VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent review into the care and treatment of F and G

A report for
NHS South of England (formerly NHS South East Coast)

February 2012

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Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

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1. Introduction

1.1 F killed G in a community home in Kent in 2004. Both were living in a supported housing scheme and receiving mental health services from the East Kent NHS and Social Care Partnership Trust (now part of the Kent and Medway NHS and Social Care Partnership Trust). A national charity ran the supported community house which closed a year or so after the incident.

1.2 F had been in contact with mental health services since the 1980s. He was diagnosed with schizophrenia in 1982. In the late 1980s F moved to Leicestershire where mental health services looked after him again. He moved to Kent in April 2003 and was in the care of Younger People Mental Health Services[1] when G died.

1.3 Older People Mental Health Services looked after G in Kent in 2004. He had been a client of the supported housing provider for more than ten years and had lived in another Kent town before moving to his community home. He had mental health problems, emphysema and poor eyesight.

1.4 F pleaded guilty to the manslaughter of G and was convicted on 23 December 2005. The court made him the subject of a hospital order under section 37 of the Mental Health Act (1983). The court also imposed a restriction order without limit of time under section 41 of the Mental Health Act (1983). F is a patient in an NHS medium secure unit.

1.5 After the case, the chief executive of East Kent NHS and Social Care Partnership Trust commissioned an internal investigation into the care and management of F and G. Two trust staff carried out the investigation. An independent management consultant specialising in investigations and a consultant psychiatrist from South West London and St George's Mental Health NHS Trust helped them. They consulted F's parents during the investigation and shared the report's findings, conclusions and recommendations with them. G had no known relatives.

[1] The trust now calls these services younger adult mental health services.

1.6 The internal investigation report was completed in October 2006. All its six recommendations concerned managerial and operational matters. The trust submitted the report to NHS South East Coast – the responsible strategic health authority (SHA) - in December 2006.

1.7 In 2011 NHS South East Coast commissioned Verita to carry out this independent review into the care and treatment of F and G.

1.8 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Ed Marsden, managing partner of Verita, did the work. His biography appears at the end of the report.

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

2. Terms of reference

Commissioner

2.1 This independent review is commissioned by NHS South East Coast with the full cooperation of Kent & Medway NHS and Social Care Partnership NHS Trust (the trust). It is commissioned in accordance with guidance published by the department of health in HSG (94)27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the good practice guidance issued by the National Patient Safety Agency in February 2008.

Terms of Reference

The review will provide independent scrutiny of the care of F and G largely by means of a documentary review. The review will be conducted by a single investigator, supported by a peer reviewer. The work will be conducted in private and take as its starting point the trust's internal review.

The documentary review will examine the following:

- *the internal review, including the methodology, appropriateness of the panel members, the interviewees and the evidence considered.*
- *the extent to which care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies, in particular:*
    - *the adequacy of any risk assessments and risk management plans carried out for both F and G, specifically any relating to the potential for F to harm others;*

- *any relevant gaps or issues found which were not investigated as part of the internal investigation in relation to the care and treatment provided for F and G during their last episode of care with services to the time of the offence;*

- *the care programme approach and how it was carried out in relation to F's and G's care and trust policy;*

- *the progress made against the recommendations from the trust's internal investigation;*

- *any new developments or improvements in services since F's and G's engagement with mental health services.*

A report will be written for NHS South East Coast that includes:

- *a general overview of the care and treatment of F and G from their first contact with services. This will be followed by a detailed chronology of events of the last episode of care leading up to the offence;*

- *an analysis highlighting any missed opportunities and findings based on the evidence received;*

- *any areas of notable good practice, new developments or improvements put in place since this incident which are relevant to this case;*

- *measurable, achievable recommendations for action to address the learning points to improve systems and services.*

2.2 The full terms of reference are to be found at appendix A.

3. Executive summary and recommendations

Executive summary

3.1 F killed G in a supported community house in Kent in 2004. F was 41 years of age. He had been in the care of mental health services since the 1980s and was being cared for by East Kent younger people mental health services. He was treated for schizophrenia for about 18 years. It was well controlled with depot medication. F had a history of drug and alcohol misuse.

3.2 G was 68 when he died, and living in the same supported community house as F. East Kent Older People Mental Health Services had known him since 2001. He had a history of depression and anxiety. He smoked and suffered from a number of physical health problems.

3.3 Both men were in the care of East Kent NHS and Social Care Partnership Trust. F and G were friends before the incident and F saw G as a father-figure. G gave F money for drink and drugs.

F

3.4 F transferred from Leicestershire services to Kent in spring 2003. He moved to the supported community house, where he knew no-one. His discharge was poorly organised. He was an in-patient immediately before his transfer and on enhanced CPA, but local mental health services received little information about him, with little time to put in place proper arrangements for his after-care. This was poor practice.

3.5 East Kent NHS and Social Care Partnership Trust tried to get more information about F from services in Leicestershire after the allocation meeting on 11 April 2003. But they did not persevere. However, the local CMHT took on his case soon after he moved to the supported community house in June 2003.

3.6 The support available in the house did not meet F's needs. Staffing difficulties and disputes with other residents left him increasingly vulnerable. Over his 18 month tenancy he lost interest in his daily activities and started drinking heavily and taking illicit drugs.

3.7 AM and two other CPNs visited him regularly and F had three CPA reviews during his 18 months in the community home. Three needs and risk assessments were conducted by the CPNs. He was well served by the local CMHT.

3.8 F's medication was well managed and he was moved on to atypical psychotic medication in a planned way. His CPNs acted appropriately when F expressed concerns about his vulnerability and counselled him about his apparent excessive drinking and occasional non-compliance with medication. The CPNs appeared to liaise effectively with staff in the supported community house.

3.9 F stopped his depot medication at his own request in June 2004 and started taking oral risperidone. He took the oral medication inconsistently and sometimes while drinking and using illicit drugs. Non-compliance with medication and drinking featured in F's relapse indicators.

3.10 Staff in the supported community house and the clinical team thought F was at risk of being exploited by others. Adult protection procedures were used by the CPNs to address this. Practitioners had no evidence that F was a risk to others, particularly as services in Kent did not know his forensic history.

3.11 F was drinking heavily just before the offence and taking his medication erratically. He had also been distressed by the arrival of a new resident. F's clinical team saw that he was relapsing and counselled and supported him accordingly. However, the clinical team had no reason to believe that his relapse would result in violent behaviour, especially because he was usually anxious and needy.

3.12 The clinical team were still worried about F's susceptibility to exploitation. Paradoxically, the national charity's independent review after the homicide suggests that F and G became friends and that F took advantage of G's vulnerability and asked him for money to fund his drinking.

G

3.13 G was an elderly, isolated man with a history of depressive and physical illness. Late in his life he moved from a supported community house in Chatham to the same low-to-medium intensity supported community housing as F.

3.14 G's depressive illness - for which he took medication – and poor physical health confined him to his bed. Consequently he neglected himself. Support workers occasionally engaged him in activities but the evidence we have seen suggests that G needed more care than the supported community house could give. However he twice took up a day hospital place and also attended Age Concern. These placements broke down because G did not attend, or because he behaved badly.

3.15 G's CPN and care manager thought that he needed more support. They organised periods of respite care but G resisted them because he had to pay. He accepted that he needed to move from the supported community house into residential care. His application for funding was refused by KCC. He was both physically and mentally unhealthy. A district nurse never properly assessed this. This was an oversight.

3.16 G was subject to standard CPA and his last review was in November 2003. Practitioners working separately from the multi-disciplinary team missed the opportunity to put G on enhanced CPA in September 2002. This was immediately after G had been refused funding for a residential home for the elderly with 24-hour support.

3.17 G's new CPN did not visit him for a few months and then took a different view of his needs. G was not moved onto enhanced CPA. Had he been, he would likely have been eligible for social services funded residential care and might therefore have moved.

3.18 The internal investigation report did not mention the nature of the relationship between F and G. The national charity's independent review contained interview evidence from other residents in the house. It suggested that F and G were close friends. It also suggested that G was giving F money. F confirmed both points at interview.

3.19 Nothing in the records suggested that F was a threat to G or indeed to anyone else in the supported community house. No one could have foreseen the events that led to G's death.

Independent review and the trust internal investigation

3.20 In the summer of 2005, the national charity commissioned an independent review of the circumstances leading up to the incident. A specialist consultancy did the work. The scope of the review was limited because it was done during the criminal proceedings, but it still contained helpful insights into the management of the home and the nature of the relationship between F and G. The review found deficiencies in the management of the supported community house but said that F's attack on G could not have been prevented. It said alcohol misuse in the house was a problem but staff and managers could not have known what happened there out of hours. No one knew how much F drank or what residents said to each other. The review found that F's mental state declined during his stay. According to the independent review there had been no formal re-assessment of F's individual support plan by the house staff during his time there.

3.21 The charity agreed to take action based on the review's 13 recommendations.

3.22 The trust carried out a detailed investigation into the care and treatment of F and G. F was not interviewed but the trust investigation team did talk to national charity staff who worked in the supported house. The investigation explored seven issues to do with their care and treatment. It concluded that they were properly placed and cared for. The trust team were not aware of the independent review commissioned by the national charity and did not know about the existence of the report at the time of their investigation.

3.23 We do not agree with the internal investigation team's assessment, but we have had access to more information and have spoken to F.

3.24 F's needs were not fully met by the supported community house but the CMHT staff were attentive to his mental health care. G's CPN, care manager and support workers recognised that his needs increased between his arrival in the house in 1999 and his death in 2004. His mental and physical needs would have been better met in a residential home after September 2002.

Implementation of the reports' recommendations

3.25 The charity commissioned an independent review in the summer of 2005, which was done by a consultancy specialising in supported housing. The police restricted the scope of the review because of the criminal proceedings. Its purpose was to look at the events leading up to the incident, identify strengths and weaknesses of the management of the house and make recommendations to reduce risk. The review included discussions with staff and residents and a chronology of the care of F. It made 13 recommendations.

3.26 The charity's director of service improvement received the final report in July 2005. At that point the charity had produced an action plan. There is no information about what progress has been made but a letter of July 2005 from the consultancy that did the independent review said:

> "*(the charity) are fully committed to implementing the recommendations in the report*."

3.27 Dr W (Medical Director) said at interview in 2011 that the trust's investigation and action plan had not been passed to the new Kent and Medway NHS and Social Care Partnership Trust. There had been no check on the actions arising from the 2006 internal investigation report but the trust had fully appraised the case when the SHA wrote to the acting chief executive in 2011 about this independent review.

Recommendations

R1 The trust should assure itself about current arrangements for transferring patients outside of Kent into local services and from local services to other trusts. The arrangements should include an internal escalation procedure to executive director level if information is not being made available. The procedure should be included in the current version of the CPA policy.

R2 The trust should consider discussions with the management teams of other trusts that 'import' large numbers of patients to Kent. These discussions would ensure that clinical teams plan transfers early and provide all necessary information.

4. Approach and structure

Approach to the review

4.1 The review was held in private. NHS South East Coast's terms of reference asked that we conduct the work "*largely by means of a document review*". Our investigation therefore comprised a review of written material and four interviews with clinicians and managers. The trust's records were comprehensive and the standard of the internal investigation report and supporting papers was good. They included notes of interviews with practitioners and managers. Given this, we did not consider it necessary to interview anyone directly involved in the care and treatment of F & G.

4.2 We met F, his consultant psychiatrist, nurse and independent advocacy worker at the start of the review and explained what we were doing. F was worried about the delay in commissioning the independent review. We relayed this to NHS South East Coast. Subsequently, we talked to F about his care and treatment.

4.3 F agreed in writing to let us have access to his medical and other records. We told him that the SHA was likely to publish the report. F has been given the opportunity to comment on the draft report and has done so with the assistance of his consultant psychiatrist(s).

4.4 We discussed with F and his consultant psychiatrist whether we should involve his parents. F talked to them and they decided that they did not want to participate because their questions had been answered by the internal investigation report.

4.5 The trust prepared an up-to-date action plan with original recommendations and the supporting paperwork e.g. a policy document to show what has since changed. We also read an independent review commissioned by the national charity responsible for the supported community house F and G lived in. We did not review F's records from his time in the care of mental health services in Leicestershire and London.

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

Structure of this report

4.7 Section five contains the details of the care and treatment of F and G.

4.8 Section six discusses the independent review commissioned by the national charity and the trust's internal investigation.

4.9 Section seven reports on the progress made tackling the organisational and operational matters identified in the trust's internal report.

4.10 Section eight sets out our overall analysis.

5. The care and treatment of F and G

The care and treatment of F

5.1 F was 41 at the time of the incident in November 2004 and being cared for by East Kent Younger People Mental Health Services. He had been in the care of mental health services since the 1980s. He was born and raised in Kent and has two siblings. He was divorced in 2003. He has no children. He was treated for schizophrenia for about 18 years. This was well controlled with depot medication. He moved onto risperidone at his own request in the summer of 2004 after a planned trial. F has a history of drug and alcohol misuse.

5.2 At the time of his offence F had been living in a supported community housing scheme in Kent since June 2003. He met G when he moved into the house and they became friends. At interview F said that he saw G as a father-figure and '*connected with him*'.

Transfer to Kent in 2003

5.3 F moved from Leicestershire to Kent in spring 2003. Before that, he was admitted to a mental health unit run by Leicestershire Partnership NHS Trust because of an overdose. He wanted to move to Kent after the breakdown of his marriage and told his care team in Leicestershire that he wanted to be placed in supported housing.

5.4 F's discharge was poorly planned, with little or no discussion between the two provider trusts. He was discharged as an in-patient to his parents' home and was on enhanced CPA with a diagnosis of chronic schizophrenia. He suffered from auditory hallucinations and anxiety and sometimes drank heavily. An assessment and care plan completed by his care team in Leicestershire in April 2003 said:

> *"(F)….. has attempted to harm himself when distressed. However, he currently presents as a low risk of harm to others."*

5.5 The plan also said:

> *"(F)…… is susceptible to financial exploitation and should be protected against such."*

F's needs assessment form mentioned his financial exploitation and his application for supported housing.

5.6 The local CMHT discussed F at its allocation meeting on 11 April 2003. That day a team member contacted services in Leicestershire to ask for more information about F's care, treatment and management. On 14 June they received a three-page letter from an SHO (on behalf of the RMO) at Leicestershire Partnership NHS Trust dated 10 April 2003. It said that F had been discharged on 11 April 2003. A doctor in the Leicestershire trust said the responsible CPN would contact the local CMHT to discuss a handover, care plan and a way to ensure that the CMHT knew when F moved to their area. This did not happen. According to trust procedure, the local CMHT team should have received a formal, face-to-face CPA handover from services in Leicestershire. Dr W confirmed at the interview that at the time these handovers did not always happen.

5.7 On 25 April 2003 the local CMHT sent F an outpatient appointment for 25 July. Dr W was to be his consultant psychiatrist. They also made arrangements for F to receive his medication, even though he was living with his parents – well outside the CMHT's catchment area.

Supported community housing 2003/4

5.8 F moved into the supported housing project at the end of June 2003. A national charity ran the house, which accommodated ten men with a history of mental health problems. Support workers were available between 9am and 5pm Monday to Friday. Residents could contact a staff member in an emergency out of hours. The trust's internal investigation report describes the house as a low to medium support project. Clients living there needed support but could also manage on their own temporarily.

5.9 F said that at first he was well supported, but this declined over time because there were not enough staff. He said:

> *"the area manager used to call in occasionally and the manager from Hythe house used to come in occasionally, but there was no regular staff nine-to-five, Mondays to Fridays, as there had been."*

5.10 The specialist consultancy report[1] independently corroborates F's comment about staffing problems. F said that inconsistency in staffing made him feel vulnerable, so he drank heavily.

5.11 When he first joined the supported community house, F undertook voluntary work at a local tourist attraction. He also attended MIND and a fitness class. F said that he gave up these activities during his time in the supported community house and that "*drinking became my way of life*".

5.12 AM, a CPN from the local CMHT, took on care coordinator responsibility for F on 3 July 2003. AM discussed F's care and treatment with his GP. AM told staff in the supported community house that he would be responsible for F.

[1] The consultancy specialises in supported housing, and conducted the independent review to look at the events leading up to the incident.

5.13 On 7 July AM (CPN) met F at the supported community house. He assessed F's mental state and discussed his medication with Dr W (RMO). AM (CPN) administered the weekly depot injection. He also discussed F's drinking.

5.14 AM (CPN) visited F regularly at the supported community house to monitor his mental state and give him his medication. F's mental state was stable for the next two months although he did once attempt to lacerate his arms. The lacerations were superficial.

5.15 On 24 September F had a CPA review with AM (CPN), Dr W (RMO) and his support worker from the house. They discussed boundaries in the house and F's use of alcohol. F was getting involved in other residents' disputes and drinking more than he should. His CPN completed mental health risk and needs assessments. They found that F was at risk of exploitation and self-neglect. He remained on enhanced CPA.

5.16 At the review Dr W (RMO) decided to reduce F's depot medication and put him on a trial of atypical anti-psychotic medication. She wrote to F's GP about this change on 25 September 2003:

> *"(staff from the supported community house) report that he seems to be quite institutionalised and reliant on them for direction with his day-to-day activities."*

The care plan said that non-compliance with medication was one of nine relapse indicators.

5.17 F was generally well and in regular contact with AM between September 2003 and late February 2004. However, there were two problems. F was anxious and vulnerable to financial exploitation. An internal memo from a manager at the national charity to support staff in the house said:

> *"You are to speak to….CPN and if possible…. (the RMO) to express the concerns The Society has around F's vulnerability and the possibility with the background we have on F, that this maybe around his paranoia. To reinforce in 1 to 1's with <u>all tenants</u>, that lending, giving money to another tenant is unacceptable and F is to inform staff or his support team if he continues to be asked."*

The memo also recorded concerns about F slashing his wrists and highlighted "*the concerns (F) has around Knifes*".

5.18 Staff in the supported community house reported to AM (CPN) in February 2004 that other residents were taking F's money. AM suggested calling the police and raised the matter of adult protection proceedings. The police were informed on 1 March. They told F that they would warn the person taking his money.

5.19 GA became F's CPN in mid-March. Between March and June F appeared settled apart from drinking heavily when he visited his ex-wife in Leicester in late March.

5.20 F had a CPA review on 5 April 2004. After the meeting, Dr W (RMO) said that F's mental health had deteriorated because of the financial exploitation but "*the situation now seems to have been resolved, with the intervention of the local police, and F reports feeling much more cheerful*". Dr W (RMO) and the clinical team also agreed to a proper trial of atypical anti-psychotic medication as F wanted to stop his depot injections (Clopixol). The plan was to stop the depot injection altogether. The care plan from that review said that non-compliance with medication and alcohol misuse remained relapse indicators.

5.21 AM and GA (CPNs) did another needs and risk assessment on 5 April 2004. It said that F was "*vulnerable to exploitation by unknown parties*" and "*would lend money and be unassertive in getting it back*". He remained on enhanced CPA.

5.22 An agency out-of-hours social worker completed an adult protection alert for F on 2 May. Apparently a resident had hit F. The social worker reported the matter to a staff member in the supported community house. The duty social worker followed this up with F and her team leader.

5.23 Another CPN (CM) took over the care of F in late July.

5.24 F was generally unsettled in August 2004. He had stopped taking his medication and was drinking heavily. He complained of auditory hallucinations telling him to self-harm. He said he did not think of harming others. The independent review commissioned by the national charity after G's death says the residents confirmed that F was drinking at this time. He restarted his medication when CM (CPN) challenged him about it and agreed to seek help with his drinking.

5.25 He appeared more settled in September but he said he felt vulnerable to other residents. F said of this:

> *"there was the difficulty I was getting from three other residents, who were making my life quite difficult there and I didn't feel that I had anyone I could turn to."*

5.26 F reported to CM (CPN) on 14 October that another resident was threatening and exploiting him. With F's agreement, CM reported the matter to the police and completed the adult protection paperwork. She also informed the team leader, Dr W (RMO) and F's father. The police and CM held a case conference at the supported community house on 18 October but the police did not pursue the matter because they did not think F would perform well in court. Staff in the house contacted CM (CPN) in late October to say that F had been robbed and had lost jewellery. F had been drinking and the case notes indicated that he might have given the jewellery to a friend.

5.27 CM (CPN) did a further risk assessment of F on 15 October 2004. The assessment said that F was still at risk of exploitation but that he was "*no known risk*" to others.

5.28 F had a CPA review on 29 October. In her letter to his GP, Dr W (RMO) said that F "*has again stopped his anti-psychotic medication and resumed binge drinking*". She also said:

> *"This has resulted in a number of difficulties between him and others, most particularly to him being threatened and exploited. (F) seems to have taken on board the role that alcohol plays in this, and has arranged to see a counsellor from our Alcohol Team. We have impressed upon him the need to resume medication, to prevent any resurgence of his auditory hallucinations….Adult Protection proceedings will be commenced, due to the risk of him continuing to be exploited."*

5.29 CM (CPN) completed another mental health assessment form on 29 October. She recorded major recent events such as non-compliance with medication and excessive use of alcohol. She also noted that adult protection proceedings had begun. Non-compliance with medication and excessive alcohol intake remained important relapse indicators in the care plan. F remained on enhanced CPA.

5.30 F said he took a taxi from the supported community house to Leicester two weeks before he committed his index offence. He went to see his ex-wife and her partner. He bought them food and clothes and took them out for a meal. His ex-wife would not allow him into her council flat at the end of his visit and he returned to Kent feeling "*totally rejected*".

5.31 CM (CPN) planned to visit F 11 days before the index offence but had to re-arrange. When he/she contacted the house the staff said F had been distressed by a new resident. F had gone to see his parents when CM visited next day.

5.32 CM visited F five days later and found him hyperactive and talking loudly. He said he was stable and that he had not been drinking or taking illicit drugs. F confirmed at interview that he was taking illicit drugs, including cannabis and ecstasy. He also said that he regularly took money from G to fund his drinking.

5.33 Six days later during the evening F attacked G in G's room. G sustained 28 knife wounds, bruising and bone injuries. He died in his room as a result of the attack. The police found that money had been taken from G's room.

5.34 The police arrested F four days later on suspicion of murdering G.

5.35 F was admitted to an intensive care unit run by East Kent NHS and Social Care Partnership Trust three days later, under section two of the MHA (1983). Before admission he had become distressed during an interview with police at Dover police station. The doctors who assessed him there found him to be:

> *"acutely psychotic, hallucinating, fearful and expressing suicidal thoughts."*

5.36 The police told the trust during the admission to the intensive care unit that F had previous convictions for theft and a probation order for an assault causing actual bodily harm (ABH). Before the incident local mental health services knew of the theft and probation order but not about the ABH. The mental health needs assessment form of 24 September 2003 records this but contains no reference to the ABH, neither do the documents Leicestershire Partnership NHS Trust sent to the CMHT in April 2003 mention it.

5.37 At interview F said this about his 18 months at the supported house:

> *"My perception was that going to nine-to-five support was totally wrong for me anyway. It was too big a leap."*
>
> *"I was feeling very vulnerable and worthless and rejected. Those are words that I would not be able to use in those days because I didn't have the insight that I have now."*

"...my drinking was my life, and my drinking became my structure if I am being 100 per cent honest. My drinking became my way of life and the structure to my day. That is what I was looking for."

"...the way I coped was to go to the pub all day, every day."

"I didn't enjoy it. I suppose it was a cry for help really but it just did not come out that way, because I didn't have anybody to cry to."

Practitioners stopped his medication after his admission to the medium secure unit in summer 2005. He was diagnosed with a personality disorder.

Comment

F was transferred to Kent from the care of services in Leicestershire. He moved to a home, where he knew no-one. His discharge was poorly organised. The Leicestershire Trust passed only limited information to local mental health services. There was little time to make proper arrangements for his after-care and F had to stay with his parents while he waited for admission to the supported community house. The local CMHT had to improvise to ensure F received his medication. He had been an in-patient immediately before his transfer and was on enhanced CPA. As the internal investigation said, this was poor practice.

The trust tried to get more information from services in Leicestershire about F after the allocation meeting on 11 April 2003 but did not persevere or escalate the matter to trust senior management. The local CMHT took on his case soon after he moved into the supported community house in June 2003.

The support available in the house was not sufficient. F felt vulnerable because of inadequate staffing and arguments with other residents. Over his 18-month tenancy he lost interest in his daily activities and started drinking heavily and taking illicit drugs. F was vulnerable, needy and anxious during his time in

Leicestershire. His re-location to different housing in a different part of the country should have been planned more carefully.

AM and two other CPNS visited F regularly and he had three CPA reviews during his 18 month residence. Needs and risk assessments were conducted. The local CMHT served him well and his CPNs got on well with him. Their interventions reassured him and stopped things getting worse.

His medication was managed actively and he was moved on to atypical psychotic medication in a planned way. His CPN(s) acted appropriately when F expressed concerns about his vulnerability and counselled him about his excessive drinking and occasional refusal to take medication. The CPNs liaised effectively with staff in the supported community house.

F stopped his depot medication at his own request in June 2004 and started taking oral risperidone. He took it inconsistently and sometimes while drinking and using illicit drugs. Drinking and refusal to take medication were some of F's relapse indicators.

Staff in the supported community house and the clinical team thought F was at risk of being exploited by others. Adult protection procedures were invoked to address this. Practitioners did not believe that F was a risk to others. Services in Kent knew nothing about his forensic history.

Just before the offence F was drinking heavily and taking his medication erratically. He had also been distressed by the arrival of a new resident in the supported community house. F's clinical team saw that he was relapsing and counselled and supported him. The clinical team had no evidence that he would become violent because he was usually anxious and needy.

The clinical team were still worried about F's susceptibility to exploitation. Paradoxically, the national charity's independent review after the homicide says that F and G became friends and that F took advantage of G's vulnerability and asked him for money to fund his drinking.

The care and treatment of G

5.38 G was 68 when he died. East Kent Older People Mental Health Services had known him since 2001. He had a history of depression and anxiety. He smoked and suffered from a number of physical health problems.

5.39 G was born in Gravesend in 1937, one of five children. His father died when he was 11, his siblings were fostered and he went to a children's home. He was married for 16 years and separated in the late 1990s. The couple had no children but were foster parents. G kept in contact with one foster child until after her marriage.

5.40 G lived in Chatham for much of his life and had various paid jobs, including working in a paper mill. Later in life he was a resident in a supported community house in the Medway Towns provided by a national charity. According to the notes G asked to move to new supported house in another part of Kent in 1999 after he was falsely accused of inappropriate behaviour.

5.41 G and F lived in the same supported housing scheme. An independent review commissioned by the housing provider in 2005 suggested that F and G had a close relationship.

5.42 G first came under the care of East Kent older people mental health services when his GP referred him to the service on 13 February 2001. His GP thought he was depressed. G had been living in the supported home for a couple of years by the time of this referral. He was also attending a drop-in centre staffed by volunteers. G was a reserved, quiet man. He appears to have had one close friend in the supported community house, who left to get married in December 2000. His departure affected G.

5.43 A locum consultant psychiatrist visited him at home to assess him a week after the GP made his referral. He found that G was suffering from a depressive illness and prescribed anti-depressants.

5.44 G was seen in outpatients regularly in 2001. In August that year his consultant psychiatrist referred him for an assessment for a residential placement. His referral letter said:

> "*I note from Dr H's previous letter that he supported assessment for residential placement and I concur with this*".

A care manager from Kent County Council (KCC) assessed his social care needs on 23 October 2001 and found that he was independent in all activities of daily living and did not need residential care.

5.45 G was quite well but he spent a lot of time in bed despite the efforts of his support worker.

5.46 G's consultant psychiatrist and GP saw him in late February and early March 2002. Both thought that G should be relocated. The record in the notes said:

> "*D/W Dr A + Dr F who both feel that G's problems would be greatly assisted if he was accommodated in a more supportive environment*".

They thought this would better suit his needs and be more supportive, but G refused. Appendix D shows the number of occasions that health care professionals and others either discussed G's need for residential care or increased support.

5.47 A community psychiatric nurse and a KCC care manager – who had conducted the October assessment – assessed G jointly on 11 April 2002. They found that G had become set in his routine and less able to care for himself. They agreed that a week in respite care would help G regain his confidence and motivation. The notes said:

> "*Over this time [3 years in semi-supported environment] his abilities to manage have gradually decreased. He would now benefit from a short period of respite care to assist him*".

A week or so later the care manager organised a week of KCC-funded respite care at a local residential home. This appeared to improve G's motivation and self-care. The supported home also employed more workers. They spent some time encouraging G to get up each morning and engage in activities. However G was never assessed or visited by a district nurse despite his physical health problems.

5.48 G was placed on standard CPA at his initial review meeting on 2 May 2002. He was to work with his support workers and the CPN was to monitor his mental state with regular visits. His risk assessment showed that he was not considered at risk of suicide/self-harm, harm to others, self-neglect, exploitation or any other risks. A note said: "*G would be at risk of self-neglect is (sic) he lived on his own, but with the assistance of the support workers within the house the risk is reduced.*"

5.49 The CPN made regular home visits to G in 2002 and referred G to a day hospital. The CPN said in July 2002 that staff in the supported home did not feel that they were meeting G's needs and the notes recorded that "*the home do not feel that they are meeting G's needs".* G did not want to move to residential care despite his successful placement week. G was admitted to the day hospital on 7 August 2002.

5.50 G's support worker contacted the CPN in September 2002 to say that G might accept residential care. The CPN and a care manager visited G on 11 September and he said he wanted to transfer to the residential home. The notes said:

> "*When we visited on the 11 September he [G] felt that the time had come for him to move to* [the residential home]… *on a permanent basis.*"

The KCC turned down the recommendation of the joint assessment because they thought health and social services should develop a more intensive programme of community support. G was disappointed. His CPN and care manager then agreed that he should be placed on enhanced CPA. The trust's internal investigation report said the following about this matter:

> "*It is confirmed that EK2* [G] *should now be on an Enhanced Care Package following the refusal of funding for a permanent residential placement. The*

notes say that arrangements are made by CPN4 for CPN5 to do a Joint Assessment with the Care Manager."

5.51 G's CPN wrote to his GP on 19 September 2002 to say that she was taking a one-year sabbatical. A senior colleague with a pre-existing caseload of his own took on her patients. A worker from the supported home contacted the care manager on 16 October 2002 to ask that the new CPN build a rapport with G and persuade him to attend the day hospital. Despite this, the new CPN first saw G on 14 February 2003 - four months later. And the joint assessment for enhanced CPA was never carried out.

5.52 The new CPN visited G regularly between February and June 2003. The nursing record contains relatively little about G's mental state or degree of motivation over this time. G was re-admitted to the day hospital on 3 June 2003 but his attendance was sporadic. He had been discharged by October. He was also seen regularly in outpatients and a clinical psychologist reviewed him. His general presentation throughout this period appeared as that of an older man who was poorly motivated, flat and fearful. He spent his waking hours in bed and was in poor physical health. The CPN described G as a "*fish out of water*" in the supported community house and said that he would have benefited from the company of someone of his own age, although he thought the younger residents liked G.

5.53 G had a CPA review meeting on 28 November 2003. The clinical team arranged to increase G's support worker hours, for a worker to take him to the cinema and for G to be weighed monthly.

5.54 G received seven home visits from the CPN over the next 12 months. He was seen in the outpatient department on three occasions and subject to a CPA review.

5.55 Someone stole £100 from G's room on 21 May 2004. The theft was reported to the police and they came to the home. They suspected a fellow resident but no one was identified. Staff took a statement from at least one resident. The internal investigation documentation shows that at least two residents routinely took or borrowed money from G.

5.56 The last recorded visit from the CPN was on 27 August 2004, with a plan to visit in four weeks' time. G's consultant psychiatrist saw him in outpatients on 13 September 2004. No further entries appear in the clinical records until the morning after G's death.

5.57 G took £250 out of his account on 7 October 2004 for an unexplained purchase. He denied that the money was for another person.

5.58 G was attacked and killed in his room by F. Subsequently F admitted taking £95 from G's wallet.

Comment

G was an elderly, isolated man with a history of depressive and physical illness. Late in his life he had to move to low-to-medium intensity supported housing.

G's depressive illness - for which he took medication – and poor physical health confined him to bed. In doing so he neglected himself. Support workers occasionally engaged him in activities but G probably needed more care than the supported community house could give. However, he twice took up a day hospital place and also attended Age Concern. These placements broke down because G did not attend or because he behaved badly.

G's CPN and care manager thought that he needed more support. They organised periods of respite care but G resisted them because he had to pay towards them. Eventually he accepted that he needed to move from the supported community house into residential care. His application for funding was refused, probably because those making the decision did not understand the complexity of his needs. He was both physically and mentally unhealthy. A district nurse never properly assessed his physical needs. This was an oversight.

G was subject to standard CPA and his last review was in November 2003. Practitioners working separately from the multi-disciplinary team made the

decision to put G on enhanced CPA in September 2002 but did not actually do so. This was immediately after G had been refused funding to move into a residential care home.

G's new CPN did not visit him for a few months and then took a different view of his needs. Consequently G was not moved onto enhanced CPA. Had he been, he would have been eligible for social services funded residential care and might have moved into residential care. G should have been on enhanced CPA. He had complex needs that demanded the involvement of a range of professional staff.

The internal investigation report did not mention the nature of the relationship between F and G. However the independent review the national charity commissioned contained interview evidence from other residents in the house. It suggested that F and G were close friends. It also suggested that G might have been giving F money. F confirmed both points at interview.

Nothing in the records suggested that F was a threat to G or indeed to anyone else in the supported community house. No one could reasonably have foreseen the events that led to G's death.

6. The independent review and trust internal investigation

The independent review commissioned by the national charity

6.1 The national charity commissioned an independent review in summer 2005. A consultancy specialising in supported housing did the work. The review was restricted in its scope after discussions with the police. The purpose of the review was to look at the events leading up to the incident, identify strengths and weaknesses of the management of the house and recommend ways to minimise risk. The review included discussions with staff and residents and a chronology of the care of F. It made 13 recommendations.

6.2 The charity's director of service improvement received the final report in July 2005. At that point they had produced an action plan. A letter from the consultancy that conducted the independent review dated July 2005 said:

> "*(the charity) are fully committed to implementing the recommendations in the report*."

6.3 The independent review found.

- Staff could not have done anything that might have prevented G's death.
- F was not seen as a risk to others during his time in the house.
- F became a greater risk before the incident because of his drinking and non-compliance with medication. Practitioners believed he was at greatest risk of self-harm.
- F was vulnerable to abuse and had been the subject of an interagency protection conference just before the incident.
- Statutory mental health services and the supported housing provider had shared lots of information.
- The CPN(s) were in close contact with staff, F and G.
- Relationships between senior staff and statutory mental health services were sound.

- Local statutory services were not involved in F's referral to Kent (services in Leicestershire made contact after F had moved in with his parents in Kent).

6.4 The body of the report also contained findings. It made the following comment about the national charity's application and assessment procedure:

"In practice this means that no re-assessment had taken place – including no re-assessment of risk. This makes it difficult to work purposefully or identify progress. The work with XY (F) had not moved forward and in many ways he had deteriorated since taking up residence… This needs to be addressed."

6.5 The report said:

"Within [the house]… *the issue of alcohol misuse has been of greater concern."*

6.6 It also said that better service user documentation would:

"Provide a framework for structured management of support work which at present does not apparently occur."

6.7 The reviewer said this about service provision:

"It is therefore necessary to assess a service user's suitability for a service on the basis of their being able to live in a group setting without support for a number of days on a regular basis. In addition (the supported housing provider) needs to ensure there is a comprehensive feedback of events occurring during the unstaffed period."

6.8 On line management, the reviewer found:

"There have been considerable staffing difficulties both at [the house]… and the [local]…office….there was no evidence of formal induction, training or supervision during this time…In addition there is no system in place for support work that is carried out to be ratified (by a first line manager)."

6.9 The report summarised the views of service users of XY (F):

"All service users were of the opinion that XY (F) was not a person who was aggressive or violent to others….They were aware of the closeness of the relationship between XY (F) and G."

"XY (F) was seen as a very heavy drinker in the period leading up to the incident….Associated with this was a perceived high level of money available to XY to purchase alcohol. Service users did not know the source of this money with different reasons being given by XY (F)."

The trust internal investigation

6.10 The trust commissioned an internal investigation in late 2005 in anticipation of the conclusion of F's criminal case. The trust delayed the internal investigation until after the proceedings to allow the investigation team to have access to all of F and G's records. Two members of staff (the trust risk manager and CPA co-ordinator) carried out the investigation. An independent consultant psychiatrist and a consultant who specialised in investigations gave advice.

6.11 The trust team were not aware of the independent review commissioned by the national charity and did not know about the existence of the report at the time of their investigation.

6.12 The chief executive wrote to F's parents on 10 February 2006 to tell them about the investigation. Two of the team met F's parents at their home on 28 March 2006. The investigation team met staff from the supported housing to discuss their work.

6.13 The internal investigation comprehensively assessed the organisational and operational matters arising from the care and treatment of F and G. The investigation had written terms of reference and its work consisted of:

- interviews with staff involved in the care and management of F and G
- a review of the clinical records of F and G
- a review of trust policies
- the development of a chronological timeline and an analysis of themes
- use of a semi-structured questionnaire with a cross-section of trust staff
- two focus groups

6.14 The investigation found the following:

- F's care and treatment between 2003 and 2004 was reasonable
- no information suggested F was a risk to others
- F's placement in supported housing was appropriate
- F's transfer by statutory mental health services in Leicestershire fell below the national expected standards.

6.15 The internal investigation team concluded that:

- G's placement in supported housing was appropriate
- G's increasing needs were assessed and met by older adult mental health services.

The report is 46 pages excluding a document with the staff questionnaire results. Its factual basis comes from a wide range of sources including clinical records, policy documents, individual interviews, group discussions and a questionnaire. PL, a member of the investigation team and now the trust lead for serious incidents, said it was unusually detailed. The trust executive team decided to use an external consultant to help staff learn how to conduct a thorough internal investigation.

6.16 The investigation team identified four issues about F's care and treatment and whether the attack on G could have been prevented. These were the change of F's medicine from Clopixol to risperidone, the appropriateness of his placement in the supported community house, the transfer of responsibility for the delivery of mental health services to F from Leicestershire to Kent, and why the mental health service in Kent did not identify F's risk to others.

6.17 They identified three matters about G. They were the application of CPA, the appropriateness of his placement in the supported community house and the joint assessment process by health and social care.

6.18 The investigation report examines these seven matters.

6.19 The investigators did not interview F.

6.20 Dr W (RMO) did not see the final report and did not know the investigators' conclusions and recommendations until earlier this year.

Comment

The charity's independent review was restricted because it was carried out during the criminal case. Nonetheless, it contained helpful insights into the management of the home and the relationship between F and G. It found deficiencies in the management of the supported community house, but that F's attack on G could not have been prevented. It suggested that alcohol misuse in the house was a problem and that staff and managers had no means of knowing what went on in the house out of hours. No one knew clearly the extent of F's drinking or what passed between residents. The independent review said that F's mental state and functioning had probably declined during his 18-month stay and that he had not been reassessed. The charity committed to taking action on the review's 13 recommendations. We have seen no information about what they did.

The trust carried out a detailed investigation into the care and treatment of F and G but did not interview F. It is comprehensive, in contrast to many internal investigation reports. The investigation explored seven issues associated with their care and treatment. It found that they were properly placed and cared for.

Our impression is different from that of the internal investigation team. It is based on having had access to more information and having spoken to F.

The supported community house did not meet all F's needs but the CMHT staff were attentive to his mental health care. G's needs increased between his arrival in the house in 1999 and his death in 2004. His CPN, care manager and support workers recognised this. A residential home would have been better suited to his mental health and physical needs.

7. Implementation of the trust recommendations

7.1 The trust internal investigation took 11 months and made six recommendations. PC, then director of performance and governance at the trust, sent the completed report to NHS South East Coast in December 2006. Ms C also asked the trust's director of mental health (eastern and coastal directorate) to "*develop your action plan and make sure it is monitored through your directorate team meetings*".

7.2 Dr W (medical director) confirmed in 2011 that East Kent trust had not passed on the investigation and action plan to the new organisation. Consequently, no formal monitoring of the actions arose from the 2006 internal investigation report. The trust had made a full appraisal of the case when the SHA wrote to the acting chief executive in 2011 about this independent review.

7.3 PL, SI lead, confirmed that she has seen all investigations and action plans following the merger. She has ensured that all actions have been completed and the cases closed.

7.4 The trust has well-established systems for investigating and managing incidents and disseminating learning. Dr W is the executive director responsible. She chairs a trust-wide group that can commission a clinical incident learning review into a serious incident. A staff member experienced in root cause analysis leads the review and reports back to the group. The trust serious incident lead and her team chase progress on investigations and action plans.

7.5 Staff learn (including support staff) via the medical director bulletin, the '*learning from experience*' groups and the service directors. Dr W and the trust SI lead consider staff are learning from incidents and changing practice and systems as a result. Dr W said that in the last two years the trust had reported a 10 per cent reduction in serious incidents and that NPSA data showed that patient safety-related deaths had fallen. Organisational processes, including the implementation of CPA and risk assessments (the timely conduct and updating following an event), remain the most significant recurring themes from the investigations. At the time of writing the trust is considering how different training and more sophisticated clinical tools can help these enduring problems.

7.6 The trust offered a variety of examples to demonstrate commitment to learning and changing practice, including:

- posters displayed on wards about items that pose a potential risk to patients e.g. plastic bags
- additional specialist training for staff who work with patients suffering borderline personality disorder
- dedicated clinical risk trainers
- a new policy for depot medication clinics
- research about homicides or suicides that happen within seven days of the last contact with trust services, the outcome of the research will be reported to the trust-wide patient safety group.

7.7 We assessed each recommendation with the help of the trust management team.

Recommendation 1

All staff involved in the transfer of care for service users transferred into the mental health service, or across mental health services in Kent, must ensure that their practice complies with CPA Association guidelines.

7.8 Dr W said that in 2004 and at present, staff understood the importance of handling transfers efficiently. The trust was an ‘importer’ of patients from elsewhere, particularly from London. The practice was to obtain as much information as possible from a trust transferring a patient, ideally in written form, with a face-to-face handover. Some trusts still made transfers at the last minute without passing on all necessary information.

7.9 The most recent version of the CPA policy, ratified on 23 March 2010, sets out the information that should be included in all transfers. It does not say what to do if this is not received and it gives no escalation policy.

Recommendation 2

There needs to be an operational policy for community mental health teams in Kent and Medway NHS and Social Care Partnership.

7.10 The structure of community mental health teams has changed regularly since 2004. The policy supporting their operation has also been re-written. CMHTs are changing again in 2011 to fit with commissioning changes and in anticipation of clinical commissioning groups.

Recommendation 3

The director of governance must ensure that there is an annual audit of professional and management supervision, and that appropriate actions are taken based on the results of these.

7.11 Incident data showed that supervision of staff was not as regular and robust as it should have been. Much has been done to improve supervision. Audits are conducted at least annually.

7.12 A supervision policy is regularly updated in response to comments from staff and lessons from incidents.

7.13 CPNs receive management supervision sessions every six weeks. These meetings are on a one-to-one basis and the supervisor maintains a written record. A supervisor may ask to see a number of cases and review, for example, the regularity of visiting and the quality of the record-keeping. Where necessary, a supervisor sets objectives for the person supervised.

7.14 Staff are expected to raise concerns at their regular team meetings about the presentation and management of patients.

Recommendation 4

The report generated following the analysis of the questionnaire issued during this investigation must be considered by the trust's governance team and the Eastern Coastal Directorate.

7.15 The trust action plan summarises the changes brought in after the questionnaire:

- new training programmes covering CPA and risk management
- introduction of electronic records
- regular CPA audits

7.16 The trust updated the action plan in June 2011 and it contains evidence of audits from 2006. It shows the improvements in services since 2004 and outlined a three-day CPA training programme called, *Key concepts in the Care Programme Approach*.

Recommendation 5

The trust needs to find a mechanism or mechanisms for achieving a greater degree of clarity and consistency in practice in older adult services around how and why service users are placed on enhanced CPA.

7.17 The assistant director of older people mental health services said he thought the policy on why clients went on enhanced CPA was clear at the time of the incident.

7.18 The trust now has a CPA pathway (formerly enhanced CPA) and a care pathway (formerly standard CPA). Clients who are allocated to the CPA pathway have complex needs and significant indicators of risk. A number of agencies are likely to be involved in their care and treatment. They have a care co-ordinator and a multi-disciplinary team makes decisions about care and treatment. This almost always involves a psychiatrist. The client usually has a formal CPA review annually but it can take place more regularly if necessary. If the person lived in a supported community house the staff are involved in the review. The assistant director confirmed to us that trust staff understand why clients are on a care pathway as distinct from CPA.

7.19 The assistant director said that older adult services had changed significantly since 2004. The service is now need-based rather than age-based. For example, a fit and healthy 71-year-old man would have his needs met by younger adult mental health services. He would previously have transferred to the care of the older people mental health services at 65 years. The assistant director said integration with social care remains an issue.

7.20 Day hospital services have been phased out and replaced with recovery and wellbeing services. These services focus on living well and recovering. A client like G would attend such a service with an individual treatment programme. The trust has also introduced a service for assessing memory/cognitive changes since the publication of the dementia strategy. Carers are included in individual assessments. The client may see a multi-disciplinary team for their care and treatment. Older adult mental health services have also developed a highly regarded home treatment service.

7.21 The assistant director finds that the trust generally has good relations with providers of supported housing. He said there were many informal, strong relationships between the trust and other agencies. He thought some of these relationships would need to be formalised, particularly to reduce the duplication of services. He expected more discussion between management teams, agencies and stakeholders as cuts are made.

Recommendation 6

There are two issues relating to the joint assessment process that must be addressed. The first is the design of the joint assessment form and the second is that clear direction needs to be given to care coordinators and care managers regarding their responsibility to ensure that appropriately additional professionals are engaged in the joint assessment process where specific needs of the service user are clearly identifiable.

7.22 The trust's CPA documentation has changed significantly since 2004. Older adult mental health services now use an individual needs portrayal to gather information about a client. This form is geared to the needs of older adults and is usually completed with the client and staff. It may take a number of visits to complete. The form contains triggers to involve other agencies. Assessments may be joint e.g. carried out by younger and older adult mental health services. Responsibility for care may be shared. Agreement would be reached about which service would take responsibility for care coordination. The current trust care pathway and CPA policy dated May 2011 says that today G would receive "*support from a care coordinator*" and "*a comprehensive multi-disciplinary, multi-agency and self-directed assessment covering the full range of needs and risks.*" This would be supported by a written care plan and a formal multi-disciplinary and multi-agency review at least six monthly.

7.23 The assistant director of older people mental health services said he was confident that care coordinators now ensured joint assessments between services. He thought mental health services understood the interplay between mental and physical health problems, particularly as a result of the work of agencies such as NICE. He would now expect mental health services, working closely with the supported community house and primary care staff, to give proper attention to G's physical health problems. The trust has had a *Physical health & examination policy* since 2007 and it includes guidance about the physical assessment of older people. It contains practical tools for making such an assessment and prompts for patients receiving long-term care. For example, staff are prompted to weigh patients in long-term care six monthly, review their medication and consider the impact of lifestyle factors such as smoking and exercise. The trust is currently carrying out a routine review of the policy.

7.24 The assistant director also recognised that problems arose when services overlap. The trust is working to integrate intermediate care services.

8. Overall analysis

General overview of care and treatment

8.1 F's transfer to Kent could have been handled better. It was made at the last minute, with insufficient time for local services in Kent to plan for his arrival. The local CMHT had to ask for more information and point out that F would be outside their catchment area when he went to live with his parents.

8.2 Local services assessed him promptly in April 2003 and became intensively involved in his care and treatment once he moved to the supported community house in 2003. He received regular visits from his CPN and had three CPA reviews during his 18 months in the house. He also had a programme of activities in the day.

8.3 F drank increasingly heavily during his stay in the supported community house. Once his depot injection in June 2004 was stopped he became less compliant with his medication. Both his drinking and his non-compliance were indicated in his relapsing. His mental state had deteriorated significantly by November 2004. Those responsible for his care were more concerned about his vulnerability to exploitation. There was no reason to think he would be violent and his attack on G came as a surprise.

8.4 G received regular input from health services in Kent. As his needs increased he should have moved to residential care. This might well have happened if he had been moved to enhanced CPA in September 2002, as his CPN suggested.

8.5 G suffered from poor health. His GP and hospital services saw him but he had no regular assessment from a district nurse.

Missed opportunities

8.6 Services in Kent did not pursue Leicestershire for further information about F when he transferred. If they had they might have learnt about his ABH charge in 1992. They did not escalate their concerns to trust senior management but made the best they could of a poorly conceived and planned discharge from Leicestershire.

8.7 G was considered for enhanced CPA in November 2002. His increasingly complex needs would have justified this decision. The change in CPN meant that G was not moved to enhanced CPA.

8.8 The trust lost sight of the internal investigation report after the merger in 2006. The implementation of the recommendations of the report was not being monitored and supported by the relevant committee in the trust. The six recommendations have been tackled in any event.

Notable good practice, new developments or improvements

8.9 The local CMHT promptly picked up the care and treatment of F despite the poorly organised transfer from Leicestershire.

8.10 Both F and G received sustained input from the local CMHT CPNs.

8.11 Communication between staff in the supported community house and statutory mental health services was regular and good.

8.12 The trust carried out a detailed internal investigation. F's parents were given the opportunity to read and discuss the findings of the report with the investigative team. This is good practice and not always carried out by trusts.

Appendix A

Terms of reference

Independent review of the care and treatment of F and G

Commissioner

This independent review is commissioned by NHS South East Coast with the full cooperation of Kent and Medway NHS and Social Care Partnership Trust (the trust). It is commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the *Good Practice Guidance* issued by the National Patient Safety Agency in February 2008.

Terms of Reference

The review will provide independent scrutiny of the care of F and G largely by means of a documentary review. The review will be conducted by a single investigator, supported by a peer reviewer. The work will be conducted in private and take as its starting point the trust's internal review.

The documentary review will examine the following:

- The internal review, including the methodology, appropriateness of the panel members, the interviewees and the evidence considered.

- the extent to which care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies, in particular:

    - the adequacy of any risk assessments and risk management plans carried out for both F and G, specifically any relating to the potential for F to harm others;

- any relevant gaps or issues found which were not investigated as part of the internal investigation in relation to the care and treatment provided for F and G during their last episode of care with services to the time of the offence;

- the care programme approach and how it was carried out in relation to F's and G's care and trust policy;

- the progress made against the recommendations from the trust's internal investigation;

- any new developments or improvements in services since F's and G's engagement with mental health services.

A report will be written for NHS South East Coast that includes:

- a general overview of the care and treatment of F and G from their first contact with services. This will be followed by a detailed chronology of events of the last episode of care leading up to the offence;

- an analysis highlighting any missed opportunities and findings based on the evidence received;

- any areas of notable good practice, new developments or improvements put in place since this incident which are relevant to this case;

- measurable, achievable recommendations for action to address the learning points to improve systems and services.

Approach, advice and interviews

Consent to access F's clinical records will be sought and he will be offered an opportunity to meet with the investigators.

As this review has been scoped principally as a documentary review it is anticipated that the only interviews that will take place will be with trust managers to assess the progress they have made in implementing the recommendations from the trust investigation.

If any other interviews take place Verita will follow good practice in the conduct of any interviews by, for example, offering the opportunity for interviewees to be accompanied and allowing them to comment on the factual accuracy of their interview transcript.

If required, a general psychiatrist will provide professional advice along with other experts.

Verita will notify the commissioners immediately if they identify during the course of their work a serious cause for concern regarding service delivery.

This review is not part of any disciplinary process.

Timetable

The review will begin once consent has been received for the disclosure of records and when the majority of source records have been received.

Verita will aim to complete the review within four months of starting work.

Monthly reports on progress will be provided to NHS South East Coast.

Publication

NHS South East Coast will determine the publication, distribution and handling arrangements after consultation with the investigation team and other interested parties.

Appendix B

Documents reviewed

- Court transcript of sentencing
- Trust internal investigation report and associated papers
- Independent review of the supported community house
- Medical, nursing and other records of F
- Medical, nursing and other records of G
- Trust document setting out action taken that address recommendations

Appendix C

Interviewees

- Dr Karen White, medical director
- Penny Lamb, trust SUI lead
- Jon Parsons, assistant director, older adult mental health services

Informal discussions with

- Marie Dodd, acting chief executive, Kent & Medway NHS and Social Care Partnership Trust

Meetings with

- F

Appendix D

Analysis of G's records and other documents for references to the desirability of him moving to residential care or having further support

Date	Comment	Author	Comment location	Reference Number
17/07/2001	"His support worker suggested that he be considered for residential care; I would support this."	Dr H	Letter to Dr A	1
24/08/2001	"I note from Dr H's previous letter that he supported assessment for residential placement and I concur with this"	Dr F	Letter to Dr A	2
03/10/2001	"D/W ST wants a joint assessment with PD [G's CPN]"	Dr F	Out-patient notes Psychiatry	3
23/10/2001	"He would benefit from a short period of Respite care to enable staff to monitor his progress over the 24hr period" "Following the Respite G will require close monitoring & possibly a care package" "Over this time [3 years in semi-supported environment] his abilities to manage have gradually decreased. He would now benefit from a short period of respite care to assist him"	ST	KCC Assessment Profile	4
29/11/2001	"staff... have also been looking at alternative placements since he does not fit the criteria for Social Services Placement"	Dr F	Letter to Dr A	5
25/02/2002	"Patient pulled out of going into residential care…Staff feel he does not help himself"	Dr F	Out-patient notes Psychiatry	6

06/03/2002	"[G] has blocked plans to get him into The Paddocks… which would, perhaps, have been better for him"	Dr F	Letter to Dr A	7
14/03/2002	"he [G] was seen by his GP yesterday who said that G should be moved to the [residential home]…"	JT	East Kent Trust Mental Health Directorate (case notes)	8
15/03/2002	"D/W Dr A + Dr F who both feel that G's problems would be greatly assisted if he was accommodated in a more supportive environment"	JT	East Kent Trust Mental Health Directorate (case notes)	9
19/07/2002	"MP [G's support worker] has concerns that the … home is no longer meeting G's needs"	JT	East Kent Trust Mental Health Directorate (case notes)	10
22/07/2002	"[the home] do not feel that they are meeting G's needs"	JT	referral form for Winslow day hospital	11
11/09/2002	"In my opinion he would greatly benefit from 24 hour care in a residential setting that has suitable trained staff that are able to accommodate his needs effectively."	Dr F	Letter to AR	12
12/09/2002	"I discussed the situation with G, his support worker and Caroline Gale and it was decided that G required urgent 24-hour care." "Because of G's general anxieties and lack of self-motivation he requires on-going monitoring and encouragement throughout the day" "When we visited on the 11 September he [G] felt that the time had come for him to move to [the residential home]… on a permanent basis"	JT	Letter to AR	13

20/09/2002	"It is confirmed that EK2 [G] should now be on an Enhanced Care Package following the refusal of funding for a permanent residential placement. The notes say that arrangements are made by CPN4 for CPN5 to do a Joint Assessment with the Care Manger"	JT notes	Internal Investigation report	14
19/02/2003	"[G] also expressed a wish today that he would like to be living in a residential environment and I will pursue this line of thought with his care manager, ST"	PD	Letter to Dr A	15
28/11/2003	"support worker hours to be increased"	CPN	East Kent Trust Mental Health Directorate (case notes)	16

Appendix E

Biography

Ed Marsden

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management before founding Verita in 2002. He combines his responsibilities as Verita's managing partner with an active role in leading complex investigations and advising clients on the political repercussions of high-profile investigations. He is an expert in investigative techniques and procedures. Ed is an associate of the Prime Minister’s Delivery Unit where he has carried out three assignments on immigration.