the opinion of the officer in the case before withdrawing the charge?***
5. ***How would such a case be dealt with today?***

We did not receive answers to these questions. We have listed them as they should be considered in relation to the work that we recommend should be undertaken with the Metropolitan Police Service and the Crown Prosecution Service. (See below R4.)

PSY1 was not consulted by the police before the decision to withdraw the charge. If he had been his response would have been unequivocal: 'Do not withdraw it. Go ahead.'[269]

M5 (Service Manager START) told the internal investigation 'it had been left up to the victim to press charges.' This action had in his view put mental health services in a difficult position with regards to any future action in relation to PT'[270]. This was not correct. SB gave a statement to police saying:

> **"At this time I am not willing to attend Court to provide evidence and I am happy to leave the disposal of the case to Police, however should my**

[269] PSY1 transcript (1) 14
[270] 1-764

evidence be required at a later date I will be happy to give [sic] at court if required."[271]

There does not appear to have been liaison between the clinical team (in particular PSY1 who was PT's RMO) and the Crown Prosecution Service (CPS). If there had been it might have been possible for the medical team to discuss the merits of continuing the prosecution with CPS representatives. The argument for proceeding with the case was that it may have resulted in a hospital order being made under part 3 of the MHA.[272] ***This would have given a clear statement of the risks posed by PT to anybody involved in his future management. We view this as a lost opportunity which could have altered his future management and care.***

R4 The trust work with the Metropolitan Police Service and the Crown Prosecution Service to develop protocols to allow senior clinical input into decisions to grant bail and decisions to withdraw criminal charges in cases involving mentally disordered offenders.

Part 2

Forensic services

10.4 The North London Forensic Service is based at Camlet Lodge, Chase Farm Hospital, Enfield. It is managed by the trust. In 2003 it provided a range of secure inpatient facilities and a monitoring service for patients placed in secure hospitals outside of the trust. It also provided an assessment service for patients referred by community and inpatient teams, a court diversion service based in magistrates' courts in Tottenham and Highbury, and an assessment service for prison referrals.

[271] 3-234 and 235
[272] Part 3 MHA deals with 'patients concerned in criminal proceedings or under sentence.'

The reason for the referral

10.5 We asked PSY1 why he wanted to obtain a forensic assessment:

Q. *Just a general question about your decision to seek a forensic assessment. Would it be fair to make the assumption that you chose to obtain a second opinion from a forensic assessor because you perceived PT to be potentially high risk?*

A. *Yes. He had spoken about things.*

Q. *I am making an assumption now that you are not going to seek this type of forensic assessment, because it is a resource-intensive assessment, unless you are clear in your own mind that you want a second opinion?*

A. *Yes, for two reasons. First of all as you say the risk, which perhaps was not out-of-the-ordinary, almost like an Intensive Care Unit, but certainly also because of the odd-ness of the presentation. I was not sure what was going on and wanted to have a second opinion about that.*

Q. *Was it mainly for a second opinion or did you have any expectation that he might have taken over the care of PT at all?*

A. *Not at all.*

Q. *So it was purely advice?*

A. *Yes.* [273]

10.6 DR3 wrote a forensic referral [274] to the North London Forensic Service on 31 January 2003. She also wrote an Admission Summary (also known as a part I summary)[275] to accompany the referral.

Comment

The two week delay between his admission and DR3 writing the forensic referral and the part 1 summary is acceptable and reflects common practice. The admission summary is of a good standard and contains information to convey appropriate warnings of risk to other mental health professionals. It mentions that PT used a meat cleaver to smash windows, that he said he would have killed his neighbour if he had been there at the time of the attack

[273] PSY1 transcript (1) page 29
[274] P2-383
[275] P2-384

and that he said he wanted to kill children playing outside his house. It also mentioned that PT had felt suicidal at times. In the final paragraph it says PT:

> **"…was currently posing a high risk to himself and others if he was not in a contained environment"[276].**

Receipt of the forensic report

10.7 PSY1's report to the SUI investigation[277] states that on 31 March 2003 he intended to ask the SHO to 'chase the Forensic Report' not 'refer to forensic psychiatrists' as the SHO recorded. The SHO does not seem to have tried contacting PSY2's secretary and it is unclear when the forensic report was first seen by PSY1. A copy was received in the post on 21 April 2003. PSY1 told us it could have been faxed to him ahead of that date although he was not sure.[278] The panel inquiry into the homicide says it was faxed on 31 March 2003[279].

Comment

By the time PSY1 received the report PT had been 'lost' to mental health services. He had been discharged from section. His last contact with mental health professionals was on 24 March 2003.

If the report was faxed on 31 March 2003 it is inexplicable why PICU staff did not send it to the CMHT. If the report was not faxed, we believe the six week delay between assessment and delivery of the report by post was excessive.

The forensic report

10.8 PSY2, consultant forensic psychiatrist and medical director of the North London Forensic Services, wrote the report. PSY2 saw PT on 12 March 2003. The forensic report's conclusions were [our underlining]:

[276] P2-387
[277] P2-103
[278] PSY1 transcript 1 page 29
[279] P2-25

"I cannot say that (PT) seemed to me to be significantly depressed or otherwise suffering from a disturbance of mood during this interview, and it was not either my impression that his comments about his neighbour and the other people who have 'wronged' him were indicative of clear delusional thinking. I suppose I found myself in agreement with the diagnostic conclusions about him written in the notes, to the effect that he has 'a schizoid/paranoid personality disorder', which at times will be aggravated by depression with psychotic features. Terms such as his feeling 'annoyed' with others and 'wronged' by them occur so frequently in his conversation that it would not be unexpected that when he perceives a particular affront or injustice against him from some source, his capacity to interpret such actions as being deliberate could develop a paranoid delusional quality. His low self worth and associated depressive symptoms could well progress to angry blame directed towards others and in these terms I think it could be said that he shows a worrying potential for renewed aggressive outbursts in the future. Unfortunately, I could discern nothing from this interview with him which would give rise to optimism that he might be motivated or responsive to the type of psychologically based therapies which might, with time, provide him with some of the insight and self-awareness which he conspicuously lacks at present. It is possible that, if a persuasive picture were to emerge on detailed questioning of a rapid cycling mood disorder (about which I must say I was not entirely convinced), a mood stabiliser might be added to his present antidepressant medication. I think it will, however, be important (as he himself suggests) that he should be seen on a regular basis as an outpatient, in the hope that any more major fluctuations in his mood state might be detected at an early stage. I would not, myself, necessarily regard it as crucial that he should spend an intervening period in Finsbury ward before he is discharged, although clearly a demonstration of his stability in a more open environment would be desirable."

10.9 When we asked PSY2 why he recommended that PT should be seen on a regular basis as an outpatient he said:

"…in terms of outpatients I suppose I was envisaging exactly that, that this was a man I thought with an emotional vulnerability or instability, with a

paranoid world view, schizoid personality, paranoid traits, who could come into difficulties and who might benefit from being seen, or having the opportunity to be seen and to voice his concerns at the moment with a professional in that kind of way."[280]

Comment

The report was criticised in the original SUI investigation for being in 'narrative style'[281]. M5 felt it 'would be more readable if a clearly discernable structure was utilised' and believed the narrative style made 'it difficult to incorporate any conclusions into risk assessment and risk management planning'. He said that 'there is no consideration of other potential issues in a return to the community, for example: specific risk to the neighbour if he (PT) returns to live in his parents' home, whether alternative accommodation should be considered and the potential role for CMHT workers in monitoring mental state'.[282] PSY2 told us he accepted the criticism of his report-writing style and had subsequently changed it.

The report was clear and contained sufficient information to convey the impression that PT was a potential risk in the future, at least to others, and that he would need regular review in the community. The report was not accurately summarised by PSY1 in his referral form and as we have discussed (chapter 6) we think the report itself was apparently not seen by CMHT staff. This contributed to CMHT staff failing to identify the risks that PT presented and the subsequent decision of the CMHT to discharge him.

PSY1's referral form is the only information he prepared that we are confident was seen by the CMHT assessors. He wrote the following about PSY2's recommendation:

> **"He has been seen by forensic psychiatric team, who recommended follow up in the outpatient department"[283].**

[280] PSY2 transcript page 6
[281] P2-70
[282] P2-70
[283] P2-434a

Because the CMHT never evaluated the full report the reference to the 'outpatient department' may have given the team the impression that PT's case was neither risky nor complex and could be managed as a standard CPA case.

11. The response to the homicide

Introduction

11.1 This chapter is in two parts. The first part deals with the two post-incident investigations by the trust and the action plans developed as a response to one of them. The second part deals with the issue of missing records.

SUI Investigation management report

11.2 HD1[284] made a preliminary assessment before an investigation by M5. The report we have seen is dated 23 July 2004. At the time M5 was team manager of the Host (East) Assertive Outreach Team. He is now manager of START, the Short Term Assessment and Recovery team. He reviewed the contemporaneous records and obtained statements from key witnesses, some of whom he interviewed. His report contains a chronology, a list of issues of concern, a summary of findings and recommendations.

11.3 The list of concerns is as follows:

- risk assessment and risk management planning
- working in partnership with other agencies
- treatment options
- forensic assessment
- perseverance by Community Mental Health services
- processes - statutory and local.

11.4 He made a series of recommendations:

Recommendations from 2004 SUI investigation

Referrals to Forensic Services

Referrals to forensic services contain a clear summary of the expectations.

The forensic report seek to address these expectations and be explicit if this in [sic] not possible.

The forensic report prepared in a standardised format in which core assessment areas can

[284] 2-53 to 2-57

be easily discernible.

The forensic report is balanced between recounting the history and evaluating future risk in managing care. If this is not possible it should be explicitly stated.

Follow-up following Discharge

Patients leaving inpatient facilities should be followed up within a specified timescale by community services.

'Follow-up' can be defined as contact at home, contact at some other location i.e. CMHT office or successful telephone contact.

The timescale for follow-up should be agreed at the discharge meeting also attended by CMHT staff. The maximum gap between discharge and follow-up by community services should not exceed 7 days.

PICU and Discharge Planning

Discharge planning should begin whilst patients are on the PICU. Although it will always be unusual to be discharged directly to the community from the PICU facility, patients on Haringey Ward have access to Mental Health Act Tribunals and Managers Hearings and these have the power to discharge patients from section.

It is necessary that PICU staff be given training in discharge planning and working with community services.

Community services prioritise referrals from PICU and attend reviews.

Patients on the PICU should be 'owned' by community sectors and 'in-reach' should occur in a systematic manner.

Closure of Cases in the Community
Closure of cases policy should be developed. It should contain guidance on the responses of community workers to the failure of clients to respond to engagements.

Closure of cases should be managed within existing CPA processes, and decision-making processes made clear in client files.

RMO's should be involved in all decisions to 'close' cases or refer them to outpatients.

CPA and Risk Assessment

Care Programme Approach Office should take a more active role in the monitoring of CPA.

Patients/clients should be 'registered' on CPA and managerial systems designed in order to ensure CPA activity is actively scrutinized. Minimum standards for reviewing all CPA registered clients must be agreed and 'hasteners' despatched if review information is not forthcoming.

CPA office should be active in alerting both inpatient and community managers to patients/clients who are not allocated a care coordinator.

Risk assessments must be developed during the period of hospital admission and updated at the point of discharge in order to assist community services plan safe interventions.

Treatment Options

The range of treatment options especially psychological assessment must be made more

readily available to inpatients.

Comment

HD1's action in speedily commissioning an investigation was an appropriate response to the seriousness of the incident and followed the incident management policy current at the time.

We consider that M5 prepared a thorough report within a short time frame. He was not given any time off to conduct his investigation. His factual account of events is largely accurate. His list of issues is relevant and focussed and his findings and recommendations sound. In general we think the trust was well served by this investigation. M5's report was reviewed at a 'high level SUI meeting' on 23 August 2004 and he gave evidence to the subsequent panel inquiry. However, the trust never formally acted on the recommendations contained in his report [285]. The Incident Management Policy current at the time required that:

> **"An action plan for the implementation of local recommendations [following the SUI management report] must be produced, which includes identification of lead officers and time scales for completion of recommended action."[286]**

This policy was not followed.

R5 Following consultation with M5 the recommendations contained in his SUI investigation management report are updated, reviewed and added to any action plan that follows our investigation.

Panel Inquiry

[285] 'Formal' in this context means reflected in an action plan with targeted response times and regular review. HD1 considered that M5's report was very detailed and was sufficient to have informed the trust about the problem areas exposed by the PT case whilst an independent investigation such as ours was commissioned. (HD1 transcript page 5)

[286] Barnet, Enfield and Haringey Mental Health NHS Trust Incident Management policy page 11

11.5 A panel to investigate the incident was also established. The trust's incident management policy states that:

> *The Trust's Incident Review Group will make recommendations to the Chief Executive for the Trust if it is felt that following review of the SUI Management Report a Panel Hearing should be held*[287].

M5 completed his report in July 2004 but it is recorded in the minutes of a 'High Level SUI' meeting on 17 June 2004, attended by the Trust Chief Executive and others[288], that a panel inquiry should be established. We asked HD1 why it was thought necessary to establish a panel inquiry. She said it was a decision taken at 'corporate level' and she was not consulted.[289] There is no mention of M5's investigation in the minutes of the meeting.

11.6 VCE1, who was vice-chair of the trust, chaired the panel inquiry (it is titled as such on the front page of the report). A nurse member from the trust and two members (from medical and social work backgrounds) from other trusts sat with him. The panel met four times between November 2004 and January 2005, scrutinised paperwork and interviewed witnesses. The panel inquiry report is undated and the date of publication of the report is uncertain. Minutes of a 'High level patient safety incidents' meeting on 28 February 2005 recorded that the report had been completed in January but publication was delayed because of difficulties in contacting the medical member.[290] The report was discussed at a trust board meeting on 9 May 2005.

11.7 The panel inquiry report contains a number of factual errors the most serious of which we have listed below:

Page 1	The summary is inaccurate. No mention made of PT being placed on section 3

[287] Barnet, Enfield and Haringey Mental Health NHS Trust Incident Management policy page 13. The guidance about the establishment and management of panel inquiries was not available to us and so we are unable to comment as to whether the establishment of the inquiry followed this guidance.
[288] 7-160 to 7-162 We are unable to reconcile these minutes with the reference in the report of the panel inquiry which states: 'The Investigating Officer's report was reviewed at a High Level Patient Safety Review Meeting on the 23rd August 2004. At the meeting the Chief Executive asked that a panel inquiry be held into the care and management of Mr. PT by the inpatient and community services.' (Para 1.3 panel inquiry Report 2005)
[289] HD1 transcript page 4
[290] 7-148

	MHA on 13/2/03 or discharged from the section on 21/3/03. The summary reads as if PT was only discharged on 17/6/03 whereas he had not been seen since 24/03/03.
9.1	PT's parents are Greek Cypriots.
	There is no reference in the chronology to PT's court appearance on 24/1/03.
13.2.2 (a)	Referrals to Canning Crescent were not made on 10/2/03 or marked NFA.
13.2.2 (b)	A referral was made to the day hospital, not the CMHT.
13.2.2(d)	PT was not seen on 14/4/03. He was not seen at all after 24/03/03.
13.2.2(e)	The section 3 MHA was discharged on 21/3/03 not 23/3/03.
13.2.3(a)	Referral on 21/02/03 was to the day centre, not the CMHT.
13.3.6(h)	'The Panel had also ascertained that that Mr PT had not only damaged the neighbour's car but had also smashed every window in the house.' This is incorrect, he did not smash 'every window in the house' just the door and front downstairs room.

In other places contemporaneous judgements/conclusion are accepted without analysis:

13.2.2(g)	'DR1 appropriately tried to do a home visit on the 15th August.'
13.3.3(a)	'Mr PT is correctly assessed [CPA form 3.2.08] as being of medium risk of self-harm or harm to others.'

11.8 The panel's recommendations were as follows:

R1 That the Trust should review the systems, procedures and professional processes which were of concern to the Panel:

- Care Programme Approach
- Risk Assessment
- Community Mental Health Teams
- Record Keeping
- Community Team involvement in the PICU
- Constructive dialogue with the police

R2 That there should be clear documentation of these systems, procedures and professional processes which should be effectively communicated to all required to work with them. This should include training and refresher training.

R3 That the Trust should carry out an audit of patients currently subject to CPA in order to ensure that those patients have effective care plans with assigned Care Coordinators, that there is clinical responsibility for the procedure, that the documentation is adequately completed and that plans are reviewed in accordance with good practice and with the Trust's procedure.

R4 That the Trust should carry out an audit of risk assessments and associated documentation in order to determine that these are in accordance with good practice and with the Trust's procedure.

R5 That the Trust should carry out and audit of recordkeeping to ensure compliance with the Trust's policy, national standards, effective care of patients and effective communication between professionals involved in the care of those patients.

R6 That the Trust should meet with Mr PT's parents to advise them of the results of the Panel's Inquiry.

R7 That the Trust should meet with the widow of the neighbour and, whilst bearing in mind the confidentiality of the patient attempt to answer questions which she posed to the panel.

11.9 DN1, director of nursing, prepared a clinical governance report for the May 2005 trust board meeting. Her report included a summary of key sections of the panel inquiry report. Because the panel inquiry report was, in parts, inaccurate and omitted important information, her summary was similarly misleading.

Comment

The trust board must expect to receive accurate and reliable reports focussing on shortcomings in risk assessments after a serious incident. The panel inquiry report was neither accurate nor reliable. We are concerned that the loss of the nursing notes was not reported as a SUI and not subject to an investigation.[291] We consider that the recommendations to the trust board, apart from recommendation 6 and 7, were too general and lacked focus.

We think the shortcomings of the report were probably due to aspects of the organisation and management of the review rather than the expertise of the panel. The panel report was written by a person who was not a panel member and was not present at any of the hearings.[292] DO1 (Interim Director of Nursing and Clinical governance) told us this was because the manager of the panel inquiry became unwell. It should have been recognised that the author of the report was significantly disadvantaged. Arrangements should have been put in place to support her and remedy any deficiencies arising from the fact that she was not present when evidence was heard. In any event it was envisaged that the report would be written by a person who was not a panel member. This practice needs to be reviewed. (See chapter 14 R10.)

Time planning for the inquiry was unrealistic. This was a 'high profile hearing' involving around 20 witnesses yet panel members were asked to commit three

[291] The absence of the notes was commented upon. 'The Panel was hampered by the absence of the nursing notes.' (Paragraph 13.2.1) In August 2005 one of the panel members (PA1) in responding to being sent a draft of the report commented 'I think more could be made of the nursing notes missing'. As far as we can tell his advice was not acted upon. 1-1003

[292] 1-1087

days to the exercise[293]. Drafts were still being circulated and discussed in August 2005, ten months after evidence was heard.[294] On 28 July 2005 a request to review the report by adding a fuller chronology and analysis was minuted[295].

The SHA asked for further information when the draft report was sent to them. On 31 October 2005 the SHA told the trust it was considering:

> **"…an independent scrutiny of the internal inquiry to provide both a critique of the inquiry and to address any deficiencies within it. However, the SHA is not proposing to commission a full independent inquiry at this stage."[296]**

DO1 reviewed the report and provided further information. The independent scrutiny suggested by the SHA did not take place.

We were concerned about the reasons for commissioning a panel inquiry if it was known that an independent investigation was likely to follow. DO1 told us the panel inquiry was commissioned in mid 2004 because of uncertainties at the time about the need for an independent investigation. He said the trust would have been criticised if their existing SUI policy had not been followed. (It is correct that the Department of Health was in the process of reviewing circular HSG (94)27. It was amended in June 2005. (See chapter 2).

Action plan

11.10 An 'action plan' was drawn up following the publication of the panel inquiry. On 28 April 2005 it was minuted[297] that this action plan was to be reviewed at the next Board Meeting. According to the minutes[298] of the High Level Patient Safety Meeting in June 2006 the plan was considered by the May Trust

[293] 1-1039
[294] 1-1100
[295] 7-133
[296] Email from M9 (Senior performance Manager (Mental Health) North Central London SHA to M7 31.10.05
[297] 7-137
[298] 7-140

Board meeting. The action plan was also considered at High Level Patient Safety Meetings on 1 November 2005 and 15 February 2007.

11.11 We have seen two undated documents which appear to represent the trust's commitment to implementing the action plan. One is a document that we think is likely to have been completed around November 2005. The other is a matrix of action plans linking the recommendations from the panel inquiry with others arising from similar investigations. It is unclear if this document is still subject to ongoing review.

Comment

We have not listed all the action plan points and we do not disagree with any of them. However they are too general. We think specific issues of concern would have been more helpful for the trust. To give two examples:

1. ***'Reviewing the systems, procedures and professional processes of the Community Mental Health Teams' should have identified the shortcomings in screening referrals to the CMHT.***

2. ***'Constructive dialogue with the police' should have identified the particular areas where dialogue was needed such as the decision-making process around the discontinuance of charges against a mentally disordered offender.***

Further action planning

11.12 We became aware during our investigation that the trust and Haringey Teaching Primary Care Trust (HTPCT) had established a Joint Mental Health Clinical Services Improvement Group (JSIG) to:

> **"collaboratively address risk management issues in relation to serious incidents that cross primary and secondary interface."**[299]

[299] Joint Mental Health Clinical Services Group terms of reference December 2007

The group's focus is on contacts between primary and secondary mental health services such as those between psychiatric services and GPs. However, it also gives the PCT assurances about the quality and effectiveness of its commissioned services.

Comment

The breadth of JSIG's remit would permit it to give further consideration to the PT case even though PT had little contact with his GP[300]. The group's action plan dated March 2008 identifies a number of action points that are relevant to our investigation.

R6 JSIG should be involved in implementing the action plan stemming from the recommendations contained in this report.

Missing nursing notes

11.13 There would have been two sets of records relating to PT's inpatient care and treatment, the nursing notes and the clinical records. The nursing notes would have been completed three times a day to provide a running record of all dealings with PT by nursing staff. They would have provided an appraisal of his mental state and how that changed during inpatient admissions. They would also have recorded contact with the patient's family and other professionals such as the CMHT.

11.14 We were offered no adequate explanation for the notes loss. The closest was provided by M6, who in 2003 was clinical services manager. She spoke about the time she was notified of the homicide:

[300] As we have noted elsewhere PT had little contact with his GP. The last time that he was recorded as having contact with his general practice was on 13/6/02 where he was probably seen by a nurse. He never consulted his general practice about any psychiatric problems. It appears that the discharge summary from PSY1 was sent to the GP on 18/06/03 (but labelled 'letter from outpatients') as this seems to have triggered DR10 into issuing a repeat prescription for escitalopram 10mg on 25/06/03. There is no suggestion that this was ever collected. His GP was also notified that PT had not attended his out patient appointment in October 2003 however there is no record of the CMHT sending any letter to the GP to say he had been discharged.

"At that time I was also notified by HDIS2 - because HDIS2 must have gone through the notes - that they couldn't locate the nursing notes, so when I went there I spoke to, I think it was [the previous PICU manager] who was in charge at the time, and the normal process - it wasn't a good system, but that was the system that was in place - they had uni-disciplinary notes, separate nursing notes and separate medical notes, so the process that I met was that when the person is discharged, they transfer all the nursing notes into the medical notes, and then it's sent to the medical records. So that's what he told me, that everything had been sent to the medical records"

11.15 The absence of the nursing notes hampered all subsequent investigations. It meant there was no coherent record of PT's inpatient treatment from January to March 2003. It was, for example, difficult to objectively assess his changed mental state between admission and discharge. Because of this we consider the comment of the panel inquiry that there was "good evidence" that PT "made improvements and that he was well and ready for a transfer to an open ward"[301] should have been qualified.

11.16 There was also no record of the contact his primary nurse and others might have had with the CMHT so records of any attempts by nurses to develop a community plan were lost.

Comment

We first wrote to the chief executive of the trust about the loss of the notes on 21 January 2008 but received no reply. We received a response from DO1, the Acting Director of Operations, dated 9 May 2008. A search for the notes was commissioned after our investigation manager met DO1. The search took place on 29 May and 17 June 2008.[302]

We note that in July 2005 DN1, Director of Nursing, emailed M7, Serious Incidents Manager, after a meeting with DB and her solicitor. She said:

[301] Paragraph 7.2.2(c)
[302] Trust Board Report 9 June 2008

"…we need to make further efforts to find the missing nursing notes, wonder if you can get on to this…"[303]

R7 The trust reviews its SUI policy to ensure that the loss of any patient's health records is treated as an SUI.

Other missing records

11.17 We asked to see the original CMHT records relating to PT that we assumed the trust had in its possession after our meeting with DO1 on 15 July 2008. At the beginning of our investigation the trust had given us copies. We wanted to see original documents because we were concerned that not all documents had been accurately copied. On 29 July 2008 we were told the original CMHT documentation could not be found.[304]

R8 The trust immediately reviews the way in which all records (both electronic and paper) are secured after any serious incident to ensure there is no recurrence of the loss of vital clinical information.

Conclusions

11.18 The recommendations made by M5 in his SUI report were not given the attention they deserved, or that existing trust policy required. A panel inquiry was established with no explicit reference to the SUI report. Because of organisational problems the panel report was inaccurate in important areas of detail, did not identify important areas of concern and was unfocussed in its recommendations.

11.19 In 2004 the trust's acceptance of the loss of clinical records appeared complacent. By 2008 the trust's response to our request to properly investigate the loss demonstrated a profound misunderstanding of the seriousness of the issue. Recent evidence of the loss of the original CMHT records indicates the continuance of a serious problem which is yet to be addressed.

[303] 1-1098
[304] Letter M7 (Patient Experience Manager) to Verita 29 July 2008

12. Care and treatment in 2003

Introduction

12.1 PT received care and treatment from the trust from January to the end of March 2003. From the end of March until the autumn of 2003 inpatient and community mental health services tried to engage with, and monitor, PT. This chapter addresses the context in which PT's care and treatment was delivered during this time.

The Barnet, Enfield and Haringey Mental Health NHS Trust (from the CHI report)

The trust was established in April 2001 following the merger of Barnet Community Healthcare NHS Trust, Enfield Community Care NHS Trust and Haringey Healthcare NHS Trust. It provides secondary mental health services to the residents of Barnet, Enfield and Haringey as well as parts of Cheshunt and south and east Hertfordshire. The trust provides a range of inpatient, outpatient and day hospital services for adults, older people, children and adolescents from over 28 sites. Its budget for 2001/2002 was £119.6 million and the trust employs over 2,000 staff. The trust's population is geographically dispersed and services are organised around the three boroughs, Barnet, Enfield and Haringey.

For 2007-2008 the trust employs over 2,600 staff, and has an annual income of £170m.

Part 1

The CHI report

12.2 A convenient starting point from which to consider the care and treatment offered to PT is the Commission for Health Improvement (CHI) report published in June 2003. It is a review of the 'clinical governance' of the mental health services provided by BEHMHT:

> *"Clinical governance is the system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care, ensuring high standards, safety and implementation of patient services."*[305]

12.3 Within the context of a trust 'committed to delivering care in a challenging working environment that includes services for people from areas of high

[305] Clinical Governance Review of Barnet, Enfield and Haringey Mental Health Trust. Commission for Health Improvement 2003 page 1

deprivation[306]' the section of the report entitled 'overall impression of the trust' identified significant areas of weakness including a lack of clinical leadership and poor risk management.

The general context of PT's care in 2003

12.4 HD3 was Director of Haringey Mental Health Services between September 2003 and October 2007. She said funding in 2003 was 'pretty tough'. She felt that there had been areas of progress during the time she had been in post and in particular referred to more developed community services.[307]

12.5 DN2 joined the trust in 2001 as Director of Nursing and Assistant Chief Executive. She left in December 2003. She described services in Haringey at the time as 'beleaguered and chaotic' with 'incredible pressure' in the system.[308] Without criticising individuals she identified the absence of strong clinical leadership and fragmented leadership roles as significant difficulties. For examples she referred to a split medical directorship and splits in the CMHT leadership. She referred to problems with the 'integration agenda': nurses and social workers working together with very different perceptions of their role and, in particular, nurses being asked to adopt a more holistic role within the community teams. She did not think the CMHTs were functioning adequately. She said inpatient beds were full and allocation to care coordinators was proving difficult because work was not being done to ensure cases were put though to the community team. She referred to the delay in the appointment of care coordinators and the failure to review case loads. She identified poor linkage between community and inpatient services and poor relationships between police and mental health services.

12.6 HD4 (assistant director community services) reflected on the failure to appoint a care coordinator for a section 3 MHA patient entitled to section 117 MHA after care services. She said it was an example of an inability to think in a proper 'holistic care planning way'. She said:

[306] CHI report page 2
[307] HD3 transcript page 12
[308] DN2 page 5

"…when people feel overwhelmed with what they see as work rather than people, pieces of paper are people, people start to do the gate-keeping and pushing stuff back and only doing the tasks, rather than thinking in a strategic way about what this person is likely to need. That is my assumption about what happened, and it is certainly one of the challenges of trying to change practice in 2003/2004 where everything brought in to help people think in a more strategic way was seen as, 'You are killing us with work literally"[309]

Specific problem areas

Bed Capacity

12.7 There were capacity problems across the trust but they were particularly acute in the PICU:

"The trust has capacity problems, with beds constantly fully occupied and in some areas occupancy rates are as high as 130%. As a result service users are being placed in the private sector and some wards, designed for 18 beds, are occupied during the day by up to 36 service users."[310]

12.8 PSY1 told us there was constant pressure on beds in PICU. In 2003 bed occupancy was on average 150 percent:

"So those figures would be about people who were on the books, so a lot of people would be on leave but the bed would be used for somebody else so it was always a shuffle to find a bed, especially in the week."[311]

12.9 M6 said that the idea of 'leaving somebody on the PICU books' was unclear and therefore presented risk:

"Somebody is either in PICU or not in PICU. Somebody is either discharged or not discharged, you leave people on books when they're on leave, within the inpatient service, but that leave is part of the treatment regime to

[309] HD1 transcript page 12
[310] CHI report page 6
[311] PSY1 transcript (1) page 8

gradually discharge the person, so they're really admitted, they have not been discharged."[312]

12.10 There is a reference in the notes to PT being 'left on the books'[313]. M1's interpretation of that phrase was literal. After discharge his medical and nursing notes remained on the PICU:

"That meant he can go on leave, but usually you would have transferred his notes to the other ward, because when patients leave our ward, whether they go to another hospital or they go wherever, the notes are transferred to the other ward. May be because he was going to come back for medication and all that, and assessment, his notes were supposed to stay on the PICU."[314]

12.11 N1 was quite clear that when PT left the PICU some input in to his case, at least for a short period, was maintained.

"So once he is still on your books, what you do, you need to show that at least there is some input which is being given to this client if he goes there in the community."[315]

12.12 The input that he identified involved telephoning PT's home. In the absence of the nursing notes it is not possible to identify the duration of this follow-up. A Greek speaking nursing assistant who worked on Haringey ward decided, following PT's absconsion, to 'pass by' PT's house on his way home. He knocked on the door and there was no answer. The date of this visit is unknown.[316]

Comment

We identify two linked issues: bed occupancy and PT's refusal, which went unchallenged, to occupy a bed on another ward. Bed occupancy and management is still an issue in most units. The CHI report suggested that St

[312] M6transcript page 24
[313] P2-366
[314] M1transcript page 14
[315] N1transcript 23
[316] This information was provided by Hempsons, solicitors for the trust, in a memorandum dated 17 October 2008.

Ann's bed occupancy was higher than other London hospitals. This partly reflected the fact that community services had no clear management structure and no crisis resolution teams at the time. Case management problems within the CMHTs led to delays in responding to new referrals from inpatient wards which in turn may have delayed discharges.

Availability of junior doctors

12.13 PSY1 had the support of a Senior House Officer (SHO). After his SpR, DR2, left on 30 April 2003 he did not have the support of a staff grade psychiatrist.[317] M6 was asked about the use of junior doctors at the time:

> *"They basically didn't have experience for PICU. Some of them had to ask you about how to monitor seclusion. Generally, there were times when it didn't feel safe, because, as I said, I've worked in PICU for quite a while, you needed a staff grade with experience to work on a PICU."*[318]

12.14 M1's analysis was different. She described medical input to the PICU as 'good.'[319]

The Community Mental Health Teams

Management of the team

12.15 The Wood Green CMHT had two co-leaders, M2 who had a nursing background and M3 who had a social work background. There was no overall team manager. There were ten CPNs, five full-time social workers, one part-time social worker, one OT, one psychologist (PSYO1) and two consultants, PSY5 and PSY4[320]. An SpR, DR1, was supervised by PSY4 and each of the consultants had an SHO at the time.

The context in which the team were working

[317] We discuss elsewhere the impact of DR4 leaving sometime in May 2003 and being replaced by a locum which resulted in PSY1 having to dictate PT's discharge summary himself. (See chapter 3.)
[318] M6transcript page 22
[319] M1transcript page 16
[320] M3 transcript page 2

12.16 M3 said the team was under a lot of pressure:

> *"At the time we were struggling, we had a number of senior nursing staff, in particular, retired, and we replaced those with some more junior staff, particularly from the wards, who wouldn't have had so much community experience. I think we were under a lot of pressure at that time. Wood Green is a very high referring area – it has very high social deprivation indices, so the referral rate is high. In conjunction with that, a lot of the community placements were, at that time, in the Wood Green area, so we would have a lot of referrals from other boroughs who had placed clients in the area; we had a very high referral rate, for London I would say."* [321]

12.17 M2 agreed:

> *"We used to get a large number of referrals most weeks, and I seem to remember at that time, and that's probably continued, that you never really had the full quota of staff or the number of staff that you feel is needed."*[322]

Delay in care planning and appointment of care coordinators

12.18 In relation to the CPA the CHI report said:

> *"Some service users told CHI it was rare for care plans to be shared with them and it could take between a week and 10 days before a care plan is in place following discharge. This is stated to be due to ward staff not routinely organising care programme approach (CPA) meetings prior to service user discharge."*[323]

12.19 There was difficulty allocating care coordinators and people had to wait in certain cases. M3 told us:

[321] M3 transcript page 2
[322] M2 transcript page 3
[323] CHI report page 8

"We would not have the resources to allocate [a care coordinator] to everybody who went in on a section 3 MHA immediately. We would be waiting for their recovery to be triggered by the ward staff so that we then pick them up with a view to beginning discharge planning."[324]

12.20 At discharge CPAs the CMHT representative might not be the allocated care coordinator.[325] M6's analysis from the perspective of an inpatient manager was that:

"…good practice would have demanded that he [PT] was referred for a community care coordinator right from the onset, because you don't have to wait. Canning Crescent, all the community teams, they have this long waiting list, that if you're waiting for the person to be discharged before, the person will not have been allocated. So right from the onset, discharge planning should be taking place if we have accepted the person. That should have been done simultaneously with admission, not just getting an ASW to come and assess the patient, but send the referral that you have a patient there who is on a section."[326]

12.21 Despite these difficulties M3 considered the team to be working well. N2 had a different view. He said there was friction and professional jealousy and that the team was not fully integrated.[327]

Comment

The CMHT was under pressure but this did not directly affect the response time in PT's case. His case was considered within five days of receipt of referral and an assessment was arranged 16 days later. However, CMHT staff could have considered the earlier contacts from the ward as referrals if they had been more willing to do so.

[324] M3 transcript page 15
[325] M2 transcript 3
[326] M6transcript 14
[327] N2transcript 2

Conclusions

12.22 The inpatient services at St Ann's Hospital were under significant pressure in 2003 with high bed occupancy and underdeveloped links with community teams who themselves were still evolving. As the CHI reported pointed out, there were 'significant areas of weakness including a lack of clinical leadership and poor risk management'.

12.23 The communication between inpatient services, especially the PICU, and those in the community was poor. This led to an expectation amongst PICU staff that there was little point referring a patient to a CMHT for allocation of a care coordinator until they moved to an open ward. When PT refused to be transferred to an open ward and then absconded this led to a failure to refer him to the CMHT for nearly four months.

13. Medical responsibility for PT's care and treatment

Introduction

13.1 PSY1 was responsible for the care and treatment of PT for most of the time under review. This chapter analyses his roles and responsibilities. Because we are critical of some of PSY1's decisions we want to restate that criticism of him should be seen in the context within which he was working. This is analysed in chapter 12.

PT as detained patient

13.2 PT was a detained patient from 17 January 2003 until 21 March 2003. On 17 January 2003 PT was admitted to the PICU under the care of PSY1. There were two failed attempts to transfer PT to other wards:

> *"10.2.03 'Discharge to Lea Ward today' He is in fact transferred to Finsbury Ward. He is then transferred back to PICU the same day and returns to the care of PSY1.*
>
> *14.3.03 'Transfer to open ward today.' Then 'reported to have absconded' whilst being escorted to open ward."*

13.3 PT remained on the PICU. Therefore his RMO was PSY1 for the duration of his section 2 and 3 MHA.

Comment

Until PT was discharged from section PSY1 had direct responsibility for his care and treatment[328] (see chapter 6). During this time he delegated some aspects of PT's care to other professionals but retained 'clinical primacy', that is overall responsibility. It was part of his clinical primacy to make sure the tasks he delegated, such as referral to the CMHT, were carried out.

Medical responsibility for PT following his discharge from the MHA

[328] This section relies on the examination of the role of the consultant psychiatrist contained in Roles and responsibilities of the consultant in general adult psychiatry. Royal College of Psychiatrists London Council Report CR140 August 2006 pages 16-19

13.4 PSY1 said all patients admitted to the PICU were allocated to a sector psychiatrist. As a PICU consultant he was not regarded as a sector psychiatrist:

> *"In PT's case it was clear that the patient was a Wood Green sector patient. I understand that he was initially allocated to PSY4. At a later stage the nursing staff informed me that it had been determined that in fact it was PSY5. It was noted on the board with key information about the patient. I have recollection of being informed of it, but cannot remember on what grounds. This is why on the 24 of March 2003 we made the plan to phone PSY5 and for PSY5 to review the patient. When I spoke with PSY5 about PT, I believed that she was the sector consultant psychiatrist. Since it was my perception that we had found it difficult to get the CMHT involved I wondered with PSY5 whether she should discuss the patient in the CMHT referral meeting. We decided instead that our team should do a (re)referral to the Wood Green duty team.*[329]*"*

13.5 PSY5 did not regard herself as the sector psychiatrist. She described a conversation with PSY1 about arranging for PT's case to be taken up by the community team. She advised him that:

> *"…the quickest and best thing would be to do a written referral to the community team."*[330]

Comment

When PT was admitted to the PICU he was not known to secondary mental health services. He would have been allocated to either PSY5 or PSY4 as they shared consultant responsibility for the area of Haringey where he lived and was registered with a GP. PT was admitted directly to the PICU but PSY1 felt he was only taking over PT's care for the duration of his stay. As soon as he was discharged he felt PT would once more be the responsibility of one of the sector consultants. This assumption would have been correct if PT had been transferred to an open ward. As he was not, PSY1 was left unsure where

[329] PSY1 addendum to statement to PT Inquiry Panel August 2008 page 3
[330] PSY5 transcript page 7

consultant responsibility rested. He continued to focus on passing responsibility to a consultant colleague even though PT was no longer in hospital and should have been referred to a CMHT.

PT's case was not referred until four months after he left the PICU. PSY1 did not appear to recognise that ending the section 3 MHA made the transfer of medical responsibility more difficult as he had effectively lost control over PT.

From 21 March 2003 (the date of the discharge of the section 3 MHA) it was PSY1's responsibility to ensure PT was discharged with an effective care plan. It was also his responsibility to ensure transfer of medical responsibility. He did not achieve either. This created a vacuum in terms of clinical responsibility because PSY1 had not passed PT to anyone else and was not effectively managing the case himself.

The system for transferring medical care for a PICU patient previously unknown to services was unclear. It is perhaps not surprising that PSY1 as a busy psychiatrist failed to see this. He also does not appear to have been assisted by his colleagues. When the referral to the CMHT was made, the transfer of medical responsibility seemed to have been accepted as DR1 (working for PSY4) tried to assess PT. However, after the unsuccessful home visit, when PT was discharged from the CMHT (and thus had no allocated care co-ordinator) an outpatient appointment was arranged with a locum SHO. By this time any sense of 'ownership' of PT's case appeared to be lost.

PSY1's workload

13.6 PSY1 had the following commitments at the time: five sessions[331] in the dual diagnosis service[332], five sessions in the PICU and one and a half sessions as joint associate medical director. He regarded the allocation of five sessions to the PICU

[331] 'Sessions' have now been replaced with 'PAs' (programmed activities) in the consultant contract that was introduced in 2003. Each PA is roughly equivalent to 4 hours of work time. 'The Joint Guidance on the Employment of Consultant Psychiatrists' published in October 2005, Appendix 1 (Consultant Contract) paragraphs 7.1 and 7.6 states that full time should be 10 PAs and that the maximum of agreed additional PAs should be 2.
[332] A service for people with serious mental health problems in addition to an alcohol or substance misuse problems.

as 'a little bit on the tight side'[333]. There were 12 beds on the PICU. He compared this to the ICU in Hackney, a 15 unit ICU with a full time consultant. Although he had significant commitments he felt he could do his clinical work adequately.[334] In his role as associate medical director he was dealing with the Commission for Health Improvement (CHI) review which he identified as occupying 'a lot of time' during this period.[335] (The CHI review took place between December 2002 and April 2003).

13.7 M6 recognised that PSY1 was busy:

> *"PSY1 was the Associate Medical Director as well, so he was very busy. He was also responsible for the community team, he was being pulled in all directions, he was doing the best that he could, really."*[336]

13.8 DN2 considered PSY1's role:

> *"PSY1 had his role as the PICU consultant, as I understood it, a responsibility for a community patch team, and was also the Associate Medical Director for the Haringey Services. I strongly supported his appointment to the Associate Medical Director role on the basis that he was given enough PAs, enough time, to be able to do that.*
>
> *It is difficult to see with that kind of workload how you can be an effective clinician, or how you can be an effective medical influencer and leader. What he tried to do is everything. He is a good guy, and his heart is in the right place would be my own personal understanding of the way that PSY1 works.*
>
> *I don't think he had enough space to think on either side. I think if he had been given enough time to think about how he could be a really effective Associate Medical Director in the way I understand the role, both in West London and in East London, he would be given dedicated time to make sure that services were being organised in a way that made clinical sense and*

[333] PSY1 transcript page 3
[334] PSY1 transcript page 6
[335] PSY1 transcript page 34
[336] M6transcript page 22

that he would be given the right support and infrastructure to deliver what he had to deliver as an Associate Medical Director.

Or he would be a clinician working in a PICU, and he would have dedicated time to think about his patients and to think about how best to put them at the centre of care and treatment, and not have them not quite fitting the system."[337]

13.9 PSY1 did not feel the support he received from junior medical staff at the PICU was always adequate. He agreed with the internal inquiry team that he had not been well served by his SHO. He confirmed that the SHO had been under administrative pressure: "there had been piles of files in his in-tray[338]".

Comment

Consultants have a duty to manage themselves effectively to make the best use of their time and skills. It is our conclusion that PSY1 was not always able to function adequately. He did not, for example, delegate effectively. We have already identified that DR3 misunderstood her instructions in January 2003 and therefore did not refer PT to the CMHT. This mistake was not picked up in subsequent meetings with the new SHO who was DR4. From the end of March to June 2003 PSY1 asked the SHO to complete a discharge summary and refer PT to the CMHT but this was never done. In June PSY1 carried out the discharge procedures himself. The internal review conducted in 2005 asked PSY1 for an explanation and recorded that:

> **"…the previous SHO had now left and the new SHO did not know the case. PSY1 therefore felt it would be unfair to ask a new SHO to do this work. In addition he wanted to make sure the discharge was done. For these reasons he made a decision to do the work himself."**[339]

PSY1 originally told us he felt he managed adequately in 2003. After reviewing the situation he later told us that the combined responsibilities of his clinical work and his role as associate medical director 'was too much for the sessions

[337] DN2 transcript page 9
[338] 1-776
[339] 1-776 (Notes of Panel Interviews)

available.'[340] We agree with this and, in particular, note that PT was an inpatient when PSY1 was also managing his contribution to the CHI review.

Conclusions

13.10 PSY1 spent two lengthy sessions giving evidence to us. He was calm, conscientious and thoughtful. He accepted that on occasion he should have done things differently. We have criticised some of his decisions but want to emphasise that we do not think he was well supported by his employers. We also think the organisational weaknesses that existed in 2003, particularly in relation to inpatient and community service links, magnified the errors he and others made in relation to the care and treatment of PT.

[340] PSY1 addendum to statement to PT Inquiry Panel August 2008 page 1

14. Changes in service

Introduction

14.1 The purpose of this chapter is to consider how a case similar to PT's would be dealt with today. In Part 1 we look at some areas of clinical governance. Part 2 examines managerial and organisational changes. In Parts 3 and 4 we consider changes to community and forensic services. In Part 5 we reflect on how these changes would affect a hypothetical case similar to PT's. We have considered weaknesses in the system that impeded the effective delivery of care and treatment to PT in 2003 and have tried to identify if they still exist.

Part 1

Clinical governance

14.2 We have adopted the definition used by the CHI reviewers in the 2003 report (see chapter 12 paragraph 12.2). We were assisted by DO1 and his statement that:

> *"I am certain that there was no clinical governance structure worth talking about three years ago, and it has moved on in leaps and bounds since that time."*[341]

14.3 His view is reflected in the CHI report which referred to policies being out of date and not standardised.

14.4 We consider below other areas covered by clinical governance including the CPA.

[341] DO1 transcript page 3

The management of SUIs

14.5 We were given a trust SUI policy[342]. We have categorised, according to that policy, two events identified during our investigation as particularly significant.

Case	Sub-type	Definition	STEIS categorisation
A patient's discharge from the PICU without a CPA care plan being in place.	Serious	Significant cases of a specified nature	Health and safety
a. Loss of nursing records[343] b. Loss of CMHT papers	Confidentiality	Serious breach of confidentiality	Confidential information leak

Comment

We think there should be discussion about treating events of this nature as level 1 SUIs in the future.

The trust SUI policy requires a board level inquiry in homicide cases. We think the need for such an inquiry should be critically reviewed in the light of any prior SUI investigation and the likelihood of the SHA (Strategic Health Authority) commissioning an independent investigation.

R9 Prior to establishing a board level inquiry the trust should always take into account the likelihood of an independent investigation taking place under the terms of HSG(94)27 and should review the scope of the SUI policy accordingly.

R10 The trust reviews the management and organisation of all SUI reviews and board level inquiries to ensure adequate provision of time and appropriate staffing. This review process should consider how the trust can best learn from the reviews and implement their recommendations.

[342] Level One Serious Untoward Incidents Management Policy (Undated) Reference OM02
[343] HDIS1 told us that missing documents are now part of the SUI policy, we were unable to locate this attribution precisely and it may be he was simply referring to the general categories that we have reproduced in the text. (Transcript 11-12)

Accessing information

14.6 A significant failing in PT's case was that CMHT assessors did not consider written information about him, such as the forensic report and ASW summaries following MHA assessments.

14.7 DO1 was confident that current information governance arrangements make this scenario less likely. Multidisciplinary notes are now maintained on RiO, the electronic health record system. DO1 said a CMHT could now access RiO to view clinical records. These would include CPA documentation, which would be completed electronically, and reports such as forensic assessments that could be scanned into the RiO system. However, staff are still advised to access both paper and electronic records. M5 told us this is because the CPA documentation is not fully available in electronic form. We asked if the CPA documentation would be available electronically in the future :

> *"The CPA documentation is generally summarised in "progress notes". That aspect of RiO is part of a future development, but it would be summarised within the progress notes."*[344]

Comment

While records are divided between electronic and paper systems the problems of accessing information in cases like PTs remain.

R11 Until a fully integrated electronic information system is available protocols should be developed to provide guidance on the documentation that should be reviewed in all CPA cases at the time of allocation, review, transfer and closure.

[344] M5 transcript page 9

The seven day target

14.8 The seven day target is a current Healthcare Commission performance indicator[345] introduced in 2005/6, which was linked to the 2002 National Suicide Prevention Strategy. This states that one target should be:

> *"Follow up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self harm in the previous 3 months".*[346]

That in turn stemmed from the NSF[347] which aimed to reduce the suicide rate by at least 20% by 2010.

14.9 HD2 (interim director Haringey mental health services) told us that:

> *"We can't discharge people without having a care coordinator identified. I think the seven day follow up performance indicator target has been a big driver in ensuring that people can't just go home and be forgotten. I think that's very much booted throughout the whole of the organisation, what we do."*[348]

He said data about seven day follow up is collected electronically and audited monthly.

The CPA

14.10 The current CPA policy was introduced in 2005. A 2008 draft policy[349] to take into account changes to the CPA process (see chapter 7) has been circulated. We have included below some paragraphs from the 2008 draft:

[345] Local Development Plan or LDP target PSA05b
[346] National Suicide Prevention Strategy for England 2002
[347] National Service Framework for Mental Health (1999) standard 7
[348] HD2 page 3 HD1 page 7
[349] Barnet, Enfield and Haringey Mental Health NHS Trust Draft Care Programme Approach Policy 2008

CPA policy 2008

3.1 An assessment should occur as soon as possible after a referral but must occur within two weeks.

5.5 If a service user does not have a Care Coordinator then the Key Practitioners (Consultant and Named Nurse) of the service user on the Ward must ensure that Consent to Share Information is completed on RiO.

6.1 All new/existing patients admitted directly to hospital will be subject to the CPA Process and a care coordinator allocated soon after admission.

a) Patients who are not known to services and therefore are not receiving care under the CPA will need to be assessed as soon as possible. In such cases the following would apply.

• The ward named nurse will assume the function of Care Coordinator and will make all the necessary arrangements for a first CPA meeting to take place in the ward round within the first week of admission.

Where the patient does not remain on the ward but requires Care Co-ordination the ward nurse must refer the patient to the appropriate community team with 24 hrs of the patient leaving the ward

8.1 A Care Coordinator will be appointed, in most circumstances within 48 hours, and no later than 7 days."

Comment

We think the 2008 policy should be amended to address the problems that occurred in the PT case. Specifically:

- ***patients not previously known to service should be assessed within a specified time***
- ***where there is no dispute about CPA eligibility a care coordinator should be appointed within a specified time***
- ***the role of the named nurse for a patient previously unknown to services must be clarified.***

The draft policy also needs to correspond with the 2008 Protocol for Interface between START and SRTs – see below.

R12 The 2008 CPA policy is reviewed and amended to take into account the problems identified in the PT case and to ensure that policy is compatible with all other relevant trust policies and protocols.

Training

14.11 HD1 and DO1 were positive about current CPA, risk assessment and care coordination training:[350]

> *"The programme of training we are now putting together on CPA is probably the best it's ever been. It's a mandatory course so every person practising will have to do it. The risk assessment training is the best it's ever been."*[351]

Audit

14.12 The CPA is now regularly audited as part of the trust's commitment to clinical governance. We were given audit reports and assisted by the evidence of HCO1, head of clinical audit. HCO1 told us the CPA audits since 2004 generally demonstrated that 'where the CPA documentation is present the quality of the data is quite good.[352]' We asked if there had been work towards assessing the CPA in a qualitative way. HCO1 said that was difficult because auditors do not have clinical expertise.

Comment

Training on the CPA and evaluation of CPA processes is part of clinical governance culture. To further develop CPA evaluation it is essential that the sufficiency of risk assessments and risk management plans are assessed for quality. We suggest this could happen during junior doctor's 'work based assessments' (now a mandatory part of their training) as a 'case-based discussion' or in their regular educational supervision sessions. For nursing staff (inpatient and community) and social workers it could be included in their regular supervision sessions. There should be further discussion within the trust on whether this should be part of the CPA audit process or clinical supervision arrangements.

R13 To further evaluate the operation of the CPA the trust should consider the development of:

[350] HD1 transcript page 6
[351] DO1 transcript page 24
[352] HCO1 transcript page 5

a. A rolling programme of inpatient and community team inspections to assess the quality of risk assessments and risk management plans. Results should be fed back to the teams, be compared over time and should guide the trust's training programmes.

b. Educational supervision for junior doctors and clinical supervision of other professional groups which should include regular detailed consideration of the accuracy and quality of a sample of risk assessments and risk management plans prepared by the supervisee.

Part 2

Changes to the management structure

14.13 HD1 was new in her post at the time of the homicide. She said she used what she learnt from M5's investigation to make some changes:

> *"I needed to re-jig the management structure below me and put in some strong CMHT managers who were able to work with the clinical leads, the consultants, to actually start to change some of the practice on the ground, which is what we did after this event."*[353]

14.14 Sector managers were introduced in 2005. One of their roles is to identify the people most suitable for transfer back to primary care. The purpose of this is to ensure that CMHT staff case loads are kept manageable, without compromising patient care and safety and the safety of others. According to HD1[354] (referring to all teams):

> "*We are in a process now, because we have changed the system, of really thinking about who we are working with and who should step back into primary care. At that time in 2003, it was happening, because we have always discharged people but I don't think it was happening in any systemised way in terms of people really thinking about who was at that*

[353] HD1 transcript page 5
[354] HD2 page 13

time eligible for secondary care, who should be in primary care. We are doing that more now and teams when they feel overwhelmed feel they have to hold the line and question everything that comes in."[355]

Part 3

Reconfiguration of community services

14.15 Community services were reconfigured in autumn 2007 to provide a single point of entry for all specialist mental health service patients. The newly configured teams are organised as follows.

14.16 The hub of the single point of entry is START *(Short Term Assessment and Recovery Team)*. This is a multidisciplinary team comprising approved social workers, psychologists, doctors and nurses. START has various components within it which are as follows:

- The multidisciplinary team is responsible for providing care coordinators for individual patients. The team works Monday to Friday, nine to five. There are three sub-teams within Haringey. These sub-teams are aligned to the support and recovery teams, which are based at three locations in the centre, east and west of Haringey. (see below)

- The duty team deals with mental health assessments and takes new referrals. It also works Monday to Friday, nine to five.

- The emergency reception centre is a 24 hour, seven day a week service. It is a walk-in assessment service. It is nurse-led but doctors are available if needed.

14.17 START can receive referrals from forensic CPNs based in police stations who may, for example, request Mental Health Act assessments.

[355] HD1 page 14

14.18 The SRTs *(Support and Recovery Teams)* provide longer term continuing care. If a patient needs care in the community for more than three to six months it would generally be provided by the SRTs. The teams are multi-disciplinary. They are based at three locations in the centre, east and west of Haringey. The central base is at Canning Crescent.

14.19 The CATT *(Crisis Assessment and Treatment Team)* provides intensive support so patients can be managed and maintained in the community rather than receiving inpatient psychiatric assessment and treatment. The team helps early discharge from inpatient units. (The terms CATT, Home Treatment Team and Crisis Team are synonymous.) HD2 told us that:

> *"…the difference between then and now is that by the home treatment team being involved they would be looking at a range of different options for treatment. Now that's not to say they wouldn't have agreed to admit, but they would have been looking at other ways that they could have supported him [in the community] if that was possible."* [356]

14.20 HDIS1 (Assistant Director Inpatient Services Haringey Mental Health Services) said a crisis team would have a role to play in the case of a patient like PT who refused to transfer from the PICU to an open ward.

> *"The crisis team will look after somebody who needs intensive input for a brief period of time, so we are looking at least daily visits. In some situations two or three times a day an individual will go and make contact with a person in their own home, usually for medication management, ongoing assessment. Once the situation has stabilised they will make a decision as to whether a person's situation can perhaps be resolved within six months. If they think only a six-month involvement will be necessary, that will be the START team, but if a longer term management plan is required, the support and recovery team for the relevant area."*[357]

14.21 HOST is the Assertive Outreach team in Haringey. It works with people who are difficult to engage with, who often have difficult histories with mental health

[356] HD2 page 5
[357] HDIS1 page 3

services and possibly multiple admissions to hospital. The team is based in Tottenham.

The involvement of professionals from other disciplines

14.22 In 2003 there was an absence of multi-disciplinary input and assessment[358] within the CMHTs. This has changed. Whilst there is still no occupational therapist in the START team, there are now psychologists. M5 told us:

> *"…what has been really good about the restructuring and START is that for the first time we have psychologists in the team and that has been a great improvement for us. They bring a more psychologically minded view to referrals and how people bring back work. They get involved with care coordinators and work together with people. For the example you mentioned we could have got the psychologist in the START team to have been either a consultant to the care coordinator or to have done some sessions."*[359]

14.23 HDIS1:

> *"They have a wider group of professionals who can offer input. The referral that went out for PT from PICU to the Halliwick Centre for psychological assessment could be done in the START team now. They have psychologists working within the START team, so if a more psychological approach was considered relevant, they are able to step in and make that assessment. But I think the timeframe for referrals has contracted and it's not a matter of sending in a referral, waiting for an allocation meeting and then waiting for an internal decision as to who will take on the case. The process is more rapid and somebody will be there to make an assessment."*[360]

[358] HD1 transcript page 13
[359] M5 transcript page 19
[360] HDIS1 page 11

Comment

If PT had been properly assessed he might have benefited from input from the following disciplines: medical, nursing, psychology, social work and occupational therapy. We think a patient like PT would now receive input from a range of disciplines. In 2004 the SUI investigation recommended that:

> **"the range of treatment options especially psychological assessment must be made more readily available to inpatients."**[361]

There are still no occupational therapists in the START team. Given what we now know about PT, we think input from an OT would have assisted in the assessment and management of his case. It follows therefore that access to occupational therapists should be prioritised as a treatment option.

Part 4

Forensic services

14.24 The North London Forensic Service Police Liaison Scheme was formed on 4 July 2005. At that time it covered the hours of 9.00am to 5.00pm. The scheme currently serves Hornsey Police Station between 9.00am – 9.00pm Monday to Friday. Hornsey is one of a number of metropolitan police stations served. Nursing staff assess prisoners in police custody. Prisoner considered to be suffering from mental disorders will be recommended for health care at an appropriate level of security. This might involve contact with local health or social services. Alternatively, and in consultation with partnership agencies, a prisoner may be remanded to prison and brought to the attention of prison medical services or the local courts diversion scheme. The police liaison scheme contacts the local psychiatric services, social services, the prison medical service and the North London Forensic Service to make sure clinical information is given to professionals within both the health and criminal justice systems.

[361] SUI investigation report recs see para 11.4 above

Comment

The police liaison scheme at Hornsey Police Station only operates between the hours of 9.00am and 9.00pm. However, we consider it likely that if a case similar to PT's was to present during the night police would wait until the police liaison nurse was on duty before requesting an assessment. If a more urgent MHA assessment was needed in a case involving significant violence, the social worker and/or doctor(s) involved would also be more likely to wait for the police liaison nurse. Therefore decisions about transferring someone in police custody are more likely to take place during the day and involve more senior clinical staff than they would have been in PT's case in 2003.

14.25 The North London Forensic Service operates a court diversion scheme in Haringey, based at Tottenham magistrate's court. The presence of a police liaison nurse at Hornsey Police Station should increase the chances of a case like PT's now is remanded to Tottenham magistrate's court for assessment by that diversion scheme.

Part 5

How would a case similar to PT's be dealt with today?

Introduction

14.26 The evidence of M5 is reproduced in annex 3. He conducted the SUI investigation in 2004 and is therefore familiar with the details of PT's case and the difficulties it presented. He is now the manager of START, the team that would today be responsible for a case like PT's. We have analysed his evidence and identified some issues arising from it.

Referral

14.27 The way mental health services are currently structured creates an expectation that inpatient units make referrals to START.[362] START is then invited to CPA meetings for referred inpatients.[363] The checks and balances in this system are with the inpatient team. Therefore whenever a patient is discussed in the inpatient setting, for example on ward rounds or nursing shift handovers, the ward staff, management and supervision structures are in place to ensure referrals to START are made and care coordinators appointed.[364] Physical proximity to the START team and the inpatient wards may assist in communication.

Comment

The weakness that existed in 2003 remains, that is the system is still dependent on the inpatient ward staff making the referral and remembering to pursue it until a care coordinator is appointed. There is also no automatic triggering of a referral to START when someone is detained under a section.

Cases similar to PT's will be unusual but not unique. HD1 said that PT's discharge from the PICU was unusual. She said a similar situation now would more likely be 'escalated' to somebody at assistant director level.[365] HDIS1 had a similar response: 'We would have to have quite a senior discussion about getting a care coordinator in very rapidly.'[366]

R14 If a person previously unknown to mental health services is admitted to the PICU and then leaves the unit and immediately returns to the community without being allocated a care coordinator this should be treated as a SUI.

[362] M5 transcript page 4
[363] M5 transcript page 13
[364] M5 transcript page 13
[365] HD1 page 7
[366] HDIS1 page 10

The referral

14.28 There is now no requirement for a referral to be in a particular form. It can be made in a telephone call or on the START referral form which comes to the START duty team.[367] A referral is logged on two electronic systems – RIO and Framework I.

14.29 The referral process with the START team starts with a referral being logged in by clerical staff, checked by a CPN then 'signed off' by a manager.

Comment

The requirement for a referral to be in a particular form caused confusion and delay in PT's case. There is now a more straightforward and sensible system. We are uncertain, however, as to whether a referral being 'signed off' by a manager amounts to effective oversight.

R15 A system to allow managerial oversight of referrals to community teams is developed which will not delay the consideration of referrals by the team but will ensure consistency in the adequacy of information available.

The patient previously unknown to service

14.30 PT was not known to mental health services prior to his in-patient admission. All previously unknown patients from inpatient settings should now be referred to START.[368] However, there is no target time for the assessment of new referrals.

R16 There should be a target time for all new referrals of previously unknown patients from inpatient settings to START.

[367] M5 transcript page 6 and HD2 transcript page 10
[368] M5 transcript page 6

The care coordinators role

14.31 M5 discussed how a case similar to PT's would now be dealt with after discharge from section 3 MHA. He identified the key role of the care coordinator:

> ***Q***. *He was seen on that Friday when he came back from being AWOL; he was discharged from his section that day; he was asked to come back on the Monday for a CPA meeting and that was when the CPA forms were overwritten.*
> ***A***. *Yes.*
>
> ***Q***. *He did come back, admittedly late, on that Monday, but then he was allowed to go home again, but was expected to come back for further reviews on the ICU. Those reviews never happened; in fact that was the last time he was seen by any of the staff. Had those circumstances been repeated now, what do you think would happen?*
> ***A***. *One of the things that comes to mind is that within seven days of someone's discharge from hospital, there is a target that we have to have made contact with them. That is a target that we are not able to negotiate at all. That is an NHS target for the trust and it is bonded by considerable sums of money if we break it.*
>
> ***Q***. *In his circumstances he was still not discharged from hospital. He was expected to come back so it would be more how you would respond to his failure to attend.*
> ***A***. *Yes. That is where I would want to draw a line in the sand. We have to have a discharge meeting at some point. As it turned out there was just this awful limbo where he was neither one thing nor the other in a sense. A demand of the care coordinator would be that we've all got to sit in a room, discharge this person and take some control.*[369]

Comment

The system for allocating care coordinators within five days of receipt of referral outlined to us by M5 (see annex 3) represents a significant advance on

[369] M5 transcript page 21 to 22

the 2003 system. However, weaknesses remain. The 2008 policy seems clear but M5 described a system of 'interim care coordination' with team leaders for each of the three MDTs within START, clinical practice specialists, holding a number of cases pending allocation. We do not think this is a robust system. It leaves decision-making and accountability unclear and the clinical practice specialist vulnerable. They may be holding an indeterminate number of complex cases and would be regarded as responsible if anything went wrong.

R17 A care coordinator should be allocated within five days of receipt of referral unless there is disagreement about a patient's CPA eligibility. If there is disagreement it must be resolved by nominated management staff within a defined short timeframe. The primary nurse will maintain ongoing responsibility for a patient's care coordination until a care coordinator has been allocated.

R18 For inpatients the CPA responsibility of the named (or primary) nurse must be clarified before referral to the START team and allocation of a care coordinator.

Carers assessments

14.32 M5 was in no doubt that PT's mother and father should have been offered a carers' assessment[370]. HD2 thought it more likely that carers would receive an assessment now than in 2003. He attributed this to a general cultural shift in mental health services.[371] The 2008 policy identifies the entitlement of carers to an assessment.[372]

Comment

Practical support for carers is a priority so we consider it important to audit the frequency of carers' assessments and compliance with statutory obligations to inform carers of their rights.

R19 CPA audit processes should include evaluation of the frequency of carers assessments offered and provided in relation to the number of entitled carers.

[370] M5 transcript page 18
[371] HD2page 2 to 3
[372] Barnet, Enfield and Haringey Mental Health NHS Trust Draft Care Programme Approach Policy 2008 paragraph 11

Case closure

14.33 The existing CPA policy[373] requires a final discharge meeting with both user and 'relevant professionals' and, where relevant, the completion of a section 117 MHA discharge form. This guidance is largely replicated in the 2008 draft policy[374].

Comment

The closure of PT's case without recognition of either his CPA status or his section 117 MHA entitlement was inexcusable. To lessen the chances of this happening again we think the CPA policy should include the requirement for a comprehensive risk assessment by a care coordinator before any case is closed.

R20 The 2008 CPA policy is revised to include a requirement that a comprehensive risk assessment is undertaken by the care coordinator before the decision to close the case of any person subject to CPA.

Conclusions

14.34 We can be reasonably confident that a case similar to PT's would be dealt with differently today. The trust has created a working CPA policy which is being appropriately reviewed. The reconfiguration of community services make it more likely that a case similar to PT's would be assessed rapidly. It is more likely that the assessors would access enough information to allow them to make an accurate risk assessment and risk management plan. The target times that now exist should assist in the rapid allocation of a care coordinator during a patient's inpatient stay. However, faults that could be remedied remain and we make recommendations accordingly.

[373]Barnet, Enfield and Haringey Mental Health NHS Trust Care Programme Approach Policy November 2005 paragraph 9
[374] Barnet, Enfield and Haringey Mental Health NHS Trust Draft Care Programme Approach Policy 2008 paragraph 13

15. Conclusions

15.1 This report details our analysis of what we consider went wrong in the management of PT's case. Witnesses referred to his case as 'unusual' but the response to this unusual case was not one of caution.

15.2 We attribute the failures in this case to a number of factors the most important of which we list below.

- An overworked consultant was in charge of PT's inpatient treatment.
- An inexperienced junior doctor failed to make the referral to the CMHT.
- The primary nurse was not familiar with the CPA process.
- There was poor transmission of information. For example, relevant reports were not sent to the CMHT.
- There was poor communication between the PICU and the community team.
- Core information that was available to the community assessors was not requested or considered.

15.3 We are critical of PSY1 in relation to a number of the decisions and actions he made about the care and treatment of PT in particular his failure:

- to ensure the timely referral of PT to the CMHT
- to use section 17 MHA leave appropriately
- to ensure effective transfer of PT's care and treatment.

15.4 We are critical of DR1 and N2 for not evaluating the background information about PT before the failed attempt to assess him on 15 August 2003.

15.5 We are critical of N1 for failing to make sure PT was referred to the CMHT so a care coordinator could be appointed.

15.6 We are critical of M1 for failing to more actively oversee the management of PT's case particularly in relation to the failure to refer his case to the CMHT.

15.7 These criticisms should be seen in the context of significant corporate failure. Of particular significance we identify the failure to:

- create and operate effective CPA policies and procedures
- provide proper support for PSY1
- put in place effective procedures for the screening and closure of cases within the CMHT
- address fragmented professional responsibilities
- identify the weaknesses in links between the PICU and the community
- ensure compliance with statutory obligations to carers[375]and to users[376].

15.8 After the homicide we further identify the failure to:

- protect patient records and deal adequately with their loss
- pay proper attention to the SUI investigation
- oversee the organisation of the panel inquiry and critically evaluate the content and recommendations of the report.

15.9 We attribute the corporate failure to all managers employed at the time with responsibility for inpatient and community services and the Trust Board which had oversight of those managers.

15.10 There were significant deficits in the care and treatment provided and offered to PT. If he had been properly treated and cared for in the community then the deterioration in his mental state that caused him to kill SB might have been detected.

15.11 We are unable to conclude that the homicide could have been prevented if PT had been more effectively monitored. On the basis of the information available when PT absconded from the PICU (14 March 2003), we accept that his future risk of violence was likely to have been assessed in the 'low-moderate' category[377]. After he absconded those risks were likely to have increased. If PT had been seen in outpatients or by the CMHT after his discharge from the PICU, staff might have been able to identify and manage the increasing risks to SB.

[375] Carers (Recognition and Services) Act 1995
[376] Mental Health Act 1983

[377] This was the categorisation suggested by PSY2 following his retrospective review. (See chapter 9.)

15.12 We end this report with comments from the judge[378] when sentencing PT:

"You took the life of a decent man who did you no harm. His family are entitled to feel very proud of him as all the reports and statements about him that I have read indicate. You attacked him without warning and without any cause whatsoever outside his home and as a result his family's life will now never be the same again; father, husband and son taken from them.

Your responsibility for that act is diminished by reason of the mental illness that all the medical reports about you, that are available to me, indicate that you were suffering from at the time you committed that act. Accordingly, your plea of guilty to manslaughter has been accepted, rightly so in my judgment, because it is the mark of a humane and civilised society that the effect of mental illness is recognised and acted upon. In saying that, I do not want anyone to think that the value of the life you took is in any way decreased by the fact that I sentence you for manslaughter and not murder."

[378] The Recorder of London 22 November 2005 Transcript 20047309

Annex 1 - Terms of reference

Commissioner

This independent investigation is commissioned by NHS London with the full cooperation of Barnet, Enfield & Haringey Mental Health NHS Trust (the trust). The investigation is commissioned 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

The aim of the independent investigation is to evaluate the mental health care and treatment given to PT from the time of his first contact with mental health services to the time of the offence. The investigation will review the trust internal investigation and assess the progress made on the implementation of its recommendations.

This is a stand alone investigation however the investigation team will also work closely with two teams conducting equivalent investigations into the care and treatment of two other trust patients. The reason for this approach is that the three investigations are expected to identify common trust-wide themes and issues. The three investigation teams will provide specific and joint recommendations which will be strong and consistent. The recommendations will be made to the trust and NHS London to help ensure future best practice in the provision of mental health care.

The investigation team will:

- Investigate and review the mental health care and treatment provided by the trust to PT from his first contact to the time of the offence.

- Assess the adequacy of the risk assessment(s) of PT and actions consequent upon the assessment(s).

- Examine the nursing and medical leadership and management associated with PT's care and treatment.

- Review the extent to which trust services adhered to statutory obligations, relevant national guidance and local operational policies.

- Complete a chronology of the events to assist in the identification of any care and service delivery problems leading up to the incident.

- Examine the extent and adequacy of interagency collaboration between the trust, local authority, metropolitan police and PT's general practitioner.

- Review the trust internal investigation and assess the adequacy of its findings and recommendations and the progress made in their implementation.

- Provide a written report including recommendations specific to the care and treatment of PT to NHS London, the trust and its commissioning primary care trusts (PCTs).

- Simultaneously work with two investigation teams conducting equivalent investigations into the care and treatment of two other trust patients. Where common trust-wide themes and issues are identified joint recommendations will be made to the trust. The aim of the recommendations will be to assist the trust in learning lessons from these adverse incidents and to help it to provide safer services to its patients, the public and staff.

Approach

The investigation team will conduct its work in private and will take as its starting point the trusts internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team. The investigation team will also seek to engage with PT and his family and also the family of the victim SB. This will assist in ensuring that the investigation and review achieve a thorough understanding of the incident from the perspective of those directly involved.

The investigation team will follow established good practice in the conduct of interviews e.g. offering interviewees the opportunity to be accompanied and give them the opportunity to comment on the factual accuracy of their transcript of evidence.

If the investigation team identify a serious cause for concern then this will immediately be notified to NHS London and the trust.

The written report will include recommendations to inform the appropriate commissioning of the service by Haringey PCT.

The investigation team

The investigation team will consist of an appropriately knowledgeable team leader and a Verita investigation manager as well as expert advisors with nursing, medical or other relevant experience.

Timetable

The investigation team will complete its investigation within six months of starting work. The six months will start once the team is appointed in full, written consent has been received for the release of PT's records (or other arrangements made for the release of the records) and sufficient documents are available to the team for interviews to start. The team leader of the independent investigation and the investigation manager will discuss any delay to the timetable with NHS London. A monthly progress report will be provided to NHS London and to Haringey PCT.

Annex 2 - PT Chronology

14/01/03 PT arrested at 01.00 for breaking neighbour's house and car windows. Bailed to return on 16th at 23.00 but failed to appear[379].

16/01 (Thu) PT re-arrested at home at 23.50 for failing to answer bail and taken to Hornsey Police Station[380].

17/01 (Fri) Police contacted duty ASW (SW1) at **01.12**[381], who then called duty psychiatrist (DR5, SpR)[382] at **02.00**. PT had been seen by FME, was apparently 'behaving strangely' and 'talking about suicide'.

DR5 initially recommended remand in police custody overnight and referral to the court diversion scheme. However police advised that 'circumstances were complicated' and 'neighbour has dropped the charges' so police couldn't hold PT and were concerned for neighbour's safety. 'Inspector' asked for MHAA[383].

DR5 arrived at Hornsey Police Station at **04.00**[384].

DR5 concluded that PT was likely to be suffering from dissocial personality traits plus biological features of depression, but that there was a possibility PT suffered from a psychotic illness given his misconstrued ideas 'i.e. kebab man'. He concluded that more collateral information was needed and that the risks of future offending by PT were high, especially towards his neighbour. He completed a **Section 4** MHA recommendation at **06.10**[385].

ASW, SW1, records making the Section 4 MHA application at **05.00**[386]. She faxed a copy of the ASW assessment form to Canning Crescent Centre at **07.39**[387].

PT was then charged with criminal damage at **06.45** and bailed to appear at Haringey Magistrates' Court at 09.45 on 24/01/03[388].

DR5 arranged PT's admission to PICU (Haringey ward, St Ann's Hospital). He suggested the need for a forensic assessment[13]. He also, at some stage that day, discussed the case with PSY1 and mentioned the charges being dropped[389].

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379 P2-304, 332, P3-205
380 P3-221
381 P2-309
382 P2-331
383 P2-309, P2-331
384 P2-332
385 P2-304
386 P2-305, P2-311
387 P2-459-466
388 P2-337, P2-292-3

389 P2-96

On the morning of admission, PSY1 (RMO) conducted a ward round.

PSY1 recorded the impression from the first interview with PT as[390]:

'?depression… but not sustained'

'Mood swings secondary to affective disorder secondary to personality instability'

'Low frustration tolerance.'

He recorded the risk as:

'High to self and others (but not in a contained environment).'

DR3 records the plan as:[391]

1. Forensic referral
2. CMHT referral
3. CPA next Friday (24/01)
4. Drug urine screen

On the same day, a Risk Assessment was completed by DR2, SpR.[392] And a 'medium' risk of self harm and harm to others was identified, associated with a provisional diagnosis of depression with psychotic features. A history of past self harm and serious violence/harm to others was identified in addition to a current risk of self harm, attempted suicide and serious violence/harm to others.

Specific events listed were:

This episode -

Smashed neighbours window with meat cleaver

Held Stanley knife against his throat

Threats to kill children in street (or anyone who annoys him) in Oct 02

[390] P2-342
[391] P2-338
[392] P2-322-323

Past –

Kicked in neighbour's door (this referred to when PT was living in his own flat)

Thoughts of carrying knife to revenge being called 'kebab man';

Intention to kill children who put firework through letterbox (Halloween Trick or Treats);

Dec 99 - Punched someone who was shining a light in his eye

Has hit brothers.

Factors increasing risk were cited as:

Getting depressed or despondent.

Telephone call from Staff nurse N1 from Haringey Ward to Canning Crescent Duty Team at **10.25**[393] to arrange a doctor to conduct an assessment for Section 2 MHA**.** PT was later assessed by DR9 who completed a **medical recommendation for S2**.[394]

18/01 (Sat) Section 2 MHA papers received by MHA Office.[395] PT advised of his rights.[396]

20/01 (Mon) Ward Round with PSY1 and DR3[397]. Attended by PT's parents.

DR3 listed a differential diagnosis for PT of:[398]

Autistic spectrum

Schizotypal or paranoid pd

Schizophrenia with negative symptom picture.

The recorded plan was to:

Book CPA 2 weeks time

Further investigate into background history.

23/01 (Thur) Seen by DR3 for further enquiries re personal and family history[399]. She considered the diagnoses of:

Depression,

[393] P2-467
[394] P2-302
[395] P2-303, 317
[396] P2-306
[397] P2-343
[398] P2-345
[399] P2-345-8

Schizotypal or paranoid pd
Dysthymia

Her plan was:

1. No medication at present
2. Discuss in ward round on Monday (27th)
3. Routine bloods taken; FBC, U&Es, LFT, vit B12 and Folate, TFT[400]
4. Risk assessment (ticked as already done by SpR – DR2[401]).
5. Needs part 1 (admission summary) and forensic referral.

She later completed a physical examination, which was normal.

24/01 (Fri) Ward Round with PSY1 [402]. PT discussed in his absence (he had been escorted to the magistrates' court). Nursing staff reported that he appeared rather emotionless but no odd behaviour.

The plan was:

1. Forensic referral
2. Discuss with psychology department
3. Try to chase up school reports, previous employers
4. Trial of antidepressants – Cipramil 10mg (in reality, escitalopram was used)

27/01 (Mon) Ward Round[403] (PSY1 not present[404]). Nursing staff reported that PT had been calm and accepting his medication, but 'was annoyed that his court case had been dropped as he thought his parents had paid the neighbour'.

PT was seen and said to be calm and co-operative. He reported not being depressed since being in hospital, but can't see any alternative to being locked up forever, 'which he knows is unrealistic'. Didn't think he'd be good at psychotherapy as he was poor at expressing himself. He was accepting medication but complained of a decreased appetite.

The only plan was to continue the 'citalopram' 10mg per day.

30/01 (Thur) Seen by DR3[405]. Mood more stable in hospital. Feeling confused about whether he needs to be in hospital or not – **has considered going home but worries the 'blackness' will come back**. Still not keen on psychology. Sleep and appetite OK, but still feels he has 'nothing to offer'.

[400] P2-288-289
[401] P2-132, 322-323
[402] P2-349
[403] P2-350-351
[404] P2-123
[405] P2-351-352

Her plan was:

1 Continue antidepressants
2 Discussed with psychology who suggest Halliwick referral but PT was not keen for this to happen.

31/01 (Fri) Ward round with PSY1 and DR3[406]. Parents attended.

Plan:

1 Halliwick referral for personality assessment
2 CPA meeting 3/2/03
3 Continue escitalopram 10mg od (7 days so far)

DR3 wrote forensic referral [407] to Camlet Lodge RSU and an Admission Summary[408].

03/02 (Mon) CPA meeting[409]. Entry signed by DR3. Attended by parents.

Discussed leave to open ward… 'he is happy to do it'.

Parents are with (sic) only 2-3 months. Rest of year they are in Greece. Guilty about burdening parents.

Financially OK – has savings. Told about benefits advisor on open ward. Talked about learning a new skill if he could remain not depressed e.g. computer maintenance. Discussed psychological assessment.

Plan:

Continue antidepressants

Consider leave to open ward and subsequent transfer

Psychological assessment referral

04/02 (Tues) Seen by DR3 to inform him she was leaving.

07/02 (Fri) Ward Round with PSY1 and new SHO DR4.[410]

Still guarded. Not opening up. Seems quite settled, appears to be a model patient. Able to concentrate (?enough) to play fantastic pool games.

Seen. Appears calm. No complaints . Not feeling depressed. Hasn't been depressed since on the ward.

[406] P2-353
[407] P2-383
[408] P2-384
[409] P2-354, 326-328
[410] P2-356

Regarding the incident in January PT stated that he felt he was wronged so he did something about it. No remorse about it. Repeated that if he had caught the children at Halloween he intended to kill them, said he lost control. When asked if they deserved to be killed he said, 'I'd have liked to see them dead I have no problem with that'. But later said that 'this might have been extreme' and admitted he 'lets thing build up and can explode later'.

He also said that if he was transferred to another ward as an informal patient he would most likely go home. Said he was scared he might get depressed again when he goes home.

Plan:

Allow on leave to Lea Ward

Decide on Section on Monday *(10/02/03)*.

Father suggests he won't be a danger if discharged and requested he received counselling.

10/02 (Mon) Ward Round.[411] Leave to open ward went OK. PT considered stable enough to be on open ward.

Plan: Discharge to Lea Ward today.

Transferred from Haringey ward that afternoon. At 16.00 banging noises were heard from the laundry room. PT had climbed over a washing machine to kick and try to break a window to escape through. He was given PRN Haloperidol 10mg and Lorazepam 2mg (both orally)[412] and escorted to PICU where placed in seclusion.

Duty doctor wrote that PT 'started trying to smash things in TV room' and that 'he couldn't handle it there- the people, not being allowed in his room'. Prefers it on Haringey ward. There had been no problem in preceding 3½ weeks. The duty doctor ended seclusion after discussion with Nursing staff as PT was calm and rational.[413]

11/02 (Tues) Seen by PSY1 for Mental Health Act Assessment. [414]

When asked about incident with neighbour, PT said he had remorse about it but 'not really sure' if it would happen again. Didn't know how he would feel if he returned home. He would not stay on open ward voluntarily.

Impression:

[411] P2-357
[412] P2-284
[413] P2-359
[414] P2-358, 360

Recovering from severe depression with a differential diagnosis of personality disorder.

Risk to others/self considered high when unwell but low when well.

Plan:

'Signed S3[415] to allow further treatment and gradual exposure to community and formulation of community treatment plan.'

See also PSY1's statement to SUI Investigation.[416]

12/02 (Wed) PT was referred to the Wood Green CMHT[417] *to organise a S3 assessment by M1, acting ward manager Haringey Ward.*

13/02 (Thur) ASW (SW4) and second Dr (DR9 – PT's GP) complete S3 and application received by managers.[418]

14/02 (Fri) Ward Round[419], PSY1 not present.[420]

PT now refusing to go to an open ward, saying that he will either try to escape or go on hunger strike. Staff explained that he could not be discharged from PICU.

Plan:

Continue medication

Discuss leave for one hour every day again in a few days.

17/02 (Mon) ASW (SW4) completed Part B of ASW Report.[421]

21/02 (Fri) Ward Round with PSY1.[422]

Attended by PT and his father. Advised to continue antidepressant.

PT refusing to go to, or even visit, an open ward. He wanted to know when he could go home and attend a day centre every day.

Plan:

Visit to therapy centre[423]

Walks around the campus

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[415] P2-300-301
[416] P2-99
[417] P2-456-457
[418] P2-295-299, 307-308
[419] P2-361
[420] P2-100
[421] P2-312-315
[422] P2-361
[423] P2-19

Psychological assessment referral

CPA meeting with PSY4 ASAP

Refer to Canning Crescent Day Hospital

Impression:

Axis I - Severe Depression with psychotic features
Axis II – Schizoid/Paranoid traits

DR2, SpR made a referral to the Day Hospital.[424] Memo sent to DR2 (undated) from M4, Day Hospital Manager asking him to re-refer PT 'when he is ready'[425]

Undated — Entry by PSY1 headed 'referral' (this presumably relates to a 'phone call made by PSY1 to discover how a referral to the CMHT should be made).

25/02 (Tues) — Referral letter from PSY6[426], clinical attaché to PSY1 to the Halliwick psychotherapy centre at St Ann's.

PT advised of his rights after being detained under S3 on 13/02/03.[427]

28/02 (Fri) — Ward Round[428]with DR2.
Nursing staff report that PT is still isolating himself. PT stated that he was worried that if he went home he might become depressed again. He used to get angry and frustrated before but he is more hopeful now. He wants to comply with medication on discharge.

Plan:

Continue same medication

To move to an open ward soon.

03/03 (Mon) — Letter from MO1[429], referrals coordinator/medical records officer at Camlet Lodge, to DR3 (who had left by then) confirming receipt of forensic referral and stating that PSY2 will make contact 'in due course'.

12/03 (Wed) — PT seen by forensic consultant, PSY2.[430]

14/03 (Fri) — Ward Round attended by PSY1, DR2 and DR4, a staff nurse and PT's father.[431]

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[424] P2-402
[425] P2-399
[426] P2-382
[427] P2-294
[428] P2-362-364
[429] P2-381
[430] P2-377
[431] P2-364, P2-100

Nurses reported that PT had been very stable on the ward. Greatly improved relating with father.

PT said that his moods had been more stable. Didn't feel depressed, felt more hopeful about life, able to enjoy himself, concentrate and motivate himself. No more suicidal thoughts.

PT said he was no longer angry with neighbour because he had repaired the damage. Believed his reaction to the neighbour was excessive, that he should have tried to talk or maybe used a stone not a meat cleaver because he could have hurt him.

PT felt that he should be discharged to the day centre. Informed of difficulty of being referred from the PICU. Agreed to go to open ward and stay in during the day. He stated that he was happy to continue with medication.

Plan:

1 To transfer to open ward today
2 Continue meds.

Later the same day DR4 recorded that PT had been reported to have absconded from hospital grounds whilst being escorted to an open ward.[432]

17/03 (Mon) Entry signed by PSY1.[433]

PT had been in contact with the ward via telephone. Father confirmed that he was at home. Police were made aware.

21/03 (Fri) Entry written and signed by PSY1.[434]

PT returned to the ward voluntarily with no problem in community reported. Didn't want to stay on Finsbury Ward, but happy to return to the PICU.

Plan:

Review on PICU

Review before discharge by CMHT – refer to Canning Crescent.

During the interview PT reported:

He had a nice week, enjoyed the weather. He had apologised to the neighbour and expressed regrets/remorse about what happened. He had no angry outbursts and no ideas of wanting to harm others.

[432] P4-413-415,421
[433] P2-365
[434] P2-365

Mental State Examination showed no abnormality.

Insight: Depressed now better with medication (which he wants to continue)

Impression: Well. Diagnosis Depression with psychotic features now in remission. Risk to self/others reduced.

Plan:

1 Leave until Monday pm *(24/03/03)*
2 Sign of (sic) Section[435]
3 Not happy to go to Finsbury ward – leave on "PICU books".
3 Medication from PICU
4 Return if becomes more depressed.

PSY1 completed a section 23 MHA discharge form ending PT's detention under section 3.

24/03 (Mon) Entry by PSY1[436]
CPA meeting held.

PT arrived late, but was well. He was still taking escitalopram 10mg

Plan:

1 See CPA form[437]
2 Re-refer to day Hospital (discussed with M4)
3 Review by PSY5 Tuesday (?25th)
4 Refer to CMHT
5 Leave until 25/3 Tuesday pm.

Contingency plan was:

Contact PSY5 for an early outpatient appointment.

In Risk Management Plan, completed by PYS1[438], steps to be taken if patient fails to attend or meet other commitments:

'RMO to contact carer/relatives by telephone'.

Action to be taken in the event of relapse /increased risk:

1 Contact PSY5
2 Out of hours: Emergency Reception Centre St Ann's Hospital

This is the last day PT was seen by any of the professionals.

31/03 (Mon) Ward Round with PSY1, DR4 and a staff nurse.[439]

[435] P2-316
[436] P2-367
[437] P2-326-329, P2-324
[438] P2324

Due for ward review. Didn't attend. Presently informal.

Plan:

1 Consultant to contact PSY5
2 Refer to forensic psychiatrists.

Letter from PYS2 (forensic opinion) typed[440].

Letter sent to PT's home address from Day Hospital Manager, M4, confirming appointment on 03/04/03 at 1pm.[441]

03/04 (Thur) Entry by DR4.[442]

Patient has already been referred for a forensic opinion on 31st Jan 03.

Pt was meant to have attended the Day Hospital but did not. Letter sent from Day Hospital to PSY1 on the same day (stamped received 08/04/03).[443]

04/04 (Fri) Entry by PSY1[444]

DNA outpatient appointment with Day Hospital.

Action.

Invite for Tuesday 12.00 8/4/03

If DNA refer to duty team at Canning Crescent.

08/04 (Tues) Planned meeting did not take place as neither PT or his family attended. No community workers present either. PSY1 recalls discussing the case with PYS5[445].

21/04 (Mon) Forensic opinion received in post from PSY2[446]

29/05 (Thur) Ward Round.[447]

PT still not referred to CMHT. PSY1 stated that he had asked DR4 to write a discharge summary (as he had done 3 weeks earlier) and refer to 'Canning Crescent CMHT'.

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[439] P2-368, P2-103
[440] P2-377
[441] P2-398
[442] P2-368
[443] P2 397
[444] P2-368
[445] P2-103
[446] P2-377
[447] P2-103, P2-369

PSY5 stated in a letter to the SUI Investigation[448] that she had 'a note in my diary for 29th May 2003 to meet PYS2 at 1.30pm' but was unclear if they actually met on that day. She recalled that PT wasn't on the ward and PSY2 didn't feel he was liable to be detained under the MHA so the plan was to discharge him. She advised how to refer PT to the Wood Green Sector Team. After this, 'it could be arranged for two members of the team, probably including one of the doctors, to visit him at home and assess the situation.'

03/06 (Tues) Entry written and signed by PSY1[449]

No referral letter
No discharge summary?? (sic)

16/06 (Mon) Psychology appointment.[450] PT did not attend.

17/06 (Tues) Entry written and signed by PSY1[451]

Dictated (presumably the discharge letter).

18/06 (Wed) Discharge summary typed[452]

Confirms PT was discharged on 17/06/03 and the plan was to continue Escitalopram 10mg a day.

16/07 (Wed) Referral form completed by PSY2[453] and sent by post.

25/07 (Fri) Referral to Wood Green CMHT recorded at 10am.[454]

30/07 (Wed) PT's referral was discussed at the weekly Wood Green team meeting.[455] Action stated as: 'DR1 and N2 *(CPN)* to assess on 15/8/03 at 10.30am and PSYO1 to see if he attended his Psychology appointment'.

Letter to PT at his home address from N2, Wood Green CMHT stating that he and DR1 will visit his home on 15/08 at 2.30pm.[456]

13/08 (Wed) Wood Green CMHT referrals meeting.[457] Action stated as: 'DR1 and N2 assessed on 15/8/03 and PSYO1 written to client but has received no reply so will probably close case'. This is inaccurate, as PT was not visited until 2 days later.

[448] P2-94
[449] P2-369
[450] P2-86
[451] P2-369
[452] P2-373
[453] P2-434, 434a
[454] P2-433, P2-434, 434a
[455] P2-83, 91-92
[456] P2-431
[457] P2-89-90

15/08 (Fri) Entry in file by N2[458]. DV with DR1, there was no reply-appears no one present at the house. He stated that he had made several telephone calls to the house prior to the visit and got no reply. Left note at the house requesting PT to contact him or DR1 at CCC (Canning Crescent Centre).

20/08 (Wed) Wood Green CMHT referrals meeting feedback was that DR1 and N2 had visited PT's home but he was not there. It was decided that DR1 would offer an outpatient appointment (OPA).[459]

27/08 (Wed) Further entry by N2.[460] No response from PT. N2 checked with GP and found there had been no contact since 13/02/02. Discussed at the Wood Green referral meeting on this date and decided to offer OPA with DR1 and 'if no response – then close the case'. He also wrote that PT had been offered an appointment with the team's psychologist (PSYO1) but no reply had been received.

M3 states the case was closed on this date[461]. M2 concurs, stating an OPA had been booked for 24/10/03[462].

02/09 (Tue) Letter sent to PT's home address by OS1, Outpatient Secretary at the CCC, offering OPA at 9.30am on 24/10 with DR13, SHO[463].

22/10/(Wed) Psychotherapy department closed the file due to lack of contact[464].

24/10 (Fri) SHO clinic Canning Crescent[465]. Plan to 'rebook him another appointment in 3 months time'.

28/10 (Tue) Letter to PT from DR7 (locum SHO to PSY4) re failure to attend OPA . Explained that a further appointment would be made for 3 months time[466]. Also sent letter to GP[467].

16/04/04 (Fri) Record of referral to Wood Green CMHT at 12.00 noon.[468]

Records of meeting between PSY4, M2 (team leader) and PM1.[469]

M2 (AE) then completed a '24-Hour Report Serious and Untoward Incidents.'[470]

19/04 (Mon) PT assessed at Charing Cross police station by West End CMHT[471].

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[458] P2-432
[459] P2-88
[460] P2-432
[461] P2-83
[462] P2-88
[463] P2-389
[464] P2-112
[465] P2-369
[466] P2-390
[467] P2-391
[468] P2-423
[469] P2-417, 371
[470] P2-424-425
[471] P2-408-413

PT had been arrested the previous evening in Hyde Park. Personnel involved: Emergency Duty Team asked to conduct MHAA. **09.00** case passed to West End CMHT, SW5 (duty ASW). At **12.30** he asked N3 (police liaison nurse, WECMHT) to assess. At **17.30** she then asked SW6 (ASW South Westminster Out of Hours Service) to organise an assessment of whether PT was fit for interview. She attend police station at **20.00**. DR14 and DR15 (Section 12 MHA approved) joined the assessment, which was conducted at some time **prior to 22.45**. SW6 records sending assessment report to GP and CMHT.

PT remanded in custody and sent to ? HMP Wandsworth

21/04 (Wed) NP1 records that 'HD5 from the Director's Office took a copy of the file for the investigation..' and that 'M3 faxed copies of the Wood Green referral minutes where PT was discussed'.[472]

14/05 (Fri) SW6 (WECMHT) records sending assessment report to GP and CMHT.[473]

[472] P2-414
[473] P2-407

Annex 3 - Extract from evidence of M5

M5 was asked about screening a new referral such as PT's and he responded:

A. *It's screened initially within duty because a lot of the work that comes through duty might have imminent risk.*

Mr Harbour *Is it risk screened by a qualified member of staff as opposed to a clerical person?*
A. *No. The logging on is done by a clerical person and the screening is done by a community mental health nurse. Then it is signed off by the manager in duty and it will be posted to the appropriate START sub-team.*

Q. *Where would PT have been posted to?*
A. *To the START central team, based on our recollection of the GP and where it is aligned to.*

Q. *What would happen then?*
A. *It would be discussed within a multidisciplinary team and within the central team. They meet twice a week to talk about referrals.*

Q. *Let's assume for a minute then that this preliminary discussion of PT's case wouldn't have happened until Monday. Would it have been discussed on the Wednesday in the central team?*
A. *They meet for their referrals meeting on Tuesday and Thursday.*

Q. *What do you think would have followed from that discussion?*
A. *I referred earlier to the protocol about the interface between START and the support recovery teams, but with PT there was not a great deal of information and START would have looked at that and considered allocation to a worker to carry out some form of assessment. They would have discussed it and thought about gathering information.*

Q. *Is the purpose of that assessment to identify a care coordinator?*
A. *Yes. It's to think about what the patient will need in terms of ongoing care co-ordination needs perhaps for accommodation, structured day time activities and care as work. It would be a wide ranging assessment.*

Q. *Are you confident then that PT's case would have been allocated within a week of his admission?*
A. *Yes. The remit within the protocol is to allocate within five days and generally we are able to do that.*

Q. *Is that allocation of a care coordinator or simply allocation of somebody to assess?*
A. *In the first instance it would be to assess and gather information.*

Q. *Is there any target time for that?*
A. *For?*

Q. *For completing the assessment.*
A. *The local authority sets a target that we have to complete an assessment within 28 days. That is one of our targets.*

Q. *When do you think that PT would have been allocated a care coordinator?*
A. *I think it would be based on what comes out of the assessment. I guess what we need to do is think about engaging with the inpatient unit, attending review meetings and discussing it with them. What is the likely pathway for this person? What is the likely prognosis for how long that person will be in? We would try to allocate a care coordinator where we think there is something about beginning to form a relationship with them that will be trusting. That can pay dividends when they are eventually discharged. It would be quite a dynamic process about supervising the person who is gathering the information and doing the assessment. We would need to think about whether they need to be the care coordinator and get involved there and then. Perhaps not with PT, but with some other patients what we find is that if they are going to be in hospital for a long time you immediately know that they will need accommodation or some other complex care package. In START we would be thinking about whether the support recovery team would be a more appropriate place to seek an allocation of care coordinator in those circumstances.*

Q. *Are you reasonably confident that the care coordinator would have come out of the START team for PT?*
A. *Initially that is what we would try to do. We would be thinking about recovery models and how we can make an intervention in this man's life that perhaps could seek to support him and introduce some structure and psychological support that means he didn't have a long career in psychiatry.*

Q. *As you know, one of the dynamics in how PT's case was dealt with in 2003 was the reluctance of the community service to get involved in PT's case whilst he was in the ICU. You identified that dynamic in your report.*
A. *Yes.*

Q. *I'm just wondering, given the pathway that you've now described, whether you would still hit that particular problem.*
A. *Being physically in the same building has helped that communication. The START teams are all a lot more involved in the inpatient units. There are a lot more settings in which we engage with colleagues from the inpatient settings in terms of ward meetings and weekly bed management meetings. The START sub-teams are all managed by clinical practice specialists who engage with colleagues in the inpatient settings. For me it doesn't feel that there is the same distance that was tangible in the PT Canning Crescent situation. It feels that we are a lot closer, both physically and operationally.*

Q. *I can understand the physical proximity, but the problem still remains, does it not, which was that, as far as one can tell, "He's going to go to an open unit prior to going into the community. We don't get involved with patients in the ICU." In other words, that delay factor surely could exist today.*
A. *It was unusual about PT leaving from the PICU and I accept that. I also feel that we are more involved with the patients in the PICU than perhaps we were. Things like the borough wide Mental Health Act assessment service and the ASWs, who are also part of START and MDT going in and doing assessments helps make us closer. Because we are a short term assessment and recovery team that works with people up to six months, we are a lot*

faster at picking up referrals. The remit of START is to work with people for up to six months and therefore meeting twice a week for referral meetings and prioritising referrals so they are not sitting around is one of the strengths of this.

After some discussion about allocation of care coordinators M5 referred us to a protocol which states:

> "*Referrals for care coordination from inpatient units must be prioritised whether the care coordinator comes from START or the SRT and allocation of a care coordinator should be made within 5 days of receipt of referral. Care coordinators will be expected to attend discharge meetings and take responsibility for contact within 7 days of discharge from inpatient care.*"[474]

We then continued with the discussion focusing on the role of the care coordinator.

> ***Q.*** *Have you been able to monitor whether care coordinators are being appointed within that target time?*
> ***A.*** *We generally are able to do it, but often what happens in fact is that the clinical practice specialist – the team leader of the sub-team – will act as the care coordinator in some respects at times.*
>
> ***Q.*** *What does that mean?*
> ***A.*** *Sometimes it is about gathering information and thinking about the support and recovery team/START consideration or perhaps whether someone will go off to a forensic service or whether they are appropriately in St Ann's hospital. Sometimes the clinical practice specialist will act as a care coordinator while that information is being gathered.*
>
> ***Q.*** *So there is a named person?*
> ***A.*** *Yes, the named community person.*
>
> ***Q.*** *If you go back to how we know PT's case was dealt with when it was eventually referred to the community mental health team, as far as we can tell, the documentation, paperwork and records should have been considered, but the forensic assessment, the inpatient notes and discharge summaries were not considered at all. They were not looked at by anybody. That is the only rational explanation for how his case was dealt with in the community. I am wondering now, you have this body of material, who would be looking at it? Would it be this notional care coordinator?*
> ***A.*** *What is new since PT's time is RiO, which is the information system.*
>
> ***Q.*** *Yes.*
> ***A.*** *I think it has been helpful. For example, when we get the referral from the inpatient ward it is logged on RiO and open for the community from RiO. You will have two open records, one in the inpatient setting and one in the community so it is very easy to pinpoint when that referral has been made and the date and the practice specialist. Then you can look at the progress notes on RiO and at the nursing observations, the updates from the ward rounds, the clerking in assessment on RiO and add their own.*

[474] Protocol for Interface Between START and SRT's. January 2008 page 3

Q. *Would the CPA documentation be available?*
A. *The CPA documentation is generally summarised in "progress notes". That aspect of RiO is part of a future development, but it would be summarised within the progress notes. That has been an enhancement over the paperwork file and geographical issue.*

Q. *Looking at PT today, the referral is made to START; it's looked at in the referral meeting; according to your new protocol a care coordinator appointment should be made within five days of receipt. The care coordinator has access to information via a computerised system and that presumably would point the care coordinator to any early material that may not be on computer. Thinking about PT, would you expect there to be an early CPA meeting within the ICU. How would that work and how would your care coordinator link in with that?*
A. *I would have expected an early multidisciplinary meeting within the patient pathway and that would be something that I would expect the community START worker to go along to in order to help them think about the needs of the patient.*

Q. *You are taking care not to call your START worker a care coordinator. Is that right?*
A. *Yes.*

Q. *Who is the care coordinator?*
A. *It may be a care coordinator, but, as I mentioned earlier, it might be the clinical practice specialist in that role leading the team and thinking about this as a new piece of work. That is the senior person within the team and they might just lead with this sort of referral where, as we know, there was some worrying information about PT when he came in. That might be something that the clinical practice specialist might take on.*

Q. *In the early days the CPA documentation will be completed fairly rapidly, won't it?*
A. *It should be.*

Q. *While he's an inpatient?*
A. *Yes.*

Q. *Who would do that initial completion of CPA material?*
A. *The ward staff.*

Q. *Would that be the named nurse?*
A. *The named nurse within the inpatient unit.*

Q. *Within a seven day period there is space on the form to nominate a care coordinator. Could that be your clinical practice specialist?*
A. *It could be, yes.*

Q. *In other words, there is a decision-maker logged on.*
A. *Yes.*

Q. *As you know, because you saw the CPA documentation in PT's case, it was silent as to who was the care coordinator. There was never a care coordinator recorded.*

***DR8**: Where would that decision be made? After the referral had been made and you'd discussed it at a referrals meeting and decided who was going to look into PT's case, either on computer or physically going to the ICU to see him, would that have been brought back then to another referrals meeting for further discussion?*
***A**. Yes. They meet twice a week and part of that is to look at new referrals, but part is also clinical discussion about new work.*

***Q**. So if somebody had gone to see him and looked at the entries on RiO and in the notes, they would have brought that back for more discussion?*
***A**. They would, yes.*

***Q**. Would it always be the person who had initially gone to assess him that would then be allocated to PT?*
***A**. No.*

***Q**. Or could it be that one person goes onto the ward, finds the information, brings it back to a referral meeting and then somebody else is asked to take PT on from there?*
***A**. Generally it would be the same person, but I made the distinction that the clinical practice specialist might be the person who does that initial gathering, scrutinising and considering because of the nature of PT. He was worrying from the very beginning and once the clinical practice specialist had scrutinised it, I would expect them to allocate it to one of their staff within the START sub-team. That is when it would be a different person.*

***Q**. Theoretically then, before the referral to START happens, the interim care coordinator would be the primary nurse on the ward?*
***A**. Yes.*

***Q**. Then, when the referral is made and somebody goes from START to do further assessment, do they become the interim care coordinator or does it stay with the primary nurse?*
***A**. In terms of the continuity of care coordinator that is what you are asking.*

***Q**. I was just thinking that three people might be a care coordinator within a very short time - the primary nurse, the first person from START and then another named person from START.*
***A**. Yes. My feelings about that question are that whilst the clinical practice specialist might be gathering information, they would be the named community worker, but I would expect the named nurse to carry on doing what they are doing.*

***Q**. After it had been further discussed within your referrals meeting and a person had been allocated to continue the work with PT, would they then be the care coordinator?*
***A**. They would, yes.*

***Q**. Do you think that inpatient staff are clear on that? The primary nurse needs to know when they have handed over the mantle.*
***A**. Yes. Can you clarify that question?*

Q. *Yes. If I was a nurse on the ICU, would I be clear when my responsibility as care coordinator ended after I had made a referral to START?*

A. *What responsibilities?*

Q. *Organising CPA meetings, finding information out from family or maybe other sources.*

A. *There is a partnership that goes on between the care coordinator and the named nurse throughout the patient pathway and certainly working with families and organising meetings has to be done in partnership. It isn't just the care coordinator who does that or just the named nurse; they have to work together. It isn't just about one person.*

Annex 4 - List of interviewees

Name	Position	Date(s) interviewed
HDSI1	Assistant Director Inpatient Services Haringey Mental Health Services	15 July 2008
HD2	Interim Director Haringey Mental Health Services	30 May 2008
DB	SB's wife	23 May 2008
DO1	Interim Director of Nursing and Clinical Governance	15 July 2008
HD3	Director Haringey Mental Health Services	30 June 2008
M2	CMHT nurse team leader, Wood Green	6 May 2008
DR1	Consultant Psychiatrist Dual Diagnosis, Haringey Mental Health Services	15 July 2008
M1	Ward Manager Haringey ward (PICU)	7 July 2008
PSY2	Associate Medical Director/ Consultant Forensic Psychiatrist	28 April 2008
HDIS2	Assistant Director of Inpatient services Haringey Mental Health Services	2 May 2008
DN2	Director of Nursing	30 May 2008
N1	Staff Nurse Psychiatric Intensive Care Unit, Haringey Mental Health Services	11 April 2008
N2	Community Psychiatric Nurse Wood Green CMHT	30 May 2008
HCO1	Head of Clinical Audit	15 July 2008
PSY1	Associate Medical Director/ Consultant Psychiatrist	28 April 2008 2 May 2008
PSY5	Associate Medical Director/ Consultant Psychiatrist, Central Support and Recovery Team	2 May 2008
HD1	Assistant Director Community Services Haringey Mental Health Services	30 June 2008
M8	Corporate MHA Manager	30 May 2008

M6	PICU Manager/Lead Nurse Haringey Mental Health Services	6 May 2008
M3	Wood Green CMHT manager	30 June 2008
M5	Service Manager START/SU report author	31 March 2008 25 July 2008

Annex 5 - List of documentation reviewed

Abuse Protection Policies

Addendum to psychiatric report by PSY10

Analysis of Action Plans LH, IC, PT

Broadmoor psychiatric reports

Care Programme Approach Policy Dec 03

Care Programme Approach Policy Nov 05

Client Confidentiality and Shared Record Keeping policy

Clinical Risk Assessment and Management Policy: Mental Health

Clinical services improvement group action plans

Clinical Strategy 2008

Cluster Analysis – work taken forward by suicide audit committee (HCO1)

Complaints and Medication Policy and Procedure

Coroner's report

Disciplinary Policy and Procedure

GP records

Guidelines for referring to CATT for Early Discharge

Haringey Ward Policies and Procedures
Operational Policy (01/99)
Ground Leave policy (01/99)
Sec 17 Policy (01/99)
Missing Patient Policy (01/99)

Haringley Mental Health Services

Health and Social Care List of Policies and Procedures

High level SUI meeting IC, ID, PT and TJ matrix action plan

Hornsey/Highgate and Wood Green Duty Service Operational Policy

Incident Management Policy

Inter Agency Sharing Of Information

Joint CPA Policy (March 1996)

Joint protocol for identification and investigation of SUIs

Language and interpretation services within Hariney

Level one SUI management policy

Observation Policy

Operational Policies

Policy For Consent To Examination Or Treatment

Psychiatric report for PT by PSY10

Research mental medical history of PT

Section 17 MHA Leave Of Absence Policy

Service level of agreements North London Forensic Service

Annex 6 - An analysis of common issues and areas of concern arising from the PT, ID and AP investigations.

1. Introduction

1.1 Three independent investigations were commissioned by NHS London (the SHA) into the care and treatment of three patients all of whom committed homicides:

AP killed KZ on 19 October 2003 and MG on 20 October 2003;

PT killed SB on 15 April 2004; and

ID killed EM on 23 December 2004. (He also seriously injured five other members of the public on the same date.)

1.2 A factor common to these investigations was the involvement of Barnet Enfield and Haringey Mental Health Trust (the trust) and the Haringey Teaching Primary Care Trust (HTPCT) in the care and treatment of the three patients. AP also received care and treatment from another London mental health trust and GP practice unconnected with the HTPCT.

1.3 The terms of reference of all three investigations included a requirement that the investigation teams work closely to allow the identification of common trust-wide themes and issues and the purpose of these recommendations is to help ensure future best practice in the provision of mental health care.

1.4 Although the purpose of this paper is to identify common themes the particular circumstances of each case was very different. For example:

ID had four brief admissions to psychiatric hospital between 2000 and 2001. Following his discharge in 2002 he had intermittent contact with mental health services, and his GP, until October 2004 when his mental health began to deteriorate. From October onward his parents unsuccessfully sought help for their son, from both the CMHT and GP.

PT had had no prior contact with mental health services until he was detained under the Mental Health Act (MHA) in January 2003. He was then treated in an intensive care unit, under section, for two months when he was discharged into the

community without adequate follow up by mental health services. His case was closed in August 2003 to the CMHT, and he was given an outpatient appointment in October 2003.

AP primarily received treatment for her mental illness from her GP. She had contact, briefly, with secondary mental health services. In 2002 she was assessed by a CMHT. In March 2003 she had an overnight stay in the A&E department at North Middlesex hospital and an overnight admission to Stonelea Hospital (North East London Mental Health Trust) the same month.

2. Chronological summaries

2.1 In-patient mental health care and treatment

	ID	PT	AP
	St Ann's Hospital (Barnet Enfield and Haringey Mental Health Trust)	St Ann's Hospital (Barnet Enfield and Haringey Mental Health Trust)	Stonelea Hospital
2000	Two admissions in June and July. On both occasions ID did not stay for any longer than one night in hospital and was treated as an 'informal patient', in other words the MHA was not used.		
2001	From 20 May 2001 until 29 May 2001 ID was detained under section 2 MHA. On 5 November 2001 ID was admitted under section 4 MHA and was discharged on 6 November 2001.		
2003		From 17 January 2003 until 21 March 2003 PT was detained under the MHA: first on a section 4, then on a section 2 and finally on a section 3.	
			On 20 March 2003 AP was admitted under section 136 MHA and was discharged on 21 March 2003.**

** On 13 March 2003 AP was assessed at A&E at North Middlesex Hospital and seen by a mental health liaison nurse.

2.2 Outpatient mental health care and treatment

	ID	**PT**	**AP**
2000	Following ID's discharge from hospital in June he was seen by a CPN at home and referred to outpatients. He was seen in outpatients in July. He was reviewed in August and October.		
2001	He did not attend out-patient appointments in February, March and July. He presented at outpatients in October and was seen in December.		
2002			
2003		He did not attend for an outpatient appointment on 24 October 2003	She did not attend an outpatient appointment at Chase Farm Hospital on 28 March or 23 May 2003.

2.3 Mental health services - community assessment and treatment

	ID	**PT**	**AP**
2000	Following his June in-patient admission ID was allocated a care co-ordinator. She visited his at home on a number of occasions in 2000.		
2001	One home visit took place in February and the care co-ordinator then discharged him from her caseload.		
2002			On 1 March 2002 AP was assessed by a duty worker and psychiatrist from West Norwood CMHT (South London and Maudsley NHS Trust)
2003	The care co-ordinator wrote to ID offering him an appointment which he did not keep.	PT was referred to the CMHT for assessment in July. An abortive assessment took place in August and his case was closed to the CMHT later that month.	
2004	In October (the homicide was in December) ID's		

	relatives requested assistance from the CMHT. No contact was made with ID.		

2.4 Primary Health Care involvement

	ID	**PT**	**AP**
General	ID had been registered with the same GP practice since 1992. He had contact with his GP until February 2004.	PT had been registered with the same GP practice for some years (date of registration is not known). He last had contact with his GP on 3 October 2001. The homicide occurred in April 2004.	
2000			
2001			Registered with GP in Herne Hill.
2002			Registered with GP in Palmers Green.
2003			AP consulted a locum GP at the Palmers Green practice three times between January and February 2003 and twice in April. There was no referral for psychiatric assessment.
2004	His last contact with his GP was on 10 February 2004. His family collected anti-psychotic medication from the practice in March, April, June and October. On 30 November his parents went to see his GP following advice from the CMHT.		

3. Common themes

Use of the Mental Health Act (MHA)

3.1 The MHA was properly used to provide a statutory framework for the assessment and treatment of PT. When it came to granting him section 17 leave, and then discharging him from section, mistakes were made. His statutory entitlement to aftercare was ignored. These mistakes contributed to PT being

discharged from hospital without any proper risk assessment and without any proper community plan being formulated.[475]

3.2 In the ID case two admissions under the MHA took place, however it appears that ID's clinical team did not take advantage of the opportunities that the act afforded. ID was not appropriately assessed and when a section 3 was indicated no action was taken to assess him prior to his discharge. This was unfortunate as the plan to manage ID in the community was not implemented. His proposed management under the CPA did not take place and ID slipped through the safety net of care.

Engagement with the patient's families

3.3 AP did not live with her family.

3.4 Although PT's family were seen on a number of occasions when PT was an in-patient his domestic circumstances were never properly understood.[476] This meant that an effective risk management plan was never developed following his return to his parent's home.

3.5 During ID's contact with mental health services in Haringey no concerted effort was made to develop an enduring therapeutic relationship with either him or his family.[477] Linked to this is the trust's failure to comply with its obligations[478] to provide an assessment, and care plan, to both PT and ID's families.

Risk assessment

3.6 There is a need to distinguish between the dynamic process of risk assessment and management which will be developed in the case of all patients receiving in-patient treatment for mental disorder and the 'static' formal processes that will be followed where patients are eligible for the CPA.

[475] PT report para 8.41
[476] PT report para 4.80
[477] ID report p120
[478] Disabled Persons (Services, Consultation and Representation) Act 1986 and the Carers Recognition and Services) Act 1995. NSF Standard 6 Caring about Carers National Service Framework for Mental Health DofH 1999

3.7 In relation to the former the risk assessments that were developed in ID's case were not 'always coherent or complete'[479]. For example although aware of his past criminal record and violent outbursts, the clinical team did not take these factors into account in accurately assessing risk.

3.8 When AP was assessed by the West Norwood CMHT (part of the South London and Maudsley NHS Trust) in 2002 indicators of high risk were not identified resulting in no further intervention and follow up.[480]

3.9 At the point of admission to hospital the risk that PT posed to himself and others was accurately identified. By the time of his absconsion from hospital some two months later there was no change in the risk assessment to allow a management plan to be developed.

CPA policy and process

3.10 The CPA had no application to AP[481].

3.11 ID and PT were regarded as eligible for enhanced CPA. From 2000 to 2003, the period that both ID and PT had (or should have had) significant contact with community mental health services, it was uncertain as to which CPA policy the trust regarded as operational. The policy that was likely to have covered the period when both PT and ID were receiving care and treatment in the community cited that the purpose of CPA was to ensure 'that all individuals are properly assessed, and that no-one who is vulnerable slips through the safety net of care.'[482] This involved providing, for each eligible individual:

an assessment of health and social care needs;
an appropriate and agreed plan of care;
an identified care coordinator; and
regular monitoring and review.

[479] Page 74 ID
[480] Para C29 AP
[481] AP para 3.19
[482] Mental Health Services 1996 Joint Care programme Approach policy para 1.2

Organisation issues

3.12 AP had little contact with secondary or specialist mental health services and so the fault lines identified in the PT and ID investigations were not apparent in the AP case.

3.13 Both the PT and ID investigations identify system weaknesses. 'There was a significant systems failure in that a disjointed tripartite system was operating whereby inpatients services, outpatient services and community mental health teams operated separately'[483] This comment, taken from the ID report, could equally be applied to the PT case. The particular weakness in the PT case was identified to be the absence of linkage between the PICU and the community.[484]

Leadership and management issues

3.14 The PT report identified two particular issues: the failure to provide proper support to PT's Responsible Medical Officer and the failure to address fragmented professional responsibilities.

3.15 The ID report refers to 'disjointed leadership and management systems.'[485]

Shortcomings in assessments

3.16 In March 2002 AP should have been further assessed and followed up following a brief interview with the CMHT.[486]

3.17 In August 2000 ID was discharged from hospital without a home visit taking place and an assessment being made.

3.18 In March 2003 following PT's absconsion he was discharged from section without a home visit taking place and an assessment being made.

Continuing monitoring of patient care

[483] Page 87 ID
[484] Para 15.7 PT
[485] Page 117 ID
[486] Para 3.22 AP

3.19 In all three cases it is likely that untreated mental illness led to the homicides being committed. It follows that if the patients had been monitored, and their illnesses had been treated, then the risk of homicide would have been reduced.[487] Effective care co-ordination, particularly in the case of PT and ID, could have reduced this risk.

Clinical record keeping

3.20 The ID report is very critical of the quality of the content of clinical records, particularly CMHT nursing records.[488]

3.21 The PT investigators did not have access to in-patient nursing records as they had been lost.

Communication between the trust, the police and the CPS

3.22 The ID report comments on poor communication between the trust and the police regarding ID's forensic history 'especially with regard to his previous convictions for actual bodily harm and criminal damage'.[489] ID's inpatient records record various issues regarding pending court cases. ID was also admitted on two occasions to the ward under police escort following violent and disorderly behaviour. However the clinical team did not take this information into account in planning ID's long term treatment and care needs and any risk that he may have posed to both himself and to other people.

3.23 In the PT case the investigators identified that the absence of liaison between the clinical team and the CPS about the withdrawal of a criminal charge against PT was a lost opportunity and could have significantly altered his future management and care.[490]

The conduct of post-incident investigations

3.24 The findings of the internal inquiry in the PT case were neither accurate nor reliable.[491]

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[487] Para 3.26 AP and para 9.22 PT
[488] Page 101 ID
[489] Page 102 ID
[490] Para 10.4 PT
[491] Page 130 PT

3.25 In the AP case the internal investigation was conducted by Haringey TPCT. The management of the investigation, in particular in relation to delay was criticised and the delay in starting the investigation was unacceptable.[492]

3.26 Both the AP and the PT report are critical of the action plans that emerged from these post-incident investigations.[493]

Care and treatment in primary health care services

3.27 The involvement of primary health care was different in each case. Prior to the homicide in 2004 the last time PT saw his general practitioner was on 3 October 2001[494]. However both ID and AP had extensive contact with their general practitioners.

3.28 In the case of ID it was considered that the GP practice had acted appropriately given both national and local practice guidelines in operation at the time. It has to be noted that changes in secondary care mental health provision can have a direct impact on the services provided in primary care. The withdrawal of practice-based CPNs to the GP practice in 2003, coupled with the poor CPA that ID received contributed to the failure of ID's care in the community.

3.29 AP received timely and appropriate care whilst registered with a GP practice in 2001-2002.[495] She then changed practice. It was then that the GP's management of her depressive illness fell short of acceptable practice as defined in paragraphs 2 and 3 of the General Medical Council's (then current) Good Medical Practice guidance 2001[496]. She also saw a locum who failed to refer her for a formal psychiatric assessment in early 2003. 'This was a crucial missed opportunity.'[497]

4. Conclusions

[492] Para 3.7 AP
[493] Para 3.12 AP. 'The initial action plan in 2006 was of poor quality.' Compare this with the PT report 'The panel inquiry report was neither accurate nor reliable…the recommendations…were too general and lacked focus.' Page 134 PT report.
[494] Para 6.21 PT
[495] Para 3.13 AP
[496] Para 3.15 AP
[497] Para 3.19 AP

4.1 Despite the differences between the subject matter of the three investigations a number of conclusions can be drawn.

Compliance with statutory frameworks

4.2 The statutory frameworks that had application in all three cases were not fully understood and this led to shortcomings in the care and treatment provided to all three patients; and in the ID and PT case their carers.

4.3 The MHA was used in both the ID and PT cases. In both cases (PT in 2003 and ID in 2004) the MHA could have been utilised more effectively. If it had been then both patients would have been subject to greater control both within the hospital and, following their discharge, in the community. The distinction between the nature and degree of mental disorder was not properly understood; in the PT case resulting in premature discharge and in the AP case resulting in failure to use section 2.

4.4 The domestic circumstances of PT and ID were different. Both lived with their parents, however PT's parents were absent from the UK for a number of months in the year whilst ID lived all the time with his parents. That notwithstanding, regular contact with both PT's and ID's parents would have contributed to the development and delivery of an effective care and treatment plan. Both PT and ID's parents were also entitled to an assessment of their needs which never took place.

The Care Programme Approach

4.5 The CPA, the framework for the assessment, management and treatment of mental health cases in the community, was inadequately complied with in the ID and PT cases.

4.6 The failures in risk assessment were various. Risk indicators were missed in all three cases. In the ID and PT cases there was a failure to modify the risk assessments to take into account changing circumstances which would have informed the management of the cases when the patients left hospital.

4.7 The CPA policy was not followed in the cases of PT and ID. The purpose of CPA planning, as set out in the trust policy that was operational at the time, was not met in either case.

4.8 The flaws in the operation of the CPA included: inadequate risk assessments of both PT and ID, failure to arrange for the carers of PT and ID to be assessed, failure to formulate an adequate care plan and then to regularly review that care plan, and in PT's case, failure to appoint a care co-ordinator. Other failures occurred in both ID and PT's cases in the context of inadequate discharge planning and case closure. In ID's case a component of the failure within the CPA process was the failure of the nominated care co-ordinator to fulfil their role. In PT's case a care co-ordinator was never appointed.

Organisation issues

4.9 Linkages and clear communication between in-patient psychiatric services and community mental health services was partial and incomplete.

4.10 Flaws in the internal investigations that followed all three incidents will have hampered the organisations involved in learning lessons from the post-incident analysis.

4.11 Record keeping was inadequate and the loss of records demonstrated significant system failures.

5. Joint recommendations

5.1 It appears that the trust and the PCT have accepted the findings of each investigation team and their recommendations. It is recommended that the trust and HTPCT prepare a joint action plan grouping the recommendations of the individual investigation teams into categories. This joint action plan should then be subject to a process of speedy review that will satisfy the SHA as to progress in each area of common concern.

Annex 7 - Recommendations listed in report

R1 The current system of offering outpatient appointments should be thoroughly scrutinised through audit. Appointments should be made and letters of confirmation should be sent to all patients offered outpatient appointments. *(Page 65*)

R2 The current trust non-attendance policy should be critically reviewed in the light of our findings. The trust should ensure that, where necessary, it is strengthened to ensure non-attendance is discussed with a named senior clinician and that nominated individuals are identified to carry out the agreed action plan which should be compatible with the risk management plan. *(Page 65)*

R3 The trust should establish a database (or modify existing databases) of all patients who are entitled to section 117 MHA aftercare. The database should contain or link with details of CPA aftercare plans as well as risk assessment and risk management information. One of the purposes of such a database would be to ensure that section 117 MHA/CPA activity can be routinely scrutinised. *(Page 104)*

R4 The trust work with the Metropolitan Police Service and the Crown Prosecution Service to develop protocols to facilitate senior clinical input into decisions to grant bail and decisions to withdraw criminal charges in cases involving mentally disordered offenders. *(Page 116)*

R5 Following consultation with M5 the recommendations contained in his SUI investigation management report are updated, reviewed and added to any action plan that follows our investigation. *(Page 125)*

R6 JSIG should be involved in implementing the action plan stemming from the recommendations contained in this report. *(Page 130)*

R7 The trust reviews its SUI policy to ensure that the loss of any patient's health records is treated as an SUI. *(Page 132)*

R8 The trust immediately reviews the way in which all records (both electronic and paper) are secured following the occurrence of any serious incident to ensure there is no recurrence of the loss of vital clinical information. *(Page 132)*

R9 Prior to establishing a board level inquiry the trust should always take into account the likelihood of an independent investigation taking place under the terms of HSG(94)27 and should review the scope of the SUI policy accordingly. *(Page 149)*

R10 The trust reviews the management and organisation of all SUI reviews and board level inquiries to ensure adequate provision of time and appropriate staffing. This review process should consider how the trust can best learn from the reviews and implement their recommendations. *(Page 149)*

R11 Until a fully integrated electronic information system is available protocols should be developed to provide guidance as to the documentation that should be reviewed in all CPA cases at the time of allocation, review, transfer and closure. *(Page 150)*

R12 The 2008 CPA policy is reviewed and amended to take into account the problems that we have identified in the PT case and to ensure that policy is compatible with all other relevant trust policies and protocols. *(Page 152)*

R13 To further evaluate the operation of the CPA the trust should consider the development of:

a. A rolling programme of inpatient and community team inspections to assess the quality of risk assessments and risk management plans. Results should be fed back to the teams, be compared over time and should guide the trust's training programmes.

b. Educational supervision for junior doctors and clinical supervision of other professional groups which should include regular detailed consideration of the accuracy and quality of a sample of risk assessments and risk management plans prepared by the supervisee. *(Page 154)*

R14 If a person previously unknown to mental health services is admitted to the PICU and then leaves the unit and immediately returns to the community without being allocated a care coordinator this should be treated as a SUI. *(Page 160)*

R15 A system to allow managerial oversight of referrals to community teams is developed, which will not introduce a delay in such referrals being considered by the team, but will ensure consistency in the adequacy of information available. *(Page 161)*

R16 There should be a target time for all new referrals of previously unknown patients from inpatient settings to START. *(Page 161)*

R17 A care coordinator should be allocated within five days of receipt of referral unless there is a disagreement about the patient's CPA eligibility. If there is disagreement that disagreement must be resolved by nominated management staff within a defined short timeframe. The primary nurse will maintain ongoing responsibility for the patient's care coordination until a care co-ordinator has been allocated. *(Page 163)*

R18 Where the patient is receiving inpatient treatment, and prior to referral to the START team and allocation of a care coordinator, the CPA responsibility of the named (or primary) nurse must be clarified. *(Page 163)*

R19 CPA audit processes should include an evaluation of the frequency of carers assessments offered and provided in relation to the number of carers entitled. *(Page 163)*

R20 The 2008 CPA policy is revised to include a requirement that a comprehensive risk assessment is undertaken by the care coordinator prior to the decision to close the case of any person subject to CPA. (*Page 164)*