An investigation into the care and treatment of service user Y

February 2012

A report for NHS London
Undertaken by Verita

NHS London

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1. Introduction, approach and structure

1.1 Y, a patient receiving care and treatment from North East London NHS Foundation trust, killed his mother, X, on 30 June 2008. X was also a patient with the trust. Y was in regular contact with the Trust from 1989 and with the borough CMHT in the period immediately before the incident.

1.2 X was found dead at home and Y was arrested on suspicion of her murder. The post-mortem examination was inconclusive. He was not charged with the killing immediately but was admitted informally to hospital. He was eventually arrested and pleaded guilty to manslaughter on grounds of diminished responsibility. He was placed on section 37/41 of the Mental Health Act for an indefinite period, and was sent to a secure psychiatric unit.

1.3 The terms of reference for this investigation do not cover the care given to Y's mother, X, but because she was also receiving care from the trust and because Y was for most of the time living with his mother we have had to address some matters relating to her care.

1.4 As normal practice we sought to interview Y at the beginning of the investigation but were unable to locate him. During the course of this investigation Y was moved to a new unit and we were able to contact and interview him before the report was finalised.

1.5 Y reviewed the report and has made a small number of comments that relate to his disagreement about the risks that he posed and his denial that he held his mother hostage. At this distance from the events that Y disputes it is not possible to make an accurate judgement on the disputed facts. We have therefore added Y's views into sections 4 and 6 of the report at the relevant points. The executive summary does not identify the particular points of disagreement that Y has with the facts as set out in the records.

1.6 The investigation team (referred to from now on in this report as 'we') comprised of Tariq Hussain, Dr Rosalind Ramsay and Ms Emily Ewart. Biographies of the team are included in appendix C.

1.7 We examined documentary evidence including policies and procedures from the trust, Y's clinical records and the internal investigation report. A list of documents reviewed is included at appendix A.

1.8 We conducted interviews with a range of staff. A list of those interviewed is included in appendix B. These interviews included the following:

- clinicians involved with X and Y
- community team managers for both X and Y's teams
- senior trust managers.

We also received written evidence from Y's inpatient consultant psychiatrist.

1.9 We followed established good practice in conducting interviews. The interviewees were given the opportunity of being accompanied by a representative or a friend at their interview. They were provided with the opportunity to comment on the factual accuracy of the interview transcript.

1.10 The trust was given the opportunity to comment on the draft report and to provide an update on changes made to services in the light of its own internal review.

2. Terms of reference

Commissioner

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

Terms of reference

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

- a review of the trust's internal investigation to assess the adequacy of its findings, recommendations and action plans;
- reviewing the progress made by the Trust in implementing the action plan from the internal investigations;
- involving Y and the family of Y as fully as is considered appropriate:
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident;
- an examination of the mental health services provided to Y and a review of the relevant documents;
- the extent to which Y's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies;
- the appropriateness and quality of assessments and care planning;
- considering the effectiveness of interagency working in particular safeguarding adult procedures and whether these were in place and carried out;
- considering other such matters as the public interest may require;
- completing an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assisting in the preparation of the report for publication.

3. Executive summary and recommendations

Incident summary

3.1 Y killed his mother, X, on 30 June 2008. At the time he was receiving care and treatment from North East London NHS Foundation trust. His mother was also a patient with the trust. Y was in regular contact with the Trust from 1989 and with the borough CMHT in the period immediately preceding the incident.

3.2 X was found dead at home and Y was arrested on suspicion of her murder. He was not charged with the killing immediately but was admitted informally to hospital. He was eventually arrested and pleaded guilty to manslaughter on the grounds of diminished responsibility. He was placed on section 37/41 of the Mental Health Act for an indefinite period, and was sent to a secure psychiatric unit.

Personal history

3.3 Y was born on 7 March 1964. He moved back to England from Australia when he was nine years old when his parents separated. His mother was diagnosed with schizophrenia and had many admissions to hospital.

3.4 Y finished school at 16 and then spent two years at home, never going out and becoming socially withdrawn. He attempted studies at two London universities in 1986 (two months) and 1988 (one year). The latter stopped when he became unwell and was admitted to Warley Hospital[1] for two weeks. In 1990 he went to Liverpool University to study English but dropped out after a year. Whilst a student there he began using illicit drugs.

3.5 Y has never been employed and lived with his mother for most of his life.

[1] Warley Hospital closed in 2001.

Admissions to hospital

3.6 Y's first contact with mental health services began in 1989 when he threatened to kill his mother. He subsequently had a number of admissions to hospital in 1993/94; 2001; 2006 and 2007. Some of these were compulsory admissions under sections of the Mental Health Act, others were informal admissions. His discharge from his last admission was on 24 May 2007.

Diagnosis

3.7 Y has been diagnosed with paranoid schizophrenia, schizoid personality disorder and personality disorder. During his 2007 admission his diagnosis was of persistent delusional disorder.

3.8 Over the years Y expressed concerns about his diagnosis and was particularly annoyed to be diagnosed as suffering from paranoid schizophrenia. He believed he was a "depressive" and always had been.

3.9 There were periods when Y was non-compliant with prescribed medication. For example, in July 2006 he told his psychiatrist that he had stopped all his medication two weeks previously. He then agreed to take oral medication and he was given a prescription for oral Clopixol, a typical antipsychotic medication which he stopped after one day.

Risk history

3.10 Y had an extensive risk history which included:

- attacking his mother
- verbal threats to kill his mother
- holding a doctor hostage with a knife
- physical threats to do harm and kill professionals
- carrying hammers and knives for protection.[1]

[1] Y has disputed some elements of the risks he posed as set out in the records we have added his views into sections 4 and 6 of the report at the relevant points.

Care Programme Approach (CPA)

3.11 Y was assessed as requiring the enhanced CPA level of care. He was initially cared for by the Hornchurch CMHT and then in March 2006 was transferred to the care of the Romford CMHT until 2007. He then was transferred back to Hornchurch CMHT when he returned to live with his mother.

Accommodation

3.12 For most of the period between 1989 -2008 Y lived with his mother. He was often ambiguous about moving away from his mother, sometimes requesting a move and at other times resisting any attempts to assist him to do so. He did move into a flat for a short period in 2006 but then gave up his tenancy and moved back with his mother. At other times professionals caring for him sought to get Y to move into supported accommodation which he was unwilling to do.

Care during 2007 – 2008

Introduction

3.13 The years 2007 and 2008 are important as they include Y's last admission to hospital when he was compulsorily admitted.

Admission to hospital

3.14 On 18 March 2007, Y held his mother hostage and waved a knife at police. He was admitted to hospital under Mental Health Act (MHA) section 2 with a diagnosis of Persistent Delusional Disorder.

3.15 A mental health review tribunal held on 27 March 2007, considered Y's application to have his section lifted. The tribunal was satisfied it was necessary for the section to remain in place for the protection of others and refused the application. The tribunal concluded that Y had an ongoing disorder with paranoid characteristics which *"became destabilised in 2006."*

3.16 The tribunal also recognised that events leading to his admission occurred at a time when, despite his continuing to take medication, there had been a number of circumstances in his life which had been disruptive. These included moving back to live with his mother, increasing responsibility for caring for his mother and the stressful circumstances of his immediate neighbourhood.

3.17 A ward round took place on 17 May 2007 and Dr W (Y's inpatient consultant) wrote in Y's notes:

> *"We identified that social isolation is a big concern for him and advised that a support worker be allocated to him and for him to be referred to MIND. Y's care coordinator has also now left the CMHT and he will need reallocation within the team. It is up to the CMHT to decide whether they can manage Y in future or whether he should be referred to the Assertive Outreach Team".*

3.18 One of the recommendations from the ward round on 17 May was that Y would need to be allocated a new care coordinator because his had just left.

3.19 A CPA discharge meeting took place on 24 May 2007. Y was described as being fine, not having any paranoid ideas or expressing any ideations of self harm and he was discharged from hospital. The discharge plan was as follows:

- community psychiatric nurse (CPN) follow up
- follow up with psychiatrist 6-8 weeks time
- referred to outreach team
- referred to MIND
- supported living accommodation.

The forensic Report

3.20 During this last admission Y was referred for a forensic assessment which was carried out and it identified some key issues about his care.

3.21 The psychiatrist who carried out this assessment wrote to Dr W. The letter was dated 29 May 2007, five days after Y had been discharged. The letter said that Y would benefit from:

- supported living accommodation (rationale - Y was preoccupied with accommodation and if he relapsed – this could be observed quickly and a low threshold for assessment could take place)

- a regular community psychiatric nurse (as opposed to being managed on duty[1] so that a therapeutic relationship with a key worker can be developed)

- psychological therapy exploring his violent thoughts and actions and dependency on his mother.

3.22 The forensic assessment concluded that if Y's mental state deteriorated, an urgent referral for assessment should take place because Y might be a risk to others.

3.23 Following contact from us Dr W who commissioned the forensic assessment checked the medical files and community files. In correspondence to us he told us that the CMHT were aware of the commissioning of the assessment and had been faxed a copy of the original report.

3.24 The forensic opinion provides a comprehensive summary of Y's mental health history and sets out clear risk indicators and advice on clinical management. The report was dated just a few days after Y left hospital. We have seen no evidence that on receipt of the forensic report that the CMHT reviewed Y's risk assessment or his risk management plans.

[1] A service user was held on duty when their allocated professional was on leave, sick or if they had left while a new person was assigned. The person covering duty was part of the team who would share the role as part of a duty rota.

Care by Hornchurch CMHT following discharge

3.25 One of the recommendations from the ward round on 17 May, a few days prior to Y's discharge, was that Y be allocated a new care coordinator because his had just left. This did not occur until almost eight months later.

3.26 The appointment of the new coordinator only seems to have happened because Y asked the CMHT in January 2008 *"…whether he had a care coordinator yet…"* It would appear that Y's prompting led the CMHT to make an allocation.

3.27 Even though a care coordinator had not been allocated, Y was being visited regularly by nurses who were administering his fortnightly depot injections. During these times Y's clinical notes show that his mental state was also being assessed at the same time as the injections were being given.

3.28 The fact that Y was being visited regularly by nurses does not reduce the need for a care coordinator. Care coordinators are important because they oversee the assessment process, care planning and resource allocation. They keep in close contact with the service user and advise the other members of the care team of any changes that may be needed to the care plan. The delay in allocating a care coordinator was a serious failure in care.

3.29 From January 2008 to June 2008 when the homicide occurred, there were regular visits to give Y his depot injection and CPA reviews were held with Y in February, March, April and May 2008. Y did not attend the meetings in March and April. He was present at the meeting in May 2008 which was held at his home. We have no concerns about compliance with CPA review policy by his care team, other than the failure to review his risk following receipt of the forensic report.

Care given in June 2008

3.30 There were phone calls on the 2 and 16 June from Y to his care coordinator and the CMHT duty worker letting them know that his mother's mental health had deteriorated and that he did not want to continue to care for her. At the beginning of June Y's care coordinator left the service. As a result Y was again cared for by a combination of visits

from a nurse to give him his depot injection with any other matters being dealt with by the CMHT duty professional.

3.31 On 20 June Y was visited by a community psychiatric nurse (CPN) and a student nurse to give him his depot injection. The CPN discussed Y's housing with him. Y stated he did not want to live at home anymore, as he did not feel he could continue to look after his mother. He told them that his confidence was low; he had not attended to his personal hygiene for a month, and was only leaving the flat on an irregular basis.

3.32 Following this visit the CPN discussed her visit to Y with the CMHT team and the concerns she had identified. The CMHT agreed that the team occupational therapist would do a joint visit with the CPN and an appointment was made for 4 July.

3.33 Y's CMHT had not seen the forensic opinion that advised that Y should be urgently assessed for admission if his mental state deteriorated because he may potentially pose a risk to others. As Y's mental state had been stable for almost all the time since his discharge from hospital in May 2007 the decision to do a joint visit in a fortnight's time was an appropriate response.

Events between 27-30 June 2008

3.34 A telephone call was received from Y by the older persons[1] CMHT, on 27 June. He told them his mother was unwell and that she had apparently misplaced his wallet and keys.

3.35 It was agreed that a joint visit from that team and Y's CMHT would be carried out that day. During this visit Y said:

> *"…he was angry and fed up of having to look after his mum when he is unwell and she keeps on acting like a five year old."*

[1] To remain consistent with the style used by the trust on its web site and in some documents we have not used an apostrophe when referencing the older persons CMHT/service.

3.36 The notes of the visit record that:

> *"During the visit Y exhibited anger towards his mother reporting he would throttle her if she got in his way however when this was challenged he said that he would not actually do it and was ventilating his anger."*

3.37 The team explored options with Y but he was adamant that he wanted to have supported accommodation and that his mother needed to go into hospital.

3.38 As well as giving practical advice on how to deal with the lost wallet and keys, the team put in place a plan to respond to the risk over the weekend. They arranged for joint visits on Saturday and Sunday from the out-of-hours staff from the adult and older persons service.

3.39 Out-of-hours staff visited Y on Saturday 28 June just after noon. Conversations with Y and his mother raised no concerns. Y told the team:

> *"…he felt tired, he stated he slept well last night and they had a fish meal last night which he cooked. He told us that he is on the waiting list for supported accommodation and is feeling slightly anxious about this."*

3.40 A member of the out-of-hours team telephoned Y after noon on Sunday 29 June. The record of the visit says:

> *"T/C to Y. He reports that he is feeling well and did not wish for a visit today. States he has been watching TV and is planning to start cooking a Sunday roast shortly. Y states his Mum has been out to the local shop this morning. He denies still feeling angry towards his mother now. No concerns raised. Feedback faxed to care coordinator."*

3.41 Y phoned the CMHT on Monday 30 June 2008, at approximately 09.10 hrs and spoke to a CPN. He told her that his mother had been sleeping since Saturday and he thought she might be dead. The CPN advised him to call the police and she arranged to visit immediately which she did with another CPN. Paramedics and police also arrived at approximately the same time, and found Y's mother was dead.

3.42 Y was arrested on suspicion of murder. The post-mortem examination was inconclusive. He was not charged with the killing immediately but was admitted informally to Mascalls Park Hospital, Brentwood.

3.43 On 3 July 2008 he confessed to ward staff that he had killed his mother and on 4 July he was taken back into police custody.

Other issues arising in the report

3.44 In the main body of this report we also deal with the following themes:

Compliance by mental health staff with adult safeguarding procedures

3.45 These procedures are intended to ensure that care of vulnerable adults is effectively coordinated and managed. In this case there were two individuals living together, who were in receipt of mental health service and dependent in different ways on each other. We concluded that safeguarding procedures were not considered or implemented.

Liaison and joint working between adult and older peoples services

3.46 As Y and X were being cared for by different teams we considered what knowledge each team had of the care needs and risks posed by the other service user. We found that the teams failed to effectively work together and keep each other properly informed. This was a serious failure.

The effectiveness of the trust investigation

3.47 We reviewed the trust report and the implementation of the trust recommendations. We concluded that the trust investigation was undertaken effectively and in a timely manner and that the recommendations in the report had been carried out.

Findings and recommendation

Findings

F1 The forensic advice made clear that Y's mother was at risk if Y's mental health deteriorated. The CMHT should have held a CPA review meeting to put in place appropriate risk management and contingency plans.

F2 The failure of the Hornchurch CMHT to allocate a care coordinator to Y after his discharge from Hospital in May 2007 until January 2008 was a clear breach of local and national guidance in respect to CPA.

F3 After the home visit to Y on 20 June and without the information in the forensic opinion and absence of crisis over the last year, the decision to have a team occupational therapist carry out joint home visits with V (CPN) was an appropriate response to their assessment of his mental health.

F4 After the home visit to Y on 27 June 2008, arranging visits over the weekend was an appropriate response to the assessment of Y's mental health and his risk.

F5 The out-of-hours team who visited and phoned Y over the weekend of 28 and 29 June 2008 had no reason to think that Y would kill his mother.

F6 If the staff who put in place the plan for the weekend of 28 and 29 June 2008 had known about the forensic assessment, carried out in May 2007, they may also have requested an urgent assessment for admission in line with the forensic opinion.

F7 The adult community team caring for Y and the older persons community team caring for X failed to implement safeguarding procedures. Safeguarding policies, procedures and practice are now more effectively embedded in the culture of the trust.

F8 The failure of the members of Y's and X's teams to realise the need for inter-team communication and possibly joint working is a serious failure and an indicator of team insularity.

F9 A management risk assessment should be undertaken at times of transition of services to assess the risks associated with the change processes and to introduce a management risk plan.

F10 We support the recent policy change that says all clients should be allocated to a care coordinator and not held on a duty list.

Recommendation

R1 The trust should ensure that its guidance on allowing staff access to information about clients they are not directly working with protects that client from unnecessary disclosure, but does not inhibit staff who need information for legitimate clinical/therapeutic reasons.

4. Summary chronology

Personal history

4.1 Y was born on 7 March 1964 on the Isle of Man and moved to Australia when he was only a few months old. His parents separated when he was nine. As a result he moved back to England with his mother. His mother worked as a secretary but stopped because of mental illness. She was diagnosed with schizophrenia and had many admissions to hospital.

4.2 Y finished school at 16 and then spent two years at home, rarely going out and becoming socially withdrawn. In 1986 he went to North London University to study history but dropped out after two months.

4.3 In 1988 he started at Westminster University to study English, History and Law but became unwell and was admitted to Warley Hospital[1] for two weeks.

4.4 In 1990 he went to Liverpool University to study English but dropped out after a year. He began using illicit drugs while he was a student there. Y has never been employed and lived with his mother for most of his life.

Outline chronology of care and treatment

4.5 In this section of the report we identify the key events to help evaluate the care that Y received.

1989-2006

4.6 Y was admitted to hospital during 1989 when he threatened to kill his mother and kicked her for no apparent reason.

[1] Warley Hospital closed in 2001.

Comment

Y was threatening his mother as early as 1989 and this behaviour continued throughout the subsequent years.

4.7 In 1992 he held a doctor hostage at knife-point during a home visit. He was placed on a supervision register[1].

4.8 In 1993/94 Y was compulsorily admitted to hospital under a MHA section 3 for threatening behaviour. He was discharged back home to his mother and was seen regularly in the outpatient clinic between 1994 and 1998.

4.9 A parish priest wrote to Y's GP in 1999 advising that Y was terrorising and psychologically abusing his mother. The priest supplied notes of his meetings with Y's mother that showed how frightened she was of him. After this, Y was compulsorily admitted to hospital but soon left without permission. The admission documentation notes that he made threats to young people and carried a hammer and a knife for protection.

4.10 Y told us in interview that he did not get on with the priest and disagreed with the priest's description that he was terrorising his mother. He also denied carrying a hammer.

4.11 In the same year Y threatened his psychiatrist and another doctor with a knife.

4.12 Y became depressed and suicidal on 30 April 2001 and was informally admitted to hospital. He was diagnosed with paranoid schizophrenia and prescribed medication. He discharged himself after a month against medical advice. The discharge summary records that an urgent CPA meeting was held on 15 May to explore the possibility of alternative accommodation as:

> *"…there is significant risk of suicide or homicide to his mother. The risk would be significantly reduced by appropriate placement of 24 hour supported accommodation."*

[1] Individuals considered to be 'at risk of harming themselves or other people' could be placed on a supervision register, with the aim of ensuring that they remain in contact with mental health services and that their care is monitored on a regular basis. This provision has now been superseded by community treatment orders.

Comment

As well as threats of violence and actual violence, finding suitable accommodation was another recurring theme in Y's care and was never satisfactorily resolved. Y was often ambivalent about what accommodation he wanted and whether he wanted to stay with his mother. Assessments by staff at various times made clear that continuing to live with his mother when he was unwell put her at risk.

4.13 He discharged himself against medical advice on 1 June 2001. The discharge letter to the GP dated 7 June 2001 (and copied to Y's CPN) said:

> *"Given his past history and the potential risk there is an urgent need to pursue arranging 24 hour staffed accommodation".*

4.14 Y attended his CPA review on 19 July 2001. In his discharge letter, the senior house officer (SHO) told the GP that Y had written a suicide letter to the consultant psychiatrist four days before the meeting but he appeared pleasant and calm on the day of the review and denied suicidal thoughts.

4.15 The discharge letter also said the consultant psychiatrist was extremely unhappy about not being able to offer Y 24-hour staffed accommodation and that his housing needed to be reviewed.

4.16 A letter from the support service accommodation manager dated 23 July 2001 to Dr U at Warley Hospital recorded that Y had made clear he did not want to live in 24-hour supervised accommodation and that he was not keen to live in a group home setting. The letter said the care coordinator would be asked to undertake a carer's assessment for Y's mother.

4.17 CPA meetings took place monthly during 2001. Y's medication and housing needs were discussed.

4.18 A MHA assessment[1] was carried out on Y on 11 September 2001. The social worker said Y took out his frustration on his mother and that he had punched her for breathing heavily. Y was admitted informally as his mother objected to the use of MHA section 3.

4.19 From February 2003, a number of attempts were made by the CMHT to get Y to agree to move to a group home but these were unsuccessful as he was unwilling to move.

4.20 Y was seen regularly between 2002 and 2005, where he was settled overall although refusing new activities.

4.21 Y wrote to his consultant on 16 February 2006 questioning his diagnosis.

4.22 In March 2006 Y wrote to his consultant saying he had written the first chapter of a book.

4.23 Y wrote to his consultant again on 3 April 2006 saying he would be refusing his medication and threatening to *"bite his face off"*. He also wrote that he hoped his consultant had an early painful death. On 5 April 2006 Y wrote again to apologise.

4.24 A CPA meeting took place in April 2006 and Dr U sent a letter to Y's GP saying Y was well and would need to be followed up by the consultant psychiatrist covering the Romford catchment area. This was because Y had moved to a flat in Romford in March 2006. No further appointment was made.

4.25 Y's CPN at Hornchurch CMHT wrote to Romford CMHT on 18 May to say that Y was happy in his new flat in Romford.

4.26 On 18 October 2006 an email from the housing department to Y's community nurse said Y had handed in his notice on his flat. The email said the council no longer had a duty to house Y if he made himself intentionally homeless.

4.27 Y moved back in with his mother.

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[1] This is carried out to determine whether a person should be admitted compulsorily to hospital under a relevant section of the Mental Health Act.

Comment

The attempts to find a place for Y in a group home and then his short stay in a flat show that the staff were trying to seriously address his need for suitable accommodation. Their efforts failed in the end so the risk Y posed to his mother resumed.

4.28 Neighbours complained of intimidation and violent threats on 1 December 2006 and Y was taken to hospital under a MHA section 136 and admitted informally. Y said that there was a campaign of hatred and homophobic abuse and that he was accused of being a child killer since his return home. The inpatient referral documentation says that X had been diagnosed with early-onset Alzheimer's disease (This was not accurate and seems to have come from Y).

4.29 Consultant Dr W reviewed Y with his fiancé on 7 December 2006. The admission records show that Y had no paranoid thoughts about staff and that home leave was agreed. The records also show that Y's mother had been unwell and that she had refused a care package.

4.30 Dr W reviewed Y on 11 December 2006, again with his fiancé. The clinical notes record he was well presented and coherent. He was given further leave. Y was reviewed again on 14 December and advised to return to the ward on 20 December but he failed to do so. On 21 December 2006 Y was reviewed in his absence and discharged. Discharge arrangements were:

- continue with medication
- follow up in community with CPN
- CPA review in six weeks time

4.31 Y completed a CPA *'statement by service users of their needs'* form saying his priority was to find somewhere decent to live.

2007 – 2008

4.32 A letter from Rethink Employment Service[1] to Y's care coordinator dated 25 January 2007 advised that Y had been withdrawn from the service because he had persistently contacted a member of staff by phone and used sexually inappropriate language.

4.33 Y was seen by Dr S (community consultant psychiatrist) and his CPN for a CPA review on 7 February 2007. He appeared well with no major worries and an appointment was made to see him again on 30 April 2007.

4.34 On 18 March 2007 Y held his mother hostage and waved a knife at police. He was admitted to hospital under MHA section 2 with a diagnosis of persistent delusional disorder.

4.35 Y told us that he had not held his mother hostage and the police made this up. He stated that the reason for the police's involvement was his actions towards his neighbours which we deal with later in the report.

4.36 A mental health review tribunal was held on 27 March 2007 to consider Y's application to have his section lifted. The tribunal concluded that Y was suffering from paranoid symptoms which were significantly disrupting his life and putting others at risk. The tribunal refused the application and we deal with this in detail below.

4.37 On 29 March 2007 a son/daughter of one of Y's neighbours - who had lived in the small four-storey block of flats for 35 years - wrote to Dr W, Y's inpatient consultant at the consultant's request. The report provides a comprehensive chronology of the difficulties neighbours had suffered from Y over a number of years. We deal with this report in detail below.

4.38 Dr W referred Y for a forensic assessment on 4 April 2007, which was carried out on the ward on 21 May 2007. We deal later with the content of this assessment.

[1] Rethink is a mental health charity providing a wide range of support services, including employment.

4.39 A ward round took place on 17 May 2007 including a discussion about arranging a discharge meeting for Y the following week. A CPA meeting took place on 24 May 2007. Y was described as fine, not having paranoid ideas or expressing ideations of self-harm and he was discharged. The discharge plan was as follows:

- CPN follow-up
- follow-up with psychiatrist in 6-8 weeks
- referred to outreach team
- referred to MIND[1]
- supported living accommodation

4.40 The forensic psychiatrist who carried out the requested assessment wrote to Dr W setting out his opinion following his assessment of Y. The letter was dated 29 May which was five days after Y's discharge from hospital. The report was faxed to the CMHT within two weeks of its receipt. We found no evidence that the report was acted on by the CMHT staff providing care to Y in the community. We deal with this in detail in another section below.

4.41 On 30 May 2007 Y asked to go back to hospital, saying he felt unwell, was lonely and having problems with his neighbours. His CMHT referred him to the local Home Treatment Team (HTT) who agreed to assess him that evening.

4.42 The CMHT nursing record says that on 7 June 2007 Y was discharged from HTT because he was *"spending more and more time around his girlfriends and being non compliant with the HTT"*

4.43 Y's community consultant Dr S reviewed him in his clinic in July 2007. The plan was for the CPN to review him and for Dr S to see him again in clinic in six months' time.

4.44 A letter was sent to Y from the CMHT on 20 July telling him he did not meet the criteria for the MIND drop-in centre, but that the Havering Outreach Team would help him with social outlets.

4.45 CPA meetings took place in February, March and April 2008 but Y did not attend the March and April CPAs.

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[1] MIND is a mental health charity providing advice and services.

4.46 On 7 May 2008, a CPA meeting took place at Y's home. The clinical notes say that Y did not feel paranoid, was well kept and had no delusional ideas.

4.47 On Friday 27 June 2008, a telephone call was received by the older persons CMHT from Y to say that he had contacted their team to inform them that both he and his mother were unwell and that his mother had lost his keys and wallet. Y said he could no longer cope with living with his mother and that she should have gone into a care home when she was discharged from the older people's inpatient ward a year earlier.

4.48 Y also said he would *"throttle"* his mother if she did not keep out of his way. Y reassured staff later that he had said this out of frustration and that he would never intentionally harm her. His mother's CMHT team and his CMHT decided to provide joint out-of-hours support over that weekend.

4.49 On Monday 30 June 2008, at approximately 09.10 hrs Y phoned the CMHT and spoke to CPN V. He told her that his mother had been sleeping since Saturday and he thought she might be dead. V advised him to call the police and she arranged to visit immediately which she did with another CPN. Paramedics and police also arrived at approximately the same time.

4.50 Y's mother was found dead at home and Y was arrested on suspicion of murder. The post-mortem examination was inconclusive. He was not charged with the killing immediately but was admitted informally to Mascalls Park hospital, Brentwood.

4.51 On 3 July 2008 he confessed to ward staff that he had killed his mother and on 4 July he was taken back into police custody.

5. Clinical diagnosis

5.1 Y has been diagnosed over the years with paranoid schizophrenia, schizoid personality disorder and personality disorder. Dr W said in a letter to the GP in April 2006, that Y's diagnosis *"remains a puzzle".* During his 2007 admission his diagnosis was of persistent delusional disorder.

5.2 Y expressed concerns over the years about his diagnosis and was particularly annoyed to be diagnosed as suffering from paranoid schizophrenia. He believed he was a *"depressive"* and always had been. He applied to gain access to his medical notes and he told Dr W in April 2006 that although he agreed with certain parts of the notes, he also disagreed with a lot of them.

5.3 The first time Dr W had seen Y was in a CPA meeting in April 2006 when he had recently been transferred from another doctor's care. Dr W assessed him as *"quite stable"* on fortnightly Depixol injections 30mg. Dr W transferred Y's care to Dr S after this meeting because Dr S was the consultant psychiatrist covering the area where Y was living.

5.4 Y sometimes did not comply with prescribed medication. In July 2006 he told his psychiatrist Dr S that he had stopped all his medication two weeks earlier. He then agreed to take oral medication and Dr S gave him a prescription for oral Clopixol, a typical antipsychotic medication, which he stopped after one day.

5.5 On 18 March 2007 Y was brought to hospital under a MHA section 2 after his arrest for trying to hold his mother hostage and for waving a knife at police. The discharge summary of 24 July 2007 records that he appeared *"extremely paranoid and suspicious about his neighbours"* and *"his mental state kept fluctuating"* while he was on the ward.

5.6 A mental health review tribunal on 27 March 2007 was satisfied that it was necessary for the section to remain in place for the protection of others. The tribunal concluded that Y had a continuing disorder with paranoid characteristics that *"became destabilised in 2006"*.

5.7 The tribunal also recognised that events leading to his admission occurred at a time when his life was disrupted, even though he was still taking his medication. He had moved

back to live with his mother, he had increased responsibility for caring for his mother and he was having trouble with his neighbours.

Comment

The consultant psychiatrists caring for Y found it hard to agree on a diagnosis. Y appears to have been suffering from paranoid delusions, believing his neighbours were watching and abusing him because they believed he was gay.

Clearly it was difficult for the consultant psychiatrists involved in the care of Y to agree on a definitive diagnosis. It would appear he was suffering from paranoid delusions focusing on the belief that despite being heterosexual he was a victim of homophobia, which caused people in his neighbourhood to abuse him and watch him. It was unfortunate that he changed consultant psychiatrists three times in 2006 because this prevented his mental state and response to treatment from being assessed over a lengthy period.

The tribunal noted that Y's mental state fluctuated during stressful circumstances even though he was still taking his medication. The social circumstances report indicated that Y's mental health had begun to decline in 2006. This was consistent with evidence he gave to the tribunal about his increasing anxiety over what he regarded as the homophobic conduct of his neighbours. In the lead-up to the killing of his mother Y was distressed that his wallet and his only set of keys to the flat had both gone missing and he was struggling to cope with living with his mother.

6. Assessed health and social care needs

6.1 We now provide a more detailed examination of Y's care from his discharge from hospital in May 2007 until the homicide in June 2008. This period covers his last inpatient admission before the incident and what staff did after the discharge planning CPA meeting in May 2007.

Hospital admission- March 2007

6.2 As our summary chronology shows, Y was admitted to hospital on 18 March 2007 under a MHA section 2 for holding his mother hostage and waving a knife at police. He applied to a mental health tribunal to have his section lifted and a tribunal was held on 27 March 2007.

6.3 The report the inpatient psychiatrist prepared for the Mental Health Review Tribunal said *"when Y is unwell he poses a significant risk to others".* The recommendations were:

- referral for a forensic assessment due to the risk that he has posed to others
- to remain in hospital and apply for the Section 2 to be converted to a Section 3
- for the CMHT to apply for a Section 25[1] community treatment order, which will hopefully help with the future management of Y once in the community.

6.4 Y's inpatient psychiatrist Dr W told us in correspondence:

> *"… the Tribunal report* [stated] *that Mr Y should stay in hospital and Section 2 be converted to Section 3 and application for a CTO to be made. Although this is a recommendation made in the tribunal report, it remains a clinical decision to convert Section 2 to Section 3 closer to the time when Section 2 expires. In this case it became practically a difficult situation as Mr Y started to recover very quickly following the tribunal hearing and became fully compliant with his*

[1] Supervised Community Treatment has been devised to provide a more effective way of managing some previously detained patients in the community safely by ensuring they remain liable to be recalled to hospital.

treatment plan, and therefore it would have been very difficult to justify an application for Section 3."

Comment

A community treatment order (CTO) would have made clear that Y was at high risk of relapse or non-compliance with treatment and so needed to be visited and engaged with appropriately. Before a CTO can be used the individual must be on a MHA section 3 and therefore this approach could not be used.

6.5 On 29 March 2007 a son/daughter of one of the Y's neighbours who had lived in the same four-storey block of flats as Y and X for 35 years, wrote to Dr W, Y's inpatient consultant at the consultant's request. The neighbour who wrote on behalf of the other neighbours described himself as having:

"…worked in a department of psychiatry for some 15 years in a London teaching hospital and medical school, mainly in education of both junior doctors and medical students and currently holds a post of education MBBS 4th Year Co-ordinator for medical student education."

6.6 The report provides a comprehensive chronology of the difficulties neighbours had suffered from Y over a number of years and the more recent incidents that led to his admission to hospital in March 2007. The following extracts provide a summary of the more recent concerns.

"On Thursday 17th March and Friday 18th March at 6am …[Y] could be heard shouting in the stairwell of the block of flats threatening his neighbours. Saturday 17th March at 5am …[Y] wrote threatening words in a permanent ink on the wall in the entrance of the flats "'I will have my vengeance on you in this world or the next'."

"On Sunday 18th March at 4.30 am …[Y] condition had deteriorated to such an extent that he was now on the stairwell with knives and threatening "I will stab you all in the heart', `You are f… c… who I will kill' 'If you don't stop those

children crying I will stab them'. In addition, the neighbour living opposite to … [Y] had a knife put through the letterbox with threatening words to the children who by which time were screaming with fear."

Comment

This report was written with professional expertise and focused on the impact Y's mental health was having on his neighbours. It provides a clear description of the risk that Y posed.

6.7 Y told us that he had not put a knife through his neighbour's letterbox and had not threatened children.

6.8 On 4 April 2007 Dr W, referred Y for a forensic assessment, which was carried out on the ward on 21 May 2007.

Discharge arrangements

6.9 A ward round took place on 17 May 2007 and a discussion took place about arranging a discharge meeting for Y the following week. Dr W's, RIO[1] entry dated 18 May 2007 says:

"We identified that social isolation is a big concern for him and advised that a support worker be allocated to him and for him to be referred to MIND. Y's care coordinator has also now left the CMHT and he will need reallocation within the team. It is up to the CMHT to decide whether they can manage Y in future or whether he should be referred to the Assertive Outreach Team".

Comment

This entry makes clear that Dr W considered Y's care to be sufficiently complex that he may need to be assessed for care by the assertive outreach team.

[1] RIO is a computer care records system that allows all staff involved with a service user to record clinical entries on a central computer. All relevant clinical staff can then access these records, whether in hospital or the community. The system became live in the trust in 2007.

6.10 One of the recommendations of the meeting on 17 May was that Y would need to be allocated a new care coordinator because his had just left. Three entries appear in the RIO notes for 14 January 2008 almost eight months after the recommendation was made. The third entry records the name of a new care coordinator who had been allocated. The first recorded visit by this care coordinator was on 11 February 2008. The first entry in the RIO notes for 14 January 2008 record that Y asked *"…whether he had a care coordinator yet…"* It would appear that Y's prompting led the CMHT to make an allocation.

Comment

Having a care coordinator allocated was particularly pertinent because the level of concern about his mental health suggested he may need to be cared for by the assertive outreach team.

6.11 National CPA guidance places a key responsibility on the role of care co-ordinator. This role is particularly important when an individual is on enhanced CPA (as Y was) because they are considered to have higher care needs and more than one professional is involved with them.

6.12 A review of the RIO notes show that Y was being visited regularly because he was prescribed fortnightly depot injections. The notes also show that the CPNs who carried out these investigations used the visits to check on his mental state.

6.13 The care coordinator's role is not reduced because a service user is being seen regularly by other professionals (as Y was). Care coordinators are important because they oversee the assessment process, care planning and resource allocation. They keep in close contact with the service user and advise the other members of the care team of any changes that may be needed to the care plan.

Comment

No one appears to have addressed Y's emotional or social care needs after his care coordinator left and he was discharged from the HTT. Y's opinion about living in supported accommodation tended to fluctuate but he might have benefited from having someone to explore this option with in more depth. Considering the outcome of the discharge ward round/CPA this delay in allocating a care coordinator was a serious failure in care.

6.14 A ward round/CPA meeting took place on 24 May 2007. Y was described as fine, not having paranoid ideas or expressing ideations of self-harm. He was discharged from hospital with this plan:

- CPN follow up
- follow up with psychiatrist in 6-8 weeks
- refer to outreach team
- refer to MIND
- supported living accommodation

Comment

The CPA documentation of this meeting made no reference to Y's mother and did not contain contact numbers of the care coordinator, duty or out-of-hours service. We deal later with the quality of CPA supervision.

Forensic opinion

6.15 The psychiatrist who carried out the forensic assessment wrote to Dr W. The letter was dated 29 May 2007, which was five days after Y had been discharged. The letter said that Y would benefit from:

- supported living accommodation (rationale - Y was preoccupied with accommodation and if Y relapsed – this could be observed quickly and a low threshold for assessment could take place)

- a regular community psychiatric nurse (as opposed to being managed on duty so that a therapeutic relationship with a key worker can be developed)

- psychological therapy exploring his violent thoughts and actions and dependency on his mother.

6.16 The forensic assessment concluded that if Y's mental state deteriorated, an urgent referral for assessment should take place because Y might be a risk to others.

6.17 Following contact from us the inpatient consultant reviewed what had happened to the forensic assessment report. He told us in correspondence that the original medical files contained a copy of the report and the community file contained a fax copy (dated 15 June 2007). We are unable at this distance from the events of 2007 to determine who from the CMHT had sight of the report.

6.18 The Safeguarding Adults Team reviewed the trust investigation report and produced a supplementary report of the incident. It says:

> *"It also has to be acknowledged that there had been various systems of recording, e.g. Paper files, Sepia Notes and RIO and this may have restricted access to background information."*

6.19 Y's inpatient consultant told us in correspondence that:

> *"In 2007 we used to get forensic reports by post. It was not available to us electronically due to confidentiality. It has only been over the past 2-3 years that*

we have been able to get reports electronically. By having it electronically we can upload it directly onto RiO or WinDip which is easily accessible to everyone involved in someone's care. We relied on paper reports, which were forwarded by mail or fax to the appropriate department."

6.20 The CPN caring for Y's mother said she was not aware of the forensic advice - in particular of the risk that Y posed if his mental health deteriorated. The other CMHT staff we interviewed who had responsibility for Y's care told us that they did not know about the forensic report.

6.21 Y's inpatient consultant Dr W told us that a representative of the CMHT attended two ward rounds during this admission and was present at the Mental Health Act tribunal hearing. The CMHT also received a copy of the discharge summary to Y's GP which refers to the forensic report. Therefore the CMHT was aware of the commissioning of the forensic assessment and as the report had been faxed to them were responsible for taking whatever action was required as a result of its recommendations.

Comment

The forensic opinion provides a comprehensive summary of Y's mental health history and sets out clear risk indicators and advice on clinical management. It was faxed to the CMHT within two weeks of its receipt. The report was part of the documentation we reviewed but we have seen no evidence that the CMHT updated Y's risk assessment or risk management plan as a result of its receipt.

6.22 At this point four reports about Y's care had been prepared over about eight weeks:

- the psychiatric report from the inpatient psychiatrist to the MHRT
- the report prepared by a psychiatric professional on behalf of Y's neighbours
- the forensic report
- the discharge meeting recommendations.

6.23 The following actions were either not taken or delayed by the inpatient and community teams:

- allocating a care coordinator for six months
- considering the forensic report and putting in place a risk and care plan in response to it
- arranging psychological therapy to help Y with anger management.

Finding

F1 The forensic advice made clear that Y's mother was at risk if Y's mental health deteriorated. The CMHT should have held a CPA review meeting to put in place appropriate risk management and contingency plans.

6.24 On 30 May 2007 Y was asking to go back to hospital, saying he felt unwell, lonely and was having problems with his neighbours. His CMHT referred him to the local Home Treatment Team (HTT) who agreed to assess him that evening.

6.25 Y was discharged from HTT on 7 June 2007. The RIO entry noted that he was *"spending more and more time around his girlfriends and being non compliant with the HTT"*

6.26 Y's community consultant psychiatrist Dr S reviewed his care in July 2007. The plan was for the CPN to review him and for Dr S to see him again in clinic in six months.

6.27 MIND wrote to Y on 20 July 2007 to tell him he did not meet the criteria for their drop-in centre, but he had been referred to Havering outreach team who would assist him with making social contacts.

Details of care during 2008

6.28 We now explore in more detail Y's care during 2008 because this covers the six months period before Y killed his mother.

6.29 On 14 January 2008 Y asked *"…whether he had a care coordinator yet".* He also wanted help to contact housing to find out about progress with his application for a change of housing for him and his mother. The older people's team visited Y's mother the same day. The CPN who visited explained to Y's team that she had a number of concerns about Y, for example he was *"uncharacteristically quiet and not present when they were working with mum."*

6.30 Y's CMHT met the same day and decided to allocate a care coordinator for Y. They allocated a locum social worker, R, who was on leave but would take on Y when he came back. He was to be accompanied on his visits by a CPN who would administer Y's depot injection.

Comment

Y should have been allocated a care coordinator after his discharge in May 2007. This didn't happen until January 2008 and the allocation was prompted by Y's request and concerns raised by the CPN from the older peoples CMHT.

Finding

F2 The failure of the Hornchurch CMHT to allocate a care coordinator to Y after his discharge from Hospital in May 2007 until January 2008 was a clear breach of local and national guidance in respect to CPA.

6.31 CPA meetings took place in February, March and April 2008 but Y did not attend the meetings in March and April.

6.32 A CPA meeting took place with Y at his home on 7 May 2008. The clinical notes recorded that Y did not feel paranoid, was well kempt and had no delusional ideas.

Comment

Despite the absence of a care coordinator for a significant time, Y was visited regularly to receive his depot injection and a number of CPA reviews were held. A visiting professional occasionally noted some deterioration in Y's mental state from which he later improved. The records show this was a period of relative stability for him. They also show several failed attempts to re-house Y and X.

Y's care coordinator, R, leaves-June 2008

6.33 R left the service at the beginning of June 2008 so his case was held on duty while he waited for another to be allocated.

6.34 A number of community nurses administered Y's depot injection, including V, who had qualified recently.

6.35 We interviewed the interim team manager in post from May 2008 about the handover arrangements from the outgoing care coordinator to the team. She said:

> *"I think he actually left on 6 June and I was out of the office and I was left a list of his clients".*

6.36 We asked how she allocated his work. She replied:

> *"I went by the document he'd left me, took it to the team, because the team had a lot of knowledge about him, and then allocated out or asked people to oversee cases, but there was a duty waiting list".*

6.37 Y tried to contact his care coordinator on 16 June, not knowing he had left. As a result Y contacted X's CMHT when he wanted to discuss concerns relating to his mother.

6.38 The interim team manager told us she had concerns about the previous care coordinator's level of competency. For instance, he failed to inform his patients that he was leaving the service and his handover was poor.

6.39 The interim team manager told us:

> *"Once R left I was disappointed. The picture that he gave me, the conversations that we had weren't portrayed in the feedback that I was getting from patients. I was disappointed but he was very much part of the team, he was very likeable, he was very caring, he would discuss his concerns if he had any."*

Comment

We have not been able to interview the former care coordinator. We gather he has left the country, which is also why the trust did not interview him.

6.40 Y had fortnightly contact with a duty CPN, who administered his depot medication at home. The team decided on 20 June 2008 that V should visit Y jointly with an occupational therapist (OT) because there appeared to be OT and nursing issues as well as Y's risk history. V told us:

> *"There were some needs that needed to be addressed via the duty worker. I came back and, obviously, because he was on enhanced CPA at the time, I could not be his care coordinator. I asked my manager whether I could joint work with somebody else, who happened to be the OT, but the OT could only fit in one time, I think it was 4 July, when we would arrange to do a joint visit to address his needs. So I did understand that he had needs but I would not do it by myself, I needed some support."*

6.41 We asked the interim team manager who a worker could bring a concern to about a duty case, given that Y was struggling to cope with living at home and caring for his mother. She replied:

> *"It would be to me, it would be to the senior practitioners. There was a senior practitioner OT in the team, there were Band 6 nurses".*

6.42 She added:

> *"Anything sat on duty tended to be your more bog-standard two weekly depot, the people who could manage without a care coordinator. So Y wasn't really held on duty long because he was allocated to V and then Q joined in as well when the team thought this is more complex, we need more input into this".*

6.43 CPN V told us she did not talk about Y in supervision because he was a duty case and she did not act as his care coordinator. She was Band 5 and only nurses in Band 6 or above could act in this capacity. She said:

> *"I wasn't his care coordinator at the time. Within the team, we used to take it in turns for being the duty worker and it just so happened that, when his depot was due, I just seemed to have a lot of contact with Y while being on duty. If it meant having his depot and being admitted, I did it. If it was telephone contact, I did it, or if it was a home visit, I did it. It would depend who was on duty at the time, as to how we supported. I was a CPN but not his CPN at that time".*

Comment

Y should have been allocated a new care coordinator straight away because of the complexity of his care needs. The decision to have two professionals a nurse and OT to jointly work with Y appears to have been reactive rather than proactive after he raised concerns about his ability to manage. The OT was not available to do a joint home visit to assess his needs for a couple of weeks, leaving Y in a difficult and stressful situation. The adult CMHT did not think that Y's accommodation was a pressing concern, although it was to Y and had been highlighted in various reports.

Staff we interviewed said clients on enhanced CPA were no longer held on duty and were now allocated a care coordinator.

Care given in June 2008

6.44 In this section we set out in detail some extracts from the RIO notes.

6.45 Home visit entry in notes on 2 June by Y's care coordinator R:

"I received a phone call from Y to inform me that he does not think he would like to continue to care for his mother."

6.46 Home visit entry in notes on 5 June by CPN V and a student nurse:

"Attended Y's home with V CPN to administer depot injection. 60mg IM Depixol injection administered as prescribed on the left side. Next injection due on 19th. No concerns or worries expressed."

6.47 Note of a telephone call on 16 June handled by duty worker:

"T/C from Y stating that he was to discuss with his care co this Thursday, who has now left the service, housing issues, with regard to leaving his current accommodation that he shares with his mum, who Y cares for as she has dementia."

"Y states that his and his mother's mental health are not good at the moment, suggested that a duty worker will visit him at home on Thursday, as Y states that he is unable to attend CMHT, as he has difficulty using public transport, he added that he has his depot injection at home as well as his CPA's."

6.48 Note of a home visit on 20 June by CPN V and a student nurse. We include this lengthy quote in full because it provides an insight into Y's situation a week before the death of his mother.

"Home visit to Y with V CPN, to monitor mental state and administer depot injection. When we arrived, CMHT older people were still present visiting Y's mother, but left shortly afterwards. Upon sitting down, Y was drinking from a cup

that Y stated he had never washed. V advised him of the health risk, but he simply laughed and stated that it "added extra flavour".

The matter of Y's housing was discussed with him. He has stated that he no longer wishes to live at home as he finds it increasingly hard to look after his mother. Y stated that he feels that his confidence is very low. He also stated that after living with his mother for such a long time he no longer feels able, or confident of, looking after himself. He stated that he has not attended to his personal hygiene in at least a month. Furthermore to this, he stated that he leaves the flat on only an irregular basis, maybe going for a walk along the Ingrebourne river maybe once every couple of weeks. However, he did state that he walked to his local newsagents most mornings, but did not feel that he had the motivation to go further afield. When asked, Y said that he was still in contact with his girlfriend, but seemed unsure as to whether they were still in a relationship.

When asked, Y stated that he would prefer supported accommodation. He stated that, as explained above, he had very low self-confidence, and that he presently felt "in a rut", as well as struggling to cope with living and caring for his mother. He stated that currently spends much of his time in bed, going to bed at 6pm and sleeping until 7am the next morning. He feels that something such as Lucas Court would be a good change for him, and enable him to move away from home whilst still retaining a good level of support during his readjustment to living on his own and looking after himself. V advised him that whilst an application for supported accommodation was possible, it was potentially a long process, and that he should not expect anything to happen quickly.

During the initial part of the conversation, Y's mother was present. During this time she sat forward and was staring ahead, without contributing to the conversation. She eventually stood up abruptly and announced that she was going to her room. Y stated that she has deteriorated recently, that she was going out less often and that this meant he was struggling to look after her.

Depot injection, 60mg IM injection, was administered on the right side as prescribed."

Comment

This entry shows that V discussed many issues with Y and used the visit to assess his mental health as well as administer his injection. The visit and the notes are to be commended as good practice.

6.49 Entry by the team occupational therapist 20 Jun 2008, on the same day as the visit by V:

> *"Discussion with V CPN with regard to her visit today with Y, as there appears to be both OT and nursing issues as well as Y's past risk history, it is decided that we will joint work, appointment made with Y for the 4th July at 1.00pm."*

Comment

The visit by V and a student nurse revealed that Y was struggling with the care of his mother and may have been showing the early signs of deterioration in his mental health. The response by V's team was to allocate an OT to the visits. It is not clear what the objective for this new arrangement was and it was not to occur until 4 July two weeks later.

The decision to carry out joint visits with a nurse and an OT as a response to the possible deterioration in Y's mental state was made without the benefit of the advice in the forensic opinion given in May 2007. Additionally no community treatment order was in place as recommended in the psychiatric report to the MHRT in March 2007. Therefore the assessment of Y was not as sensitive to the potential effects of deterioration in his mental health as it might have been with this background knowledge. The period since discharge from hospital in May 2007 had been notable by its absence of crisis.

6.50 The forensic opinion of 21 May 2007 concluded that Y's insight into his mental health problems was poor and recommended that:

> *"If his mental state deteriorates and there are symptoms or signs to indicate relapse, he should be referred urgently for assessment for admission in view of the risk that he may potentially pose to others when he becomes disturbed and threatening."*

6.51 We put to Y's CPN whether her assessment of Y's mental state would have been different if she had known about that forensic opinion. She replied:

> *"Yes, if I had seen that report I would have made a different decision."*

Finding

F3 After the home visit to Y on 20 June and without the information in the forensic opinion and absence of crisis over the last year, the decision to have a team occupational therapist carry out joint home visits with V was an appropriate response to their assessment of his mental health.

6.52 Entry Friday 27 June 2008 by CPN V:

> *"Telephone call received from the older persons service today informing duty that Y had reported, that he and his mother are unwell and that his mother had apparently misplaced his wallet and keys. Joint home visit today with [older persons CPN and a student nurse and CPN V].*
>
> *On attendance Y was relaying the events up to his keys and wallet missing, he said he was angry and fed up of having to look after his mum when he is unwell and she keeps on acting like a five year old.*
>
> *During the visit Y exhibited anger towards his mother reporting he would throttle her if she got in his way however when this was challenged he said that he would not actually do it and was ventilating his anger. [Our emphasis]*

Y continued to report that he is not coping at home very well having to look after his mother and himself. [The older persons] CPN explored options regarding X however Y was adamant that he needs to have supported accommodation and that X needs to go into hospital.

Plan
- To contact Homes In Havering
- Y to cancel his debit card.
- [older persons] CPN to liaise with CPN V
- Referral to OOH [out-of-hours team] for joint homes visits on Sat/Sun" [our emphasis]

6.53 This visit by V and the CPN from the older persons team was a week after V had visited previously and shows a further deterioration in his mental state. The notes make clear Y's frustration. He was also making what appeared to be quite overt risk statements towards his mother that were an escalation of what he had said a week earlier.

6.54 A plan was put in place to respond to the risk over the weekend by joint visits on Saturday and Sunday from OOH staff from the adult and older persons service.

Comment

CPN V, only recently qualified, had become Y's regular CPN almost by default. She was involved in the visits on both 20 and 27 June. We believe her assessments and involvement in putting in place an action plan for the weekend were commendable.

6.55 Out-of-hours staff visited Y on Saturday 28 June just after noon. Conversations with Y and his mother raised no concerns. Y told the team:

"…he felt tired, he stated he slept well last night and they had a fish meal last night which he cooked. He told us that he is on the waiting list for supported accommodation and is feeling slightly anxious about this."

6.56 A member of the out-of-hour's team telephoned Y after noon on Sunday 29 June. The RIO record says:

> *"T/C to Y. He reports that he is feeling well and did not wish for a visit today. States he has been watching TV and is planning to start cooking a Sunday roast shortly. Y states his Mum has been out to the local shop this morning. He denies still feeling angry towards his mother now. No concerns raised. Feedback faxed to care coordinator."*

Analysis of risk in June 2008

6.57 We set out below a summary of the contacts with Y in June 2008. It shows the deterioration in Y's mental health, the increasing risk he posed to his mother and the response by professionals:

- 2 June home visit, Y states he does not want to care for his mother
- 5 June home visit for depot injection, no problems detected
- 16 June telephone to CMHT, Y states that he and his mother's mental health has deteriorated
- 20 June home visit by CPN V, Y states *"…he no longer wishes to live at home as he finds it increasingly hard to look after his mother."*
- 27 June home visit by both adult and older persons team, *"…exhibiting anger towards his mother reporting he would throttle her if she got in his way…"*
- 28 June joint home visit by out-of-hours staff, no problems identified
- 29 June telephone call from Y, he states no problems, no visit made.

6.58 We considered whether the team caring for Y should or could have acted differently. We considered this in the light of Y's team's not having reviewed the forensic opinion commissioned and received in May 2007.

6.59 Y was saying he could no longer care for his mother but the only threat he had made was on 27 June. The team challenged him and he explained that he would not do it: he was only venting his anger.

6.60 The team who visited arranged for two visits over the weekend. Only one took place and this one indicated that Y's frustration had receded; the second was not carried out because Y, in a phone call, suggested he and his mother were coping.

Findings

F4 After the home visit to Y on 27 June 2008, arranging visits over the weekend was an appropriate response to the assessment of Y's mental health and his risk.

F5 The out-of-hours team who visited and phoned Y over the weekend of 28 and 29 June 2008 had no reason to think that Y would kill his mother.

6.61 The forensic opinion of Y given in May 2007 said:

> *"Mr. Y's accommodation is a major issue, which he is preoccupied with.*
>
> *If his mental state deteriorates and there are symptoms/signs to indicate relapse, he should be referred urgently for assessment for admission in view of the risk that he may potentially pose to others, when he becomes disturbed and threatening."*

If a CPA meeting to review the forensic opinion had taken place In May 2007 then a risk management plan could have been put in place. This would then have provided the CMHT staff with information to assess Y's deterioration in the light of his risk history and the advice of the forensic psychiatrist.

Finding

F6 If the staff who put in place the plan for the weekend of 28 and 29 June 2008 had known about the forensic assessment, carried out in May 2007, they may also have requested an urgent assessment for admission in line with the forensic opinion.

7. Themes arising from Y's care

7.1 In this section we review the themes arising from Y's care.

Housing needs

7.2 Y and X lived in a two-bed local authority flat in Hornchurch. X held the tenancy. Both were known to mental health services. They lived together most of the time, but from February 2003 efforts were made by his CMHT to move Y to a group home and this remained an issue for a couple of years. In April 2006 he moved to a flat in the local area. He gave notice that October and moved back in with his mother.

7.3 Y told the consultant forensic psychiatrist who assessed him in May 2007 that he would not get angry if he were in supported accommodation. He said he felt depressed when he was alone in his flat because he felt lonely and unable to cope. The forensic psychiatrist's opinion was that Y's accommodation:

> *"is a major issue, which he is preoccupied with".* The recommendation was that Y *"would benefit from supported accommodation in the long term, so that any relapse in his mental state can be observed and a low threshold for assessment for admission carried out".*

Comment

Y said several times that he would prefer supported accommodation but this did not appear to be a priority for his care team. His accommodation needs might have been taken more seriously if the forensic report had been considered by the adult CMHT.

A RIO entry on 20 June 2008 shows that Y suggested Lucas Court might be a good option for him because we was struggling to cope with living at home and caring for his mother. His CPN told him that "whilst an application for supported accommodation was possible, it was potentially a long process and that he should not expect anything to happen quickly".

Safeguarding adult procedures

7.4 Safeguarding adult procedures ensure vulnerable adults[1] are protected from abuse and harm. We reviewed the care given to Y and X against the procedures in force in 2007/2008.

7.5 The table below summarises Y's risk history and the potential safeguarding issues.

10 August 1989	Y was admitted to hospital under Section 2 after he hit his mother and threatened to kill her. He had kicked his mother without provocation and two weeks later punched her, giving her a black eye.
1992	Dr W was held hostage during a home visit by Y, who had produced a knife. Police were involved and Y was later put on a supervised register.
1993	Y admitted to hospital under Section 3. He had paranoid delusions and was carrying hammers and knives for protection
1999	Reports of physical threats to doctors with a knife and verbal threats to kill his mother and other mental health professionals.
11 May 1999	Y informally admitted following an argument between Y and his mother. His mother at the time claimed he had hit her but Y denied this.
27 May 1999	Admitted to hospital under Section 2 following further aggression towards his mother.
30 April 2001	Y admitted to hospital informally after he punched his mother. It is indicated that he was depressed and suicidal and he wrote to Dr U expressing suicidal thoughts.

[1] A vulnerable adult is a person aged 18 years or over *"who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself. Or unable to protect him or herself against significant harm or exploitation."*. "Who decides Lord Chancellors Department" (1997)

1 June 2001	Discharge summary makes reference to significant risk of suicide and possible homicide to his mother.
11 Sept 2001	Mental Health Act assessment carried out on Y. The social worker states that Y clearly takes out his frustration on his mother and that he had punched her for breathing heavily. He was admitted informally when his mother objected to the use of Section 3.
3 April 2006	Y wrote to Dr U advising that he would be refusing his medication and threatening to "bite his face off". He also wrote that he hoped Dr U had an early painful death.
1 December 2006	Y was placed under Section 136 and then admitted informally after complaints by neighbours of intimidation and violent threats.
18 March 2007	Y admitted under Section 2 following a MHA assessment at the local police station. He was arrested that same morning because he was trying to hold his mother hostage and also waved a knife at the police. He had initially put a note on his house door advising that anyone who knocks would be stabbed. He stated that he meant that note only for his neighbours and not for anyone else. When the police knocked at his door, he answered with a knife in his hand.
29 March 2007	A resident wrote a confidential report to Dr W on his request. It said all the residents in the block were afraid of Y.
21 May 2007	A forensic assessment took place and concluded that if Y's mental state deteriorated an urgent referral for assessment should take place because Y might be a risk to others.
27 June 2008	Y said he would "throttle" his mother if she did not keep out of his way. He later reassured his care team that he had said it out of frustration and that he would never intentionally harm his mother.

7.6 After the trust investigation the multi-agency Safeguarding Adults Team produced an overview report of the incident and the reports that had been prepared.

7.7 The overview report found the following in relation to safeguarding.

"There has been a Safeguarding Adults Team since 2007. Prior to this there was a Safeguarding Lead who dealt with safeguarding issues but who also had responsibility for the Care Management Long Term Team".

"It should be noted that although an Agency had sent an alert to the CMHT this was not copied to the Safeguarding Team Indeed there are no records of any alerts to the Safeguarding Team during the whole period of X and Y's engagement with the mental health services although the son had been making serious threats to his mother and others."

7.8 The trust report also identified the different information Y and X's community teams held about Y's risk history. Y's team had the records of his risk history but the trusts report states and our interviews with X's care coordinator support that X's team did not know about Y's risk to X or any of the other incidents. They knew about his risk to professionals and so visited him and X in pairs.

Comment

In thinking about two individuals being cared for by two teams, it is important to consider what safeguarding adds to this mix of care. In light of Y's long history of risk to others, a safeguarding referral would probably have led to a case review. One outcome of such a review would have probably been to put in place a set of protocols for communication and sharing of information between the two teams looking after Y and his mother.

7.9 We asked Y's CPN V, what she thought safeguarding would have added to the care of Y and his mother:

"Obviously, there will be a lot more joint working and a lot more communication between both teams about issues. There will be a lot more communication."

7.10 We asked the safeguarding lead if the fact that two individuals with mental health problems, one with a significant risk history, lived under the same roof was a safeguarding issue. She replied:

> *"I think it is a Safeguarding issue, not an adult risk issue. If there were no other matters, I think you would be looking at prevention. You would be looking at the fact that you have two people, both under the mental health services, so you are actually classifying both as having serious mental disorders. Ignore anything else, and ignore any other history, but both have been admitted to hospital on several occasions, one of which would appear to deteriorate fairly quickly…"*

Comment

The adult CMHT knew about the risk Y posed to his mother, but the older persons team did not. Safeguarding was a new concept in teams at the time of the homicide and was not yet embedded in team culture. The safeguarding lead said:

> "I think possibly nationally and not just within ourselves, I don't think people fully appreciated and valued the identification of safeguarding from an adult perspective."

We are reassured after interviewing a wide range of staff that safeguarding procedures are now more effectively embedded in the culture of the trust.

Finding

F7 The adult community team caring for Y and the older persons community team caring for X failed to implement safeguarding procedures. Safeguarding policies, procedures and practice are now more effectively embedded in the culture of the trust.

Liaison and joint working between adult and older peoples services

7.11 Y and X were being cared for by two different community teams. The evidence we received shows that the two teams appeared to be working in parallel with little communication between them. The safeguarding overview report emphasises that this should not have happened:

> *"There has been a multi-disciplinary policy and procedure in place since 2004 This was reviewed in 2008 and a member of the Mental Health Service was actively involved in the revision of this work to ensure a clearer understanding of issues and experiences around the mental health arena."*

Comment

Irrespective of the existence of safeguarding procedures, good current professional mental health practice requires teams within agencies and between agencies to work closely together where this is in the interest of clients.

7.12 The safeguarding overview report found difficulties relating to the varieties of record keeping in place.

> *"It also has to be acknowledged that there had been various systems of recording, e.g. Paper files, Sepia Notes and RIO and this may have restricted access to background information."*

7.13 Both teams were nonetheless visiting both Y and X regularly.

Comment

It is clear with the benefit of hindsight that there was a need to hold a professionals' meeting. Such a meeting is an opportunity for relevant professionals to ensure that plans for individuals take into account all relevant information.

If a professionals meeting had taken place it would have been possible to produce a shared care plan that would have separate elements of the plan that related to Y and X. One aspect that could have been explored is a possible folie a deux[1] in that neither thought the other had a psychotic illness – son thought mother had Alzheimer's and mother thought son did not need to be admitted to hospital – each 'agitated for the other to be back at home'*. X's care coordinator in interview with us referred to an* 'entwined relationship'*; difficulties re separation in relation to son moving to his own accommodation and then back to mother's. We have seen no evidence that consideration of these issues was made.*

Finding

F8 The failure of the members of Y's and X's teams to realise the need for inter-team communication and possibly joint working is a serious failure and an indicator of team insularity.

7.14 We reviewed what would be different if similar circumstances arose again.

7.15 We asked X's care coordinator about what sort of communication and relationship there was between her team and the adult team. She replied:

> *"The information that I knew about Y had come to me from X's previous care coordinator, simply because as you say, because the two were living together, there had been some conflict with that care coordinator and various team members from our side. If I am being honest, I had not had any information fed back to me. I know that on a few occasions we tried to do some joint working, which we did, but I did not have anybody ring me and tell me what the situation was with Y. I knew the information historically about Y."*

[1] A condition in which symptoms of a mental disorder, such as the same delusional beliefs or ideas, occur simultaneously in two individuals who share a close relationship or association.

7.16 The team had access to the RIO computer records of both Y and X, so we wanted to know whether the two teams looked at them to make sure they knew about any relevant information that would affect the care they were giving to their client.

7.17 Y's CPN V was asked whether there was a culture of joint working and sharing information if, for example, patients in the older adults and the adult service lived together. She replied:

> *"Not at that time. In my experience at that time, there was not. At that time, there might have been data protection issues concerning the sharing of information, and how much could you share. I think that might have been the issue at the time."*

7.18 We asked the manager of X's care coordinator whether it would possible to have access now to the notes of Y and X, looking, for example, at risk before undertaking a home visit. She replied:

> *"Yes, I think that it goes back to having protocols about information sharing. If I did not have to look at Y's notes, because I had been asked actually to look at X, unless there was a link or an alert on her file to say that there is a concern, this person is the carer and there are concerns about the carer, I would not have any need to look on the other person's file, unless it had been identified. But there would need to be consent, because if I was to open both of them and look at both of them, and find out risk from both sides but actually I had only be asked to look at one, my boss could come to me and ask me why I am accessing someone else's notes. The Trust has a way of alerting if someone is checking a note that may not necessarily be open to them."*

7.19 We asked whether this was a disciplinary matter:

> *"It is; and now that the Trust has a much clearer protocol around to access or not to access I think that people are aware that they can but there have to be requests made. There has to be a way of saying, 'Look, I am on out-of-hours to an on-call manager, I need to access this person's notes, because we have concerns about the carer, am I able to do it', then, 'Yes you can'. If there is ever a question that permission has been sought first, I think that RIO has enabled that process to become much clearer."*

Comment

The manager of the older persons team believed that it was not possible to see the notes of another client without permission.

7.20 We asked the adult CMHT interim manager whether it was necessary to seek permission before gaining access to the notes of a service user under a different team. She held a different view:

> *"I'm not aware of anything like that because you're only looking, but if you're looking at somebody's notes you have to put a reason why you're looking. There's a box".*

7.21 The trust report found that the computer system did not automatically identify a risk to another client:

> *"The fact that the older persons CMHT were not aware of the risk posed by Y to his mother also brings into question issues about the database system we presently have in use. The issue that the RIO system can flag up the son as a risk to his mother and this not be reflected on the mother's case notes may have left staff vulnerable and uninformed, if they had not completed visits in pairs" (Trust Category B Inquiry Report – 3-35).*

Comment

Clinical staff held different views about the appropriateness of seeing information about patients under the care of another team, especially if it involved looking on the database.

They all knew that there needed to be a valid reason for doing so but they were less clear about whether they needed permission first. They were also worried about disciplinary action.

These questions seem open to interpretation depending on the confidence and experience of individual practitioners. Clearer guidance would help staff.

Recommendation

R1 The trust should ensure that its guidance on allowing staff access to information about clients they are not directly working with protects that client from unnecessary disclosure, but does not inhibit staff who need information for legitimate clinical/therapeutic reasons.

Other thematic issues arising from the care chronology

CPA

7.22 As can be seen from the care chronology CPA meetings were held regularly to discuss Y's care. His attendance at these meetings was erratic. We have no concerns about the compliance to CPA reviews by his care team.

Management of the Hornchurch adult CMHT

7.23 At the time of the incident in June 2008 the Hornchurch team had an interim manager who had been in post for eight weeks. Before her appointment another interim manager -a locum social worker - was in post for six to eight weeks. The manager before that had been in that post from June 2006 until February 2008.

7.24 The interim manager from May 2008 told us:

> *"I took up the interim manager's post knowing it was not going to lead to a manager's post because the team was going to be disbanded and the land had been sold, so back in 2008 we knew we were going to have two recovery teams eventually in the borough and that's what we now have."*

7.25 Having two interim team managers between February and June 2008 meant that these managers had to settle into their roles and get to know their staff and the procedures being followed. The manager from May 2008 told us:

> *"I have to say in that first eight weeks I don't think I was looking at quality as such because I was still trying to get to know staff and get to know what was going on.*

Comment

Times of transition such as the potential closure or reorganisation of a service can lead to increased risks in the management of care. The risk increases when interim managers may be inexperienced

At the time of the incident both these factors were in place. The CPN who was visiting Y was raising concerns about his mental state. His care was effectively managed by a junior CPN (who did a good job). In the light of his past risk history this should not have happened and might not have happened if management of the team had been more consistent. In making these comments we are not critical of the individuals who held these posts.

Finding

F9 A management risk assessment should be undertaken at times of transition of services to assess the risks associated with the change processes and to introduce a management risk plan.

Supervision

7.26 Two teams were looking after Y and X so we explored the quality and supervision available to staff regularly visiting them. The team manager for the older persons team told us about X's care coordinator:

> *"I have always supervised [X's care coordinator], for instance. She has always been someone that uses supervision for both clinical and management within my team, so I have always done that for [her]. Within any supervision I give to any of my staff, I will always look on RIO, open up care plans, risk assessments, and certainly if there are safeguarding issues, or if there are queries about things, we will look at those cases on an individual basis."*

7.27 We asked V, who visited Y regularly but was not his care coordinator and who was a recently qualified CPN, how the quality of her work was reviewed at that time by her manager or the team consultant. She told us that this was not done on a one to one basis.

7.28 We asked the older persons CMHT team manager, whether supervision had improved:

> *"I don't know that the structure was as clear then as it is now. Certainly, there has been a lot of work around things like supervision trees, just to try and pull out where people sit and what lines they go under, and there has also been a change within the Trust about making sure there is live RIO supervision, that you are sitting there with RIO open, with our system, and looking at things like care plans, risk assessments."*

Comment

We are reassured having interviewed staff that quality control measures are now in place, including live RIO supervision. However, this was not the case in the lead up to the incident.

Clients held on duty

7.29 In June 2008 Y was being held 'on duty'. He had not been allocated a care coordinator after R (Y's care coordinator) left. The interim manager told us that this meant a nurse would see Y for his depot injection. If the duty staff member was not a nurse, then a nurse would accompany them to do the injection.

7.30 We were told in interview that to be held on duty meant that if the client contacted the service or there were other issues arising they would be dealt with by the person on the duty list for that day. This was effectively a holding arrangement for non-complex or risky cases. The duty officer also dealt with queries that might arise if a colleague was on leave or off sick.

7.31 Y had been held on duty for a long time in 2007 and was allocated a care coordinator only in January 2008. He was placed back on duty after his care coordinator left.

7.32 The interim manager told us that in the last year the policy had changed; they were not allowed to hold anybody on duty and if a care coordinator left, they must be

allocated another straight away. Teams still have a duty officer to deal with emergencies or queries arising during the day.

Finding

F10 We support the recent policy change that says all clients should be allocated to a care coordinator and not held on a duty list.

Carer's assessments

7.33 The Trust Category B Inquiry Report highlights that *"the two could be regarded as carers for each other, but carer's assessments were not completed for either. There is however evidence that these were offered and declined, but equally this is not documented in the notes"*. This was picked up when we interviewed staff and we asked X's care coordinator whether Y was perceived as a carer. She replied:

> *"I think it was getting to that point, but I think unfortunately it came to the point that it was in crisis. Certainly before, it had not been identified just how much of a carer's burden, shall we say, he was feeling, before it came to a crisis situation and then obviously events followed."*

7.34 We asked whether performance monitoring now took place to see how many carer assessments were being offered and made. She replied:

> *"Yes, it is part of our form and we carry out an initial assessment and do a thorough assessment and part of that monitoring process – obviously if there is somebody who we can ask that question to – if they require a carer's assessment and then we document what the outcome of that is".*

Comment

Carer's assessments should be offered routinely and documented if declined. This has been standardised and can be monitored more easily.

8. Trust investigation report

8.1 The trust completed a number of reports after the homicide:

- an initial notification report
- a 72-hour investigation report
- a panel investigation was undertaken which was completed on 28 October 2008
- an overview report was commissioned and undertaken by the London Borough of Havering Safeguarding Adults Team.

8.2 The trust's investigation had terms of reference. The investigation panel had four members including clinicians and mangers and an inquiry manager.

Comment

The investigation had appropriate terms of reference an appropriate panel and was completed in a timely manner.

8.3 The trust report looked at the care of both Y and X. It contained chronologies for both and used a Root Cause Analysis process to identify any key contributory factors and lessons to be learnt.

8.4 The report made eight recommendations.

1. Adherence to the transitional protocol when transferring people from acute care to older persons services.
2. Robust handover of clients when staff are leaving the service.
3. For a review of the database system and issues of migrating information from one system to another, but also that information on one client can be shared with information on another, when they are linked.
4. Links between teams to be reviewed to ensure that important information is communicated appropriately when the clients are linked. This could be done through a joint approach to care programming.

5. For all team members to attend and remain updated on safeguarding adult awareness sessions.
6. That when a report is requested, the contents need to be acted upon. If a decision is made not to follow advice given in a report, this needs to be documented in the notes.
7. That the issues around accommodation were complex, but needed to be prioritised to be advanced. The delay on the discharge of X from NELFT In-Patient ward may have been significant, but also could have pre-empted the issues that were raised on this weekend.
8. That carer's assessments need to be offered as routine and documented if declined.

An action plan for the implementation of the recommendations was also produced.

8.5 We reviewed with senior managers the latest version of the action plan produced in 2011. It records progress in implementing the recommendations across the trust localities. In Havering all recommendations are shown as completed but that there are some other localities where the recommendations are not fully completed. The narrative included as part of the action plan details the steps still being taken for areas where work is not completed.

8.6 Recommendations three, four and five are key to the themes we identify in this report. Recommendations three and four relate to team working and the communication between teams when the care of more than one client is linked to that of another.

8.7 We were told that by a number of interviewees that the RIO computer system does not at the moment allow for an automatic computer link to another client if the two clients care needs are linked. It produces an alert if a carer's assessment has been done. RIO is a pan-London system so changes to it cannot be made without pan-London agreement, so we asked senior managers what other process could be put in place. The operational head for Havering, told us:

> *"…there is a bit in here around communication between teams and one of the things that should be highlighted in people's care plans is that they are living with another service user and what their needs are because of that. So that should be addressed, not only within a carers' assessment, but it should be addressed within a care plan itself."*

8.8 We have seen a copy of the Partnership Working and Communication Policy, issued in January 2010.

8.9 The document control sheet for this policy says its purpose is:

> *"…to ensure that all front line staff, managers and clinicians work in partnership with service users, colleagues in teams, other NELFT teams and external agencies to promote the delivery of effective care and treatment."*

8.10 Section 4.4 says:

> *"Service users are often placed at risk when different clinical teams fail to communicate effectively about service users. Service users' care plans that require effective communication between teams often have the most complex and risky behaviours. In order to minimise risk it is essential that clinical teams within NELFT communicate with each other effectively. All service operational policies should explicitly state how inter-team communication will be effectively addressed."*

Comment

Our review of policies and our discussions with senior managers assure us that professionals are now more aware of the need to work more closely together. We have also been told that the trust has a high risk reporting process in place which enables the identification and management of service users who pose a significant risk.

8.11 Recommendation five relates to safeguarding. The action plan shows the trust has made considerable progress in ensuring that safeguarding training for all clinical staff is in place. The trust told us that:

> *"Each Directorate has a Safeguarding Lead and each team has a Safeguarding Adult Link worker. Safeguarding Leads attend Safeguarding Link Workers meetings monthly. Directorate Safeguarding Leads also attend every Integrated Governance (now known as Quality & Safety) meeting (monthly). There is a clear governance*

structure and Safeguarding is a standing agenda item on both Directorate and team business meetings."

Comment

We are assured that clinical staff now understood safeguarding and that it is integrated into the team and professional practice.

8.12 We also spoke to the senior managers about how lessons from serious incidents were shared across the trust. The operational head for Havering, told us:

"We have had SI [serious incident] workshops for senior staff and governance staff for the last two or three years, now; for the last two years we have certainly been having them six monthly. What we do is to review the themes and patterns attached to SIs.

So when we are doing the feedback from the SIs and going through the action plans, the expectation is that they will take that from these integrated governance meetings to their business meetings in the teams and that they will talk about what we have talked about at the integrated governance ones."

Comment

Our review of the trust action plan shows that it has considered carefully the recommendations and is embedding them in its operations.

Appendix A

Documents reviewed

- Clinical records 2006 – 2008
- Correspondence 2006 - 2008

Reports

- 24 hour incident report
- 72 hour incident report
- 90 day incident report
- Report concerning Y, dated 29 March 2007
- Service user Y SUI report
- Steis Report August 2008
- Safeguarding adults overview report

Policies

- CPA
- Incident reporting
- Safeguarding children
- Transfer and discharge of care of service user within the care planning process
- Partnership working and communication

Appendix B

List of interviewees

- X's care coordinator
- Out of Hours team representative
- Y's community psychiatric nurse
- CMHT interim manager
- Former CMHT manager
- Operational head
- Assistant operational director
- Social care lead and practice development officer
- Older people CMHT Manager

Appendix C

Biographies of the investigation team

Emily Ewart

Emily is a registered mental health nurse and a cognitive behavioral therapist. She is currently employed in Central London as a CPN and also carries a CBT caseload. During her career she has worked in a range of acute wards and community based positions including work as a care coordinator. Emily has gained considerable experience in the identification of patient risks and has been involved in the creation of programs for trainee therapists. In her roles she has taken a proactive involvement in the development of procedures to ensure patients conditions are meet with the correct levels of care and experience. Emily has gained a number of Graduate and Postgraduate professional qualifications.

Tariq Hussain

Senior consultant Tariq is a former nurse director who brings to Verita his considerable experience of leading change management in the fields of learning disability and mental health services. Tariq has undertaken a wide range of projects for Verita which have included mental health homicide investigations and an investigation into sexual abuse by an eating disorder clinic manager. In September 2010 he completed a three year term of appointment as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Prior to Tariq's appointment with Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting.

Dr Rosalind Ramsey

Dr Ramsey is a part-time consultant in general adult psychiatry with experience in inpatient and a range of community teams in inner London. She is also a part-time associate clinical director at a south London mental health trust.

She previously was the associate director for clinical governance and clinical lead for suicide prevention work. She has been a panel member for a number of internal serious untoward incident investigations as well as a number of external investigations and is currently a chair of a serious untoward incident and complaints panel. She has experience in quality improvement work having been a trust NICE implementation lead until 2010 and a member of a NICE committee.