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

March 2013

A report for NHS London
Undertaken by Caring Solutions Ltd

NHS
London

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EXECUTIVE SUMMARY

1. Incident description and consequences

1. On the 20 January 2011, Mr I was involved in a serious incident, in North London, which involved four young people.

2. During the incident Mr I stabbed the four young people with a knife. Three were taken to hospital with knife injuries and one young person, Mr J, died at the scene

3. Mr I was arrested and held at Tottenham Police Station. He was charged with the murder of the young person. Additional charges were made for grievous bodily harm and actual bodily harm. Mr I was subsequently remanded to HMP Belmarsh.

4. At the time of the homicide Mr I was a Service User of Barnet, Enfield and Haringey Mental Health NHS Trust (BEHT) and a resident at a Registered Residential Care Home. Mr I had been in contact with Mental Health Services since 2001 when he was transferred to North London Forensic Services (NLFS) from HMP Pentonville under section 48/49 MHA (1983).

5. In February 2006 Mr I was discharged, under a supervised discharge order Section 25a (Mental Health Act (MHA) 1983), to a 24 hour supported Registered Residential Care Home.

6. At the time of the homicide Mr I was still a resident of the Care Home and receiving Mental Health Services from the Community Rehabilitation team (CRT) in Haringey.

2. Background and Context

1. BEHT is an organisation that provides a wide range of integrated mental health and community health services. In 2011, when the incident occurred, the Trust employed 2,700 staff and their annual income was £189 million.

2. Following the transfer of Enfield Community Services, the Trust provides a full range of child and adult community health services in Enfield. The community services provide health care outside of hospitals including sexual health, health visiting and nursing for long term illnesses such as diabetes and heart failure.

3. The Trust provides specialist Mental Health Services to people living in the London boroughs of Barnet, Enfield and Haringey, these include:

    - Mental Health Services for all age groups.
    - Specialist Child & Adolescent Mental Health Services (CAMHS)
    - Addiction Services

- Eating Disorder Services
- Learning Disability Services
- Forensic Services
- Personality Disorder Services
- Improving Access to Psychological Services (IAPT Services)

4. Within all Services there are a range of professionals – medical and nursing staff; social workers; occupational therapists; psychologists and support workers.

3. *Terms of Reference - Questions and Actions*

The key questions the Independent Investigation Panel developed from the terms of reference are:

1. Was the Trust's Internal Investigation adequate in terms of its findings, recommendations and action plans?
2. What progress has been made by the Trust in implementing the action plan from the Internal Investigation?
3. Was the family of both Mr I and the victim's families involved as fully as is considered appropriate?
4. Develop a chronology of the events to assist in the identification of any Care and Service Delivery problems leading to the incident
5. What were the Mental Health Services provided to Mr I and were relevant documents in place?
6. Was Mr I's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies?
7. Were the Risk Assessment and management of that risk to others adequate?
8. Was the quality of assessments and Care Planning appropriate?
9. Are there matters of public interest which need to be considered?

4. *Level of Investigation*

1. The investigation is a level 3 Independent Investigation

5. *Findings*

1. The Trust desk top review commenced one week after the serious incident, with clear terms of reference which would have ensured that any immediate actions could be addressed in a timely manner. The Independent Panel commend this as notable practice.

2. The Internal Investigation was led by an Independent Chair and had as a panel member a BEHT non executive, whilst this gave objectivity to the process it is recommended that future panel members should remain independent of the situation being investigated, and where this is not possible ensure this is declared within the report.

3. The investigation was extensive and sought the views of many staff, ex staff members and other agencies involved with Mr I.

4. The victim and perpetrator's families were involved in the process which helped contribute to the findings.

5. The process for carrying out the review was managed in a timely and effective manner and was completed by November 2011. It is unfortunate that at the time the findings from the report could not be shared, however this was outwith BEHT's control.

6. There was a delay of four months following the presentation of the Internal Investigation Report to BEH Trust Board in May 2012. Whilst the action plan had been developed from the recommendations the group responsible for ensuring implementation of the actions did not meet until September 2012. The Independent Investigation Panel received no mitigating reason for this and consider this period to be too long.

7. The report does not follow the National Patient Safety Agency Comprehensive and Independent Investigation report format. This means that causal factors and Care/Service Delivery problems have not been clearly identified from the findings. This raises a question for the Independent investigation Panel in relation to Trust staff having the appropriate Root Cause Analysis training in order to undertake Investigations.

8. The recommendations within the Internal report appear to be statements of fact rather than SMART auditable goals which lead to the development of measurable action plans (see Appendix four for a list of the Internal report recommendations).

9. Recommendation 4 from the Internal report, in its current form, will not give reassurance to the Trust that all sections under the Mental Health Act are monitored to ensure that discharge from detention is carried out in a considered and managed way.

10. Recommendation 15 from the Internal report, does not lead the clinician to consider clinical risk and act appropriately to mitigate the risk as far as possible.

11. There is no recommendation in relation to reviewing clinical and managerial leadership, both of which from the findings within the Internal report are demonstrated as not effective in the Trust, particularly between 2007 and 2009.

12. Whilst it will be possible to evidence that actions have been completed there is no overarching stated action to ensure understanding and ongoing compliance with the recommendations.

13. All actions and recommendations are being progressed and using the National Health Service Litigation Authority framework comply with either Level 1, 2 or 3.

14. Evidence supplied to meet recommendation 15 from the Internal report can only apply to clinical areas within Trust property.

15. The actions relating to recommendation 19 from the Internal report needs to be revisited to meet the requirements, in terms of working with all schools in the Haringey area.

16. The Trust needs to ensure that the Organisational Change Policy is always followed and that the check list for closing or moving a clinical area is implemented in all cases, and that this is auditable

17. The Internal Investigation Panel were able to meet with Mr I's brother and mother, the Trust provided interpreters for them.

18. The Independent Investigation Panel was unable to secure a contribution from Mr and Mrs I Senior, although the Internal Panel did interview Mr I as part of the process, with an interpreter present.

19. Not unnaturally the family of Mr J wanted answers to the incident, however they experienced the Internal Panel as cold and lacking in openness. The Independent Investigation Panel concludes that the Trust did follow process having contacted and met with the family in a timely manner but that a lesson could be learned on understanding a family's experience of meeting with a Panel in a formal manner.

20. The Independent investigation Panel have accepted the questions and observations made by Mr J's Family at their interview and will address these within this report. They will also address those questions and observations made by the legal representative which are germane to the Independent Investigation.

21. BEH Trust Mental Health Services were available to Mr I and within these he was appropriately managed from his admission in 2001 until 2007 when the Community Psychiatric Consultant left his post.

22. The Independent Panel questions the rationale for not accepting Mr I into the Community Forensic Service, however note that this has been addressed in the Internal Investigation (recommendation 2).

23. Mr I was appropriately placed into a Residential Care Home, where it is evidenced that his risks and care needs were well documented.

24. Mr I's Section 25a (MHA 1983) lapsed due to an administration error. The Independent Investigation Panel feel that recommendation 4 of the Internal Investigation Report should be expanded to cover all Mental Health Act sections. The panel also note the work that has been carried out by the Mental Health Act Team to comply with the current recommendation 4.

25. There was no Community Mental Health Service available to Mr I after his Consultant Psychiatrist left in October 2007 until April 2008. This was predominately due to restructuring of the Community Mental Health Teams. Whilst this was addressed within the Internal Investigation (recommendation 6) and a Management of Organisational Change Policy has been developed, the Independent Investigation Panel were informed, during staff interviews for the Independent Investigation that this was not complied with during a potential closure of one ward recently. Whilst assurances were given to the Panel that this issue was addressed, the Trust need to ensure full compliance with the Organisational Change Policy, by auditable means.

26. Mr I's Care Home throughout his stay communicated well with the Mental Health Services, apart from when there was a gap in Mental Health Service delivery between 2007 and 2008. The Care Home appropriately challenged the Service with regard to this.

27. When the Care Home had a concern relating to Mr I they addressed it quickly and effectively with the Mental Health Services as can be seen from their contact with the Service when Mr I had a relapse in November 2010.

28. Mr I was not accepted by the Dual Diagnosis service, though he met the criteria in that he had a severe and enduring mental health illness and a substance misuse problem.

29. It is unclear what the status is of several Policies as there is no current review date noted. Given that there are recommendations which impact on service delivery and service review within the Internal Investigation, the Independent Investigation Panel would request that a review of the status of Policies is prioritised.

30. There were at times evidence of non-compliance with Policies, namely the CPA Policy and the Section 25a (MHA 1983) Policy. The Trust should ensure that it can evidence compliance and ongoing monitoring of Policies. Whilst the Trust has identified this within the Internal Investigation, the Independent Investigation Panel is of the opinion that the Trust should clearly describe how compliance will be monitored.

31. The Trust Policies do cross reference to other appropriate Policies and make reference where appropriate to relevant National Guidance, as an example Clozapine Policy begins with a description of NICE guidelines (National Institute for Clinical Excellence).

32. The Trust does not appear to have a universal understanding of the role of the Community Rehabilitation Team (CRT) and need to clarify and agree, both clinically and managerially, its purpose and function.

33. There are different expectations of the 'weighting system's aim (Internal Investigation recommendation 7 action point). It is unclear if it has been devised to manage those Service Users most at risk or as a tool to manage Service Users through the system.

34. The section on Risk Management within the CPA Policy is worthy of note as it clearly leads the clinicians to review dynamic and static risks.

35. Mr I had been an Inpatient of NLFS under section 37 of the MHA (1983) for over 4 years and yet was not followed up by the Forensic Community Team. There is no rationale for this and is potentially a missed opportunity for Mr I to have a more seamless reintegration back into the Community with close supervision of his behaviour, and an eventual seamless hand over to the General Adult Psychiatric Service. This has been addressed via the Internal Investigation (recommendation 2).

36. Mr I's Section 25a (MHA 1983) lapsed in 2006 due to an administration error. Mr I started to challenge his need to take Medication as he was an Informal Service User. Had he continued to remain on a Section 25a (MHA 1983) it is possible that after the amendment to the Mental Health Act (1983) in 2007, Mr I would have been transferred to a Community Treatment Order (CTO). This has been addressed via the Internal Investigation (recommendation 4).

37. The Community Mental Health Teams (CMHTs) were restructured more than once between 2006 and 2010 with the result that Mr I did not always receive a consistent service from the Mental Health Services in terms of professional involvement, timely Care Planning and appropriate risk management, though in the year prior to the incident in January 2011 Mr I did have two Care Planning meetings as per the CPA Policy, a consistent Care Coordinator (CC) and Consultant Psychiatrist and an appropriate risk and care management plan. By this time the Care Home also had good access to Mr I's CC and Consultant as demonstrated when Mr I relapsed in November 2010.

38. Communication from General Adult Psychiatry to the Forensic Services with regard to follow up for Mr I following the departure of the first Community Consultant Psychiatrist in 2007 was poor. This was compounded by the fact that Mr I, following the restructuring of the CMHTs in 2007 was left without an allocated CC. Whilst the Independent investigation Panel are satisfied that the Trust now have an Organisational Change Policy in place and impact assessments are carried with regard to change it should be recognised that any restructuring of a clinical service must prioritise the risks to the Service User and mitigate against these before any change is made. Compliance with this should be auditable.

39. Communication and follow up from the Community Services to the Care Home was lacking in 2008 when communication from the Services was poor between October 2007 and July 2008 which necessitated in the Director of the Care Home having to alert the Community Service to their lack of input. This meant that the Forensic Psychiatrist was the only source of support from the Mental Health Services at this time for a Service User who is described as being a significant risk who needs close supervision.

40. In October 2008 the Director of the Care Home appropriately escalated his concerns about Mr I's increasing risk behaviour to the allocated Community Consultant Psychiatrist setting out Mr I's behaviour during 2008. The Director of the Care Home appropriately continued to discuss his concerns at Mr I's CPA meeting held in November 2008.

41. Communication with Multi Agency Public Protection Arrangements (MAPPA) was poor. The Internal report notes the poor engagement of the Mental Health Services with MAPPA meetings and that there were no issues apparent with Mr I which warranted his continuance as a category 3 offender - which is 'a person who poses a "risk of serious harm to the public" who has received a conviction and whose risk would be better managed in a multi-agency setting'. Mr I was removed from MAPPA in November 2009. This has been addressed within the Internal Investigation (recommendation 9)

42. Risk assessments were variable, given the number of clinicians involved with Mr I from 2006 to 2011. Whilst Risk Assessments were carried out and his main risks documented the description of the severity of these changed, as did the level of detail describing each risk. It should be noted however that the CC did carry out and document Risk Assessments which were comprehensive and included the issue of knives being found. It was however quite reliant on the Care Home to implement the Care Plan.

43. The Care Home carried out regular reviews of Mr I's care which included risk history, Risk Assessment and risk management plans and when required escalated risk concerns to the Trust.

44. The Mental Health Services initially responded appropriately to Mr I's relapse. However Mr I did not have his blood test carried out to measure his Clozapine levels as intended by the Consultant, the Independent Investigation Panel note that the Internal Investigation has addressed the monitoring of Clozapine (recommendation 16).

45. Care Plans from 2006 were variable, however from 2010, when there was consistency in terms of clinical involvement, Care Plans and assessments became consistent, current and informative.

46. The CC did not follow best practice in his ongoing assessment of Mr I following his relapse. Whilst it is accepted that Mr I had improved significantly it would always be best practice for a CC to assess a Service User face to face, particularly following such a recent relapse.

47. The Panel remain concerned that the CRT was reliant on the Care Home to implement actions from Care Plans. The CRT must be clear about its remit and ensure that as part of this there is recognition of the professional accountability clinicians carry when delivering care.

48. All Community Services need to demonstrate they are actively overseeing the implementation of Care Plans, even for those Service Users in residential placement, and that this is appropriately supported and auditable.

49. The Independent Investigation Panel notes the recommendation made by the Internal Investigation Panel in relation to liaison with the schools. There are however 11 schools in the immediate vicinity of the Care Home, and a Family Centre. Whilst the Panel would not want to exclude any person from living in the Community they would advise that where there are implication of safety for the public, impact assessments are carried out and risks identified from these mitigated.

50. Under the new commissioning arrangements for Health Services the National Commissioning Board will be responsible for commissioning all Forensic Services. This will include Community Forensic services. Whilst it is acknowledged that specialist clinical advice has been sought in order to shape the new arrangements, the Trust Board should ensure that new arrangements do not cause a gap in services for Service Users to fall between General and Forensic Psychiatry.

51. The Panel is aware that the Trust has undergone a significant reconfiguration of its services and most staff interviewed by the Panel welcomed the changes. However the Panel would like to be assured that Services are now allowed to settle and develop without further significant change.

52. The National Service Framework was a ten-year programme that was completed in 2009. Associated with this programme were a series of Policy Implementation Guidance documents (PIG). There is some confusion as to the current status of these documents. Many commissioners and Trusts are reconfiguring their Mental Health Services to meet new demands in a harsher financial environment including for example, closing Assertive Outreach Services and moving their function back into mainstream Community Mental Health Teams. It is not clear from the current Policy context - "No Health Without Mental Health"; February 2011 – with its focus on well being and prevention, what is the optimum way of delivering care for people with an acute mental illness.

6. Contributory/Associated Factors

1. The National Patient Safety Agency (NPSA) determines "contributory factors as those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to Service Users and hence the likelihood of Care Delivery or Service Delivery problems occurring". Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. The removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or 'root causes' will be expected to prevent or significantly reduce the chances of reoccurrence".

2. The findings of the Independent Investigation Panel determines that, whilst there is no fundamental root or causal factor for this incident, there are several contributory factors which affected the delivery of safe and effective care to Mr I. These factors are:

3. Mr I was known to local Mental Health Services in Haringey and NLFS. He had been in contact with services since November 2001 when he was admitted to NLF Inpatient Services under a Home office restriction order – 48/49 (MHA 1983), following a transfer from HMP Pentonville. Mr I was on remand in HMP Pentonville charged with two counts of sexual assault on women. Whilst in NLFS he was placed on Section 37, (MHA 1983). Mr I had a provisional diagnosis of Paranoid Schizophrenia and a mild Learning Disability.

4. Mr I was discharged from NLFS in 2006, under Section 25a (MHA 1983) to a 24 hour supported Registered Residential Care Home. Whilst Mr I did not engage in community activities, preferring instead to spend his time in one or two Turkish cafes, until 2008 he was quite settled.

5. Mr I's condition was complicated by use of street drugs in the form of cannabis. In 2008 Mr I admitted to his Care Home Key Worker that he was using cannabis, this is noted in his Key Worker session notes from March 2008 onwards.

6. Mr I had a previous history of offending and of conviction, including violent assaults against family members and members of the public who were unknown to him. He had previously spent time in a young offender's institution and prison.

7. In 2000 Mr I was placed on the Sex Offenders Register following a conviction in 2000 for indecent assault on a female under 16 for which he received a six months prison sentence.

8. When Mr I was discharged from NLFS his Risk Assessment noted that his indicators of becoming unwell are that he becomes untidy and shows a lack of self-care; he appears distracted and vague; he becomes sexually disinhibited towards women.

9. Mr I was resistant to taking Medication and often challenged the need to take it. He had little insight into his mental health illness.

10. Mr I did not understand the impact of placing himself in dangerous situations, as an example he was taken by a Key Worker to a football match at Arsenal (against Fenerbahce, a Turkish team) and he was seated with the Arsenal supporters but revealed his Fenerbahce shirt, against advice. This drew abuse but Mr I could not understand why he should cover the shirt, denied there was any danger and appeared confused at the increasing abuse. He made matters worse by cheering the opposition players and had to be moved. He did the same again on leaving.

11. Mr I would behave inappropriately to women by staring at them and trying to engage in conversation with young girls.

12. Mr I was found to be in possession of knives by the Care Home on two occasions. Whilst a management plan was put in place by the Care Home to address this, it remained a concern of the Care Home and Community Mental Health Services that knives were found.

13. Mr I's Section 25a (MHA 1983) lapsed in August 2006 due to an administration error, he was however still subject to Section 117 aftercare. Whilst he remained on the Sex Offenders Register at this point he did understand that he was no longer subject to the requirements of Section 25a (supervised discharge).

14. Mr I was not accepted for follow up by the Community Forensic Outreach Service and no explicit rationale was given for this. Mr I was on Section 25a (MHA 1983); was a convicted sex offender; was convicted of indecent assault; had previously been convicted of affray and theft; known to use illicit substances and had a severe and enduring mental health problem and a mild Learning Disability. It remains unclear why he was not accepted for follow up.

15. Mr I received no follow up service from the Community Mental Health Teams between October 2007 and April 2009 and there was no communication to the Care Home from the Service. Mr I had got 'lost' in the system due to service reorganisation. He did however continue to be reviewed by the Forensic Consultant and did receive a consistent service from the Care Home.

16. Mr I had a number of changes to his CC and Consultant Psychiatrist from 2006 until March 2010 most of which was due to several reorganisations of the Community Mental Health Team. This created some inconsistency in his care and risk management, as is demonstrated by the variable care and risk management plans in terms of the quality and consistency of information from the Mental Health Services. It would also have been difficult to establish a base line to observe and monitor Mr I's behaviour as staff did not remain involved for long enough to identify this.

17. Whilst Mr I's his care was very consistent from the Care Home there was an over reliance on the Care Home to keep the Mental Health Services informed of any change in Mr I's behaviour.

18. There was an over reliance on the Care Home to deliver Mr I's Mental Health Services Care Plan.

19. Whilst Mr I was initially considered for inclusion onto MAPPA at category 3 level in December 2008, due to poor engagement from the Community Mental Health Services to the MAPPA process no new risk information about Mr I was communicated to MAPPA. In October 2009 Mr I was removed from the MAPPA process. From this point on Mr I had no formal supervisory structures within which to conform.

20. Mr I was referred to the Dual Diagnosis Service but not accepted, though he met the criteria. The Dual Diagnosis Service did not offer a reasonable rationale for not accepting Mr I into the Service. The Dual Diagnosis Workers are skilled at working with Service Users who have both a mental health and substance misuse issue. Cannabis was being used by Mr I and there is little evidence that this is being actively addressed by the Mental Health Services. Although it should be noted that post incident on the 20th January 2011 at 18.43 a blood sample was taken from Mr I which showed no evidence of cannabis use.

21. When Mr I had a relapse in November 2010 it was thought by the Care Home that he had not been compliant with his Medication, having run out of the room a couple of times straight after having his Medication administered. The Consultant Psychiatrist treating Mr I at the time planned to have his Clozapine levels checked, however this did not happen as the Clozapine Clinic did not receive the email sent by the Consultant. There was therefore no current baseline from which to judge Mr I's Clozapine level following the incident in January 2011.

22. Following Mr I's relapse the CC did not carry out face to face assessments, relying instead on conversations with the Director of the Care Home to inform Mr I's progress. Whilst two clinical records independently show Mr I reported as stable on the 19th January 2011, a day before the incident, his CC would be unable to judge Mr I's improvement as he had not seen him.

23. Whilst it is recognised by the Independent Investigation Panel that Mr I provided a very demanding challenge given his history and behaviour, it is not demonstrated that this was addressed by clear leadership from the Community Mental Health Services.

24. Leadership issues include; poor communication, poor liaison, poor documentation, poor care and risk management, poor compliance with operational and clinical policies, excessive reorganisation of the services leading to several changes in CCs and Consultant Psychiatrists.

7. Root Causes/Causal factors

1. The NPSA determines a root cause as “a fundamental contributory factor which if removed would either prevent or reduce the chances of a similar type of incident happening in the future”. Whilst there are several contributory or associated factors, the findings from the Independent Investigation has determined that there is no fundamental contributory or causal factor. On the 20th January 2011 Mr I was described by his Care Home Key Worker as ’being back to normal’. On the previous day he is described as being stable by another Health Professional. This was therefore an act that could not have been predicted, given his presentation at that time.

8. Lessons Learned

1. The internal report identifies and makes recommendations in relation to:

- Supervision
- Reviewing the Forensic Community Services
- Community Consultants attendance at CPA discharging planning meeting from the Inpatient Forensic Service
- Monitoring working within the Mental Health Act and Mental Capacity Act within supervision.
- Handling and Movement of Service User Records
- Assessing risks in relation to service reorganisation
- Ensuring care management of Service Users in residential placements identifies those requiring more intensive input from the psychiatric team, and verifies that they receive what is required.
- Sexual Offences Prevention Order (SOPO), where considered necessary, staff involved with the care of the Service User must ensure that they fully understand the information needed by the Police
- MAPPA Protocol
- Staff understanding the workings of Haringey Community Learning Disability Service
- Care Planning and the Dual Diagnosis Network
- Staff understanding and awareness of Dual Diagnosis
- Record Keeping
- Prioritisation of Clients by Care Coordinators
- Searching of Clients
- Communication processes between clinical teams and Clozapine clinical teams
- GP Forum, promoting a greater understanding about the role of the CRT and that the expectations by and of the parties involved are more explicit and better understood.

- Informing Service User’s GP following an Serious Incident
- Liaison with the school

2. The recommendations were developed into an action plan and the Independent Investigation Panel was able to evidence progress against each recommendation.

3. The Independent Investigation Panel would like to commend the inclusion of a recommendation in relation to Whistle Blowing. Whilst the service was undergoing extensive reorganisation many staff, during their Independent Investigation interviews, commented on their concerns in relation to keeping track of their Service Users and the mismanagement of handing over Service Users when CC roles changed. Since this time the staff have received information in relation to Whistle Blowing and most staff interviewed knew of the Whistle Blowing Policy and would feel empowered to use it.

4. The Independent Investigation Panel note the progress on the action plan and adds the following points for consideration within the internal action plan (see Appendix four for a list of the Internal report recommendations):

   - Recommendation 4 should be expanded to include an auditable process for monitoring compliance with all parts of the Mental Health Act and Mental Capacity Act.

   - Recommendation 15 can only relate to the searching of property in a clinical area within BEHT and should specify this more explicitly.

   - The actions relating to recommendations 7 and 14 needs to be clarified in terms of the weighting system so that all staff/teams have the same understanding of its purpose

   - In order to fully meet recommendation 7 and 14 the Trust must agree and clarify the role and function of the CRT and ensure this enables delivery of care in line with clinical and professional requirements.

   - Recommendation 19 does refer to all the schools in the vicinity of Haringey, and the evidence and ongoing action focuses only on the school Mr J attended. The Trust should revisit the original recommendation to ensure it complies with regard to each school.

   The Independent Investigation adds:

5. Overall clinical and managerial leadership within the Community Mental Health teams was not demonstrated as robust and effective. There is no evidence that compliance with policies, documentation, risk management and clinical interventions were monitored and where appropriate, challenged within a supervision or caseload management framework. The Trust has now reconfigured into Service Lines with clear leadership structures in place, underpinned by strong direction at Board Level. The Trust however should assure itself that leadership development is an ongoing process which leads to effective leadership at both clinical and managerial level.

6. There was a delay of four months following the presentation of the Internal Investigation Report to the BEH Trust Board in May 2012. Whilst the action plan had been developed from the recommendations the group responsible for ensuring implementation of the actions did not meet until September 2012. The Independent Investigation Panel received no mitigating reason for this and consider this period to be too long. The Trust should gain assurance that findings from Internal reports are implemented in a timely manner.

7. The report does not follow the National Patient Safety Agency Comprehensive and Independent Investigation report format. This means that causal factors and Care/Service Delivery problems have not been clearly identified from the findings. This raises a question for the Independent Investigation Panel in relation to Trust staff having the appropriate Root Cause Analysis training in order to undertake Investigations. The Trust should assure itself that Root Cause Analysis training is available to any person who is a member of an investigation panel.

8. The recommendations appear to be a statement of fact rather than SMART auditable goals which lead to the development of measurable action plans. The Trust should ensure that all recommendations are SMART (see footnote 3 in main report), and auditable so that learning is effective.

9. One of the panel members for the Internal Investigation had reviewed Mr I in a clinical capacity. Whilst this was some time before the incident there was still a potential conflict which should have been acknowledged within the Internal report. The Trust should ensure that it uses Panel members who have not previously had involvement with the issue being investigated, or where this is not possible declare it within the report.

10. Whilst it will be possible to evidence that actions have been completed there is no overarching stated action to ensure understanding and ongoing compliance with the recommendations.

11. The status of all Policies should be clear with a current review date clearly marked.

12. All Policies should have a section on how the Policy will be monitored to ensure ongoing compliance by staff.

13. An audit and/or process should have been included in the action plan to ensure compliance with each recommendation. Currently there is no clear monitoring process to ensure that each action is taken forward and that learning has taken place.

14. The Trust recently did not comply with the Organisational Change Policy. Whilst the Independent Investigation Panel accepts the process put in place to mitigate against this happening again, this process should be audited to ensure ongoing compliance

15. The Trust must ensure that Care Coordinators (CC)s, with appropriate support and clear managerial direction, follow the professional requirements of their role, and that a system is put in place to measure compliance with this.

9. Recommendations

1. The recommendations and action plan to be reviewed to take account of the Independent Investigation additional findings.

2. The Trust to ensure that the action plan continues to be monitored and its progress reported upwards via its governance reporting systems.

3. The Trust should include an audit and/or process within the Internal Investigation action plan to ensure compliance with each recommendation.

4. The Trust should assure itself that leadership development is an ongoing process leading to effective leadership at both clinical and managerial level.

5. The Trust should assure itself that the findings from Internal reports are acted upon in a timely manner.

6. The Trust should assure itself that Root Cause Analysis training is available to any person who is a member of an Internal Investigation panel.

7. The Trust should ensure that all recommendations from Internal Investigations are SMART and auditable, leading to effective learning.

8. The Trust should ensure that all Policies are current and that there is a process described to monitor compliance with each.

9. The Trust should assure itself that the process described in the Organisational Change Policy is audited to ongoing compliance.

10. The Trust must ensure that CCs, with appropriate support and clear managerial direction, follow the professional requirements of their role, and that a system is put in place to measure compliance with this.

11. The Trust should ensure that it does not use Panel members who have had other involvement with the issue being investigated, or where this is not possible it is declared within the report.

12. The Trust should ensure that where new services are set up in the community, it carries out impact assessments which identify any implication of safety for the public and put in place plans to these mitigated the risks identified.

13. The Trust must ensure that given the new commissioning arrangements for Forensic Services, no gap is allowed to develop for Service Users to fall between General and Forensic psychiatry.

MAIN REPORT

1. Incident Description

1. On the 20th January 2011, Mr I was involved in a serious incident, in North London, which involved four young people.

2. During the incident Mr I stabbed the four young people with a knife. Three were taken to hospital with knife injuries and one young person, Mr J, died at the scene

3. Mr I was arrested and held at Tottenham Police Station. He was charged with the murder of the young person. Additional charges were made for grievous bodily harm and actual bodily harm. Mr I was subsequently remanded to HMP Belmarsh.

4. At the time of the homicide Mr I was a Service User of Barnet, Enfield and Haringey Mental Health NHS Trust (BEHT) and a resident at a Registered Residential Care Home. Mr I had been in contact with Mental Health Services since 2001 when he was transferred to North London Forensic Services from HMP Pentonville under Section 48/49 MHA (1983).

5. In February 2006 Mr I was discharged, under a supervised discharge order Section 25a (Mental Health Act 1983), to a 24 hour supported Registered Residential Care Home.

6. At the time of the homicide Mr I was still a resident of the Care Home and receiving Mental Health Services from the Community Rehabilitation team (CRT) in Haringey.

2. Pre-investigation Risk Assessment

1. A risk rating[1] was carried out at the commencement of the Independent Investigation process within a framework which was first developed within the NHS Controls Assurance framework. Using this scoring system, risks can be allocated a score of between 1 and 25, with 1 reflecting negligible risk and 25 reflecting extreme risk. Table 1 sets out the framework.

2. The pre investigation risks were rated at 15. Mr I had a history of violence using a weapon. Given this history the potential likelihood of an incident occurring is set at 3 and the potential impact set at 5. A post investigation Risk Assessment will be completed following the Independent Investigation process to assess whether the risk score will change as a result of the Independent Investigation finding. This will take into account clinical and risk behaviour of Mr I during his time with the Mental Health Services and the Residential Care Home.

[1] NHS Controls Assurance Risk Scoring Methodology – NHS Litigation Authority 2008

Table 1 – NHS Controls Assurance Risk Scoring Methodology

Likelihood (the potential likelihood of the risk occurring)			**Impact** (the potential impact to individuals or the organisation of the risk occurring)
Almost Certain	**5**	Multiplied by	**5** Extremely
Likely	**4**		**4** Very High
Possible	**3**		**3** Medium
Unlikely	**2**		**2** Low
Rare	**1**		**1** Negligible

3. Background and Context

1. BEHT is an organisation that provides a wide range of integrated mental health and community health services. In 2011, when the incident occurred, the Trust employed 2,700 staff and their annual income was £189 million.

2. Following the transfer of Enfield Community Services, the Trust provides a full range of child and adult community health services in Enfield. The community services provide health care outside of hospitals including sexual health, health visiting and nursing for long term illnesses such as diabetes and heart failure.

3. The Trust provides specialist Mental Health Services to people living in the London boroughs of Barnet, Enfield and Haringey, these include:

   - Mental Health Services for all age groups.
   - Specialist Child & Adolescent Mental Health Services (CAMHS)
   - Addiction Services
   - Eating Disorder Services
   - Learning Disability Services
   - Forensic Services
   - Personality Disorder services
   - Improving Access to Psychological Services (IAPT Services)

4. Within all Services there are a range of professionals – medical and nursing staff; social workers; occupational therapists; psychologists and support workers.

4. *Terms of Reference*

1. The terms of reference for the Independent Investigation (Appendix 1) set out the following:

4.1. Aim

1. The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr I, via the objectives set out in 4.2.

4.2 Objectives

The objectives to the terms of reference are as follows:

1. A review of the Trust's Internal Investigation to assess the adequacy of its findings, recommendations and action plans
2. Reviewing the progress made by the Trust in implementing the action plan from the Internal Investigation
3. Involving the family of both Mr I and the victim's families as fully as is considered appropriate
4. A chronology of the events to assist in the identification of any Care and Service Delivery problems leading to the incident
5. An examination of the Mental Health Services provided to Mr I and a review of the relevant documents
6. The extent to which Mr I's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
7. The adequacy of the Risk Assessment and management of that risk to others
8. The appropriateness and quality of assessments and Care Planning
9. Consider other such matters as the public interest may require
10. Complete an Independent Investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication

4.3 Key Questions and Actions

The key questions the Independent Investigation Panel developed from the terms of reference are:

1. Was the Trust's Internal Investigation adequate in terms of its findings, recommendations and action plans?
2. What progress has been made by the Trust in implementing the action plan from the Internal Investigation?
3. Was the family of both Mr I and the victim's families involved as fully as is considered appropriate?
4. Develop a chronology of the events to assist in the identification of any Care and Service Delivery problems leading to the incident

5. What were the Mental Health Services provided to Mr I and were relevant documents in place?
6. Was Mr I's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies?
7. Were the Risk Assessment and management of that risk to others adequate?
8. Was the quality of assessments and Care Planning appropriate?
9. Are there matters of public interest which need to be considered?

4.4 Key Deliverables

The Independent Investigation Panel will deliver:

1. A full Report
2. An Executive Summary
3. Involvement of the Trust to consider findings and share recommendations
4. A presentation to BEHT and NHS London Strategic Health Authority
5. An up to date position on the Internal Investigation action plan

4.5 Scope

1. The investigation will complete within 26 weeks of commencement

4.6 Investigation type and process

This is an Independent Investigation conducted by a Panel of two members (section 4.9, details the panel members in terms of roles and experience). The process employed was:

1. An audit of the Internal Report using an audit tool that was originally developed in conjunction with a number of Mental Health Trusts in the North West of England and subsequently developed further by Caring Solutions UK Ltd. The findings from the audit tool was then brought together into a consolidated analysis of the Internal Report from which a number of conclusions are drawn and recommendations made.

2. An audit of the Trust's action plan, using the Trust evidence, (Appendix 2) was produced to address the recommendations made in the Internal Report to assess if the action plan has captured all of its recommendations. The level of implementation was considered.

3. A 49 page evidence trail was compiled from documentation, interviews, Internal Investigation statements, Independent Investigation interview statements.

4. A 22 page evidence trail collating information to support the chronology – section 9.4.

5. Review of documentation – Strategies, Policies and Procedures, information from other agencies, court statements, Internal desk top review, Internal Investigation report lists all documentation reviewed (Appendix 3)

6. Interviews with staff and family members
7. Interviews with Director and staff member of Residential Care Home
8. Interview with Mr I
9. Contact and meeting with Police, Metropolitan Police Service
10. Contact and meeting with the Head Master and one of the surviving victims at the school Mr J attended
11. Contact with Adult Services - Haringey Council.

4.7 Communication

1. The report will be presented to NHS London the Strategic Health Authority for consideration and subsequent publication.

4.8 Investigation Commissioner

1. The Investigation has been commissioned by the NHS London Strategic Health Authority in accordance with Department of Health Guidelines 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.

4.9 Independent Investigators:

Panel member 1: Chair of the Panel

1. Pat Shirley is an RGN, RMN, DMS with significant knowledge of Mental Health Services and systems, having recently retired as an Executive Director of Nursing and Governance for a large Mental Health and Learning Disability Trust; a post which she held for 6 years.
2. Prior to that she has worked as a senior clinician and manager in both Inpatient and Community Mental Health settings. She has also taken part in several investigations, both as an individual investigator and as a panel member.
3. Currently she has just completed three Independent Investigations into homicides by Mental Health Service Users; an 8 month fixed term part-time post as a Clinical Director for a Community NHS Service, to support its integration with a Mental Health Trust; a review of an NHS Trust Community Mental Health Service; two investigations into staff grievances (1) sexual harassment (2) bullying and harassment.

Panel member 2:

1. Dr Jonathan Scott has worked as a Consultant Psychiatrist in West London Mental Health NHS Trust since 1998. He has wide experience of Adult Services in both the Community and Inpatient care, as well as having been Clinical Director for all Local Services.

2. He has particular expertise in acute care and crisis work and is currently a Consultant for Crisis Resolution and Home Treatment Team in Hounslow.

3. He has extensive experience of commissioning, reviewing, contributing to and writing serious incident reports. Most recently he completed a homicide review for NHS London in 2012.

5. Level of Investigation

1. The investigation is a level 3 Independent Investigation

6. Involvement and Support of Service User and Relatives

1. Mr I agreed and was interviewed with an interpreter present. The Consultant Psychiatrist from the Panel led the interview. Whilst Mr I regrets what happened he denies he stabbed anyone.

2. Mr I's mother and father were contacted via letter and offered an opportunity to meet with the panel, however did not respond. A second letter was sent and again there was no response.

7. Involvement and support provided to staff Involved

1. Following the incident staff report that they were supported, at the time and following the event. During interviews for the Investigation staff reported also having access to management support and supervision.

8. Information and Evidence gathered

1. Appendix 3 sets out the list of documents used to gather evidence for the Independent Investigation. Other information was gathered by the following:

Face to face interviews

- Eight Trust staff members
- Mr I
- BEHT Non Executive Director
- Independent Chair of the Internal Investigation
- Director and one staff member of Residential Care Home
- Mr J's mother, father and other family members
- The Headmaster of the school the victims attended
- One of the surviving victims
- Metropolitan Police Officers

Telephone interview

- One staff member
- Two ex-Trust staff members.

Correspondence

8. Mr I's current Responsible Clinician (RC)
9. Deputy Director, Adult Services, Haringey Council
10. Consultant Psychiatrist, HMP Pentonville

9. Findings

This section has been considered within the framework of the key questions, as follows:

9.1 Was the Trust Internal Investigation adequate in terms of its findings, recommendations and action plans?

Process for the Internal Investigation:

1. An initial desk top review commenced on the 28th January 2011. This was led by the Director of Nursing at the time with a panel from the Trust comprising of a General Adult Psychiatrist, Forensic Psychiatrist, an Assistant Director - Patient Safety Department, and the Director from the Residential Care Home.

2. The terms of reference for the desk top review were as follows:

   - The purpose of this review is to document the events and circumstances that led up to the incident and determine the type and level of enquiry to be held by the Trust.

   - The review will also look at staff professional practice to establish whether there are any performance management issues that require attention.

3. The review will also identify if there are any lessons to be learned where action should be immediately implemented.

4. The findings of this review will be reported to the Department of Health, Care Quality Commission (CQC), NHS London, the Local Safeguarding Children's Board (Haringey) and the Head Teacher of the school the young people attended.

5. The desk top review completed in February 2011 and recommended the following:

   - That this event should be further reviewed by an Independent Panel which includes an Independent Chair and Non–Executive member of the Trust.

- The Independent Panel should include a panel member who has a specialist interest in forensic risk management, Mental Illness and Learning Disability.

6. The Independent Panel was formed on behalf of BEHT to carry out a formal Internal Investigation. This commenced March 2011 and was completed in November 2011

7. The Panel consisted of an Independent Chair, a Non Executive of BEHT, the Director of Nursing at the time, a Consultant Psychiatrist in Forensic Psychiatry and Learning Disability/Independent Medical Representative and a Panel Facilitator.

8. The Independent Investigation Panel note that the Consultant in Forensic Psychiatry briefly reviewed Mr I in 2001 when Mr I was in HMP Pentonville. This is not declared as a conflict of interest within the Internal report.

9. The terms of Reference were established and focussed on the following key areas:

    - Care and Treatment
    - Risk Assessment/Risk Management
    - The Care Home
    - Working with Carers
    - Liaison with other Agencies
    - Management of Service Change
    - Support to Staff and Victim's family

10. Identified staff were interviewed between March and August 2011. In total seventeen current members of staff and two ex-members of staff were interviewed, this included clinicians, support staff and managers.

11. Also interviewed were representatives from the Forensic Residential Care Home, Representatives from Haringey Social Services, Practitioners from the Haringey Learning Disability (LD) Team, representatives from Haringey Police Jigsaw Team and a General Practitioner (GP) from the practice Mr I attended.

12. Following a meeting with Mr J's (victim) Aunt, Uncle and Cousin in March the family were invited to meet the panel and met with them in May. This meeting was attended by Mr J's Father, Aunt, Uncle and Cousin.

13. Mr I's family had been advised by BEHT's Patient Experience Manager that the Internal Investigation Panel would like to meet with them as part of the inquiry and they met with the Panel on the 9th June 2011.

14. The Internal Investigation was completed by November 2011 and went to the confidential section of the BEH Trust Board in January 2012. The Trust's normal practice would be to bring together all persons involved in taking forward the recommendations, however at this time the incident was subjudice and this prevented public discussion. This delayed sharing the report publically until May 2012.

15. The Trust state that there was a further delay in commencing implementation of the recommendations, the group responsible for this did not meet until the beginning of September 2012.

16. The Trust Governance and Risk Management committee has the responsibility for following up on the implementations of the recommendations. Their progress is reviewed at regular intervals and also forms part of the Trust overall serious incidents action plan.

17. Whilst the Internal report is comprehensive it does not follow the guidance set out in the National Patient Safety Agency Comprehensive and Independent Investigation report format[2]. Within the framework Care and Service Delivery problems should be clearly highlighted. This leads to clear identification of causal factors and the development of recommendations and action plans. Whilst there are nineteen recommendations in the Internal report the identification of specific Care and Service Delivery problems remains unclear.

Findings of the Internal report:

18. There are 19 recommendations identified in the Internal report and Appendix 4 details the recommendations. The overall theme of the recommendations is set out in table 2.

19. Each recommendation within the Internal report is underpinned by supported evidence; however, by not using a recognised framework for the investigation, the recommendations appear to be a statement of fact rather than SMART[3] auditable goals which lead to the development of measurable action plans.

20. Recommendation 4 is applicable to all Mental Health Act Sections under the Act and not just Community Treatment Orders (CTOs). The recommendation should seek to gain assurance from the BEH Trust Mental Health Act Committee that all Sections are monitored to ensure that discharge from a Section is carried out in a considered and managed way.

21. Recommendation 15 is in relation to the searching of Mr I's belongings for the concealment of knives. However Mr I was an informal Service User and a resident of a Care Home. It would not have been appropriate for a clinician from BEHT to seek guidance on searching Mr I's property. This recommendation can only relate to clinical areas within BEHT.

22. The Internal report findings highlight failures in relation to four key areas as set out in table 2. This raised a question for the Independent Investigation Panel about the effectiveness of clinical and managerial leadership. Whilst clinical leadership has been identified in the body of the Internal report there is no recommendation to address clinical and managerial leadership to ensure it is effective.

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[2] National Patient Safety Agency – Arms length body of the Department of Health – which was set up to lead and contribute to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

[3] Specific Measurable Realistic and Time Bound - *Management Review* by George T. Doran

Table 2 – Internal report recommendations by themes

Theme	Rationale Devised from Trust Recommendations'	Recommendation number
Clinical Practice	• Clinical supervision • Community Consultants to attend discharge planning meetings • Review of care management systems • Working collaboratively with the Dual Diagnosis Service • Staff training in Dual Diagnosis	1 3 7 and 14 11 12
Risk	• Assessment of impact of Risks before Service reorganisation • Review of all case loads regarding frequency of Service User contact	6 7 and 14
Systems	• Review of Mental Health Act (MHA) Procedures • Records Management regarding handling Service User records • Ensuring contemporaneous clinical notes • Searching of Service Users' belongings in relation to clinical or safety reasons	4 5 13 15
Interface and Liaison	• Strengthen interface between Forensic Community and Psychosis service • Liaison with Police to better understand information received in relation to Sexual Offences Prevention Order (SOPO) • Revision of Trust Protocol in relation to referrals to Multi-Agency Public Protection Arrangements (MAPPA) • Staff access to the Haringey Learning Disability Community Team service eligibility criteria • Ensuring communication systems are sufficiently robust between clinical teams and Clozapine[4] Clinic • Facilitating a GP forum in Haringey • Informing the relevant GP of a serious incident involving their Service User • Liaison with the Head teachers of the local schools to achieve a better understanding of mental health	2 8 9 10 16 17 18 19

[4] An atypical antipsychotic medication used in the treatment of schizophrenia, it is marketed as Clozaril

Action Plan developed from the Internal Investigation:

23. The actions developed are pertinent to each recommendation however in some cases these are not SMART and therefore not easily auditable

24. There is an overreliance on the use of clinical supervision to monitor the implementation of some recommendations, although the Independent Investigation Panel were assured via their interviews with staff, that monitoring of the recommendations does occur within supervision

25. Some actions detail the sending of a memo to address a point raised in a recommendation. This is not an effective way of complying with a recommendation. There is no described process in place to check that all staff received the memo and/or understand and acted upon its contents.

26. Whilst it will be possible to evidence that actions have been completed there is no overarching action to ensure understanding and ongoing compliance with a recommendation, for example, by the effective use of audit.

Conclusion to 9.1

The conclusion to this section is set out below, this is also addressed as Service Delivery Problems in tables 4 and 5, as follows:

1. The desk top review commenced one week after the serious incident, with clear terms of reference which would have ensured that any immediate actions could be addressed in a timely manner. The Independent Investigation Panel commend this as notable practice – see table 3.

2. The Internal Investigation was led by an Independent Chair and had as a panel member a BEHT Non-Executive, whilst this gave objectivity to the process it is recommended that future panel members should remain independent of the situation being investigated, and where this is not possible ensure this is declared within the report.

3. The investigation was extensive and sought the views of many staff, ex-staff members and other agencies involved with Mr I.

4. The Mr J and Mr I's families were involved in the Internal review process which helped contribute to the findings.

5. The process for carrying out the review was managed in a timely and effective manner and was completed by November 2011. It is unfortunate that at the time the findings from the report could not be shared, however this was outwith BEHT's control.

6. There was a delay of four months following the presentation of the Internal Investigation Report to BEH Trust Board in May 2012. Whilst the action plan had been developed from the recommendations the group responsible for ensuring implementation of the actions did not meet until September 2012. The Independent Investigation Panel received no mitigating reason for this and consider this period to be too long - see table 4.

7. The report does not follow the National Patient Safety Agency Comprehensive and Independent Investigation report format. This means that causal factors and Care/Service Delivery problems have not been clearly identified from the findings. This raises a question for the Independent Investigation Panel in relation to Trust staff having the appropriate Root Cause Analysis training in order to undertake Investigations.

8. The recommendations appear to be a statement of fact rather than SMART auditable goals which lead to the development of measurable action plans – see table 5.

9. Recommendation 4 will not give reassurance to the Trust that all Sections under the Mental Health Act are monitored to ensure that discharge from detention is carried out in a considered and managed way.

10. Recommendation 15 does not lead the clinician to consider clinical risk and act appropriately to mitigate the risk as far as possible.

11. There is no recommendation in relation to reviewing clinical and managerial leadership within the Trust, both of which are demonstrated within the Internal report as not effective, particularly between 2007 and 2009.

12. Whilst it will be possible to evidence that actions have been completed there is no overarching stated action to ensure understanding and ongoing compliance with the recommendations.

Table 3 – section 9.1 – Notable Practice

Notable Practice
The desk top review commenced one week after the serious incident, with clear terms of reference which would have ensured that any immediate actions could be addressed in a timely manner. The Independent Investigation Panel commend this as notable practice.

Table 4 – section 9.1 – Service Delivery Problem

Service Delivery Problem
There was no clear governance process to ensure the Internal report actions, developed from findings were implemented in a timely manner. The Report was made public in May 2012 but the implementation group to develop the actions arising from the recommendations did not meet until September 2012.

Table 5 – section 9.1 - Service Delivery Problem

Service Delivery Problem
Investigation reports should be developed using a nationally recognised framework which allows for clear findings and SMART objectives, recommendations and actions Causal factors and Care/Service Delivery problems were clearly identified within the report. Recommendations and actions were not ‘SMART’.

9.2 What progress has been made on the Internal report action plan?

1. Staff were identified to implement specific areas within the action plan. Evidence against each recommendation and action arising was supplied to the Independent Investigation Panel.

2. The panel was able to evidence progress against each recommendation. This is monitored via the Trust Governance and Risk Management committee and upwards to the Trust Board.

3. The Panel was assured that the action plan had been discussed and updated at the Trust Governance and Risk Management committee; however for the purposes of the Investigation, the Independent Investigation Panel has used the original action plan with current evidence.

4. The measurement framework applied to the action plan is that applied by the National Health Litigation Authority (NHSLA) [5] which uses a set of risk management standards within Healthcare Organisations. These are set at 3 levels and the principle applied to each level can be applied to the action plan progress, as follows:

   Level 1 - Policy: evidence has been described and documented

   Level 2 - Practice: evidence has been described and documented and is in use

   Level 3 - Performance: evidence has been described, documented and is working across the whole organisation

   Appendix 2 sets out the action plan; its current status in terms of evidence and progress; the NHSLA level against each section.

   General Observations on the evidence supplied:

5. Whilst there is evidence that there is a Management of Organisational Change Policy, the Independent Investigation Panel were informed, during staff interviews, that this was not complied with during a potential closure of one ward. This was taken up with the Director of Nursing and reassurances were given to the Panel that this was addressed. There is now a check list for closing or moving a clinical area. This will be addressed more in Section 9.5 of this report.

6. The weighting system described in both recommendation 7 and 14 lacks clarity. Whilst one Senior Manager referred to it as a tool to identify and manage people and the risks they present, another called it a RAG (Red, Amber, Green) rating system to prioritise Service Users on case loads in terms of moving them forward. This will be discussed more in section 9.6.

7. As stated in section 9.1, recommendation 15 is not appropriate in terms of searching property outside of a Trust clinical area, therefore the evidence supplied by the Trust can only respond to actions taken within the Trust.

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[5] The National Health Service Litigation Authority has developed a risk assessment framework underpinned by a range of NHSLA standards and assessments. Most Healthcare organisations are regularly assessed against these risk management standards.

8. Recommendation 19 does refer to all the schools in the vicinity of Haringey, and the evidence and ongoing action focuses only on the school Mr J attended

Conclusion to Section 9.2

The conclusion to section 9.2 is as follows:

1. All actions and recommendations are being progressed and using the NHSLA framework comply with either level 1, 2 or level 3.

2. The actions relating to recommendations 7 and 14 needs to be clarified in terms of the weighting system so that all staff/teams have the same understanding of its purpose. This is addressed further in section 9.6.

3. Evidence supplied to meet recommendation 15 can only apply to clinical areas within Trust property.

4. The actions relating to recommendation 19 needs to be revisited to meet the requirements, in terms of working with all schools in the Haringey area.

5. The Trust needs to ensure that the Organisational Change Policy is always followed and that the check list for closing or moving a clinical area is implemented and used in all cases and that this is auditable

9.3 Was the family of both Mr I and the victim's family involved as fully as is considered appropriate?

This section will cover the involvement of the family of Mr I and Mr J following the incident on the 20th January 2011 in relation to the Internal Investigation process and the Independent Investigation process.

General Point:

1. The Trust was explicit in wanting to involve both the family of Mr J and Mr I in their Internal Investigation process. One point in the terms of reference for the Internal Investigation process stated the following:

    - To review the support provided to team members and the communication (if any) with the victim's family and the perpetrator's family to ascertain if the level of support and communication is satisfactory or if more action by the Trust is warranted.

Internal Investigation support:

Mr I's family.

2. On the 21st January a debriefing meeting was held at Care Home, for the staff and residents of the Home. This was also attended by Mr I's Care Coordinator and the Responsible Clinician from BEH Trust. One of Mr I's brothers was also invited to attend and did so.

3. Following the incident Mr I's Family were contacted by the Trust's Patient Experience Manager. They were advised that a Board Level Inquiry had been arranged and as part of this process the Chair of the Panel Inquiry had asked if they and other members of their family would like to meet with the Panel. On 1st June 2011, a letter was sent to confirm that arrangements had been made to enable the family to meet the Panel and to confirm that a Turkish speaking interpreter had been booked to attend the meeting. On 9th June Mr I's Mother and Brother met with the Panel.

4. The discussion with Mr I's family mainly covered the family's view of Mr I's illness. Mr I's brother had received one phone call from the Police since the incident and had been to the Care Home.

5. The terms of reference for the Internal Investigation had been transcribed into Turkish for them.

Mr J's family:

6. Following the incident, a letter of condolence was sent from the Chief Executive to Mr J's parents. The purpose of this letter was to express the Trust's sorrow at what had occurred, to explain that a Board Level Inquiry would be arranged and the purpose of that inquiry, and to invite them to meet with Trust Representatives, so that they could explain to them personally the actions the Trust would be taking. A meeting was arranged on 18th March 2011 at St Ann's Hospital with the then Director of Nursing and the Patient Experience Manager. The meeting was attended by the Maternal Aunt, Uncle and Cousin of Mr J, and it was also attended by Police Liaison Support Officers. Notes of the meeting were subsequently produced for their approval.

7. At the meeting on the 18th March the Trust asked if the family were receiving any professional support and informed them that if they needed additional support they could contact the Trust or attend their GP.

8. Mr J's Family raised questions in relation to:

   - Mr I's Care Plan, its quality and Risk Assessment and his compliance with Medication.
   - The length of time Mr I had been under the care of the Trust

9. It was explained that at that point the Trust could not answer all the questions because some of the information was subjudice and could not be discussed but that when the investigation was completed and able to be discussed they would receive a copy of the report.

10. The Independent Investigation Panel noted that the Internal report was available in May 2012 however in July 2012 the family had still not received a copy of the report from the Trust. The Panel arranged for the family to have a copy.

11. On 18th May 2011 the Father, Maternal Aunt, Uncle, and Cousin of Mr J met with the Internal Panel. They were accompanied by their Legal Representatives. A number of issues were raised, and the Chairman confirmed that the Panel would be looking in depth into their concerns during the course of their investigation. Notes of the meeting were subsequently sent to them. At their request, information was also sent about incidents relating to the Trust, as well as relevant Service User leaflets/publications, to help them develop a better understanding of the provision of Mental Health Services.

12. The issues raised by the family at the meeting of the 18th May 2011 were as follows:

    - Were representatives from the Care Home giving evidence to the Internal investigation?
    - A statement that the local community would want assurance that the matter is being fully investigated
    - A clarification for the family in relation to the timetable to conclude the investigation
    - A question about Mr I's Medication
    - An explanation in the meeting about all aspects of care for someone like Mr I
    - Whether or not it was appropriate to release Mr I from detention in hospital
    - The propriety and adequacy of the aftercare arrangements and the Care Plan
    - The efficiency of those who have been implementing the aftercare arrangements and whether they have been implemented effectively
    - The location of the Care Home, in particular whether other public institutions in the vicinity such as the school were appropriate
    - The retention of a knife by a Care Home resident, how this can be prevented in the future

13. The Chair of the Internal Panel assured the family that they would review these issues.

The Independent Investigation:

Mr I's family:

14. The Chair of the Independent Investigation Panel wrote to Mr I's parents on the 3rd July 2012, setting out the terms of the Independent Investigation and enclosing the terms of reference. The Panel requested to meet with them however received no reply. The letter stated that it was important that all views were considered as part of the review. The Panel wrote a second letter again stressing the importance of receiving their contribution to the process, but again received no reply. Each letter was translated into Turkish, as it is understood Mr I's mother spoke little English.

15. The Independent Investigation Panel attempted to contact Mr I's brother via telephone but again received no response. The Panel had no choice but to accept that Mr I's family were not going to respond.

Mr J's Family:

16. The Independent Investigation Panel wrote to My J's family via the family legal representative, setting out the terms of the Independent Investigation and enclosing the Terms of Reference.

17. The Independent Investigation Panel met with the family on the 27th July at a venue of their choosing. Attending from Mr J's family were his Father, Mother, Sister, Maternal Aunt, Uncle, and Cousin. They were accompanied by their Legal Representative.

The meeting contained both observations and questions from the family as follows:

Family Observations:

- It seemed like no one was responsible for Mr I's care.
- The family were concerned that there were repeated concerns that Mr I was not taking his Medication.
- Because the Home was private and therefore needed income there might be conflicting interest in sending Mr I back into hospital.
- There were queries regarding Mr I's level of Clozapine.
- He was on the Sex Offenders Register and the wisdom of having people with mental health problems who continue to take drugs near a school.
- The actions caused by Mr I has ruined a lot of people's lives, not just the family's but friends as well.
- The family feel this was preventable and because of his past history he should not have been placed in the Residential Care Home.

Family Questions:

- Was it normal practice for Mr I to have 24 hours out of the home each day?
- Was Mr I's Medication changed after his relapse in November 2010?
- Why was his blood not tested for Medication compliance when it was tested monthly for health reasons?
- There were many services involved in Mr I's care (the initials of each service was read out) did they not meet?
- There was a history of him touching women and children and violence – why was he walking around and was his placement appropriate?
- His placement was near half a dozen schools if not more, why were we not told of this?
- Was a Guardianship Order considered?
- Mr I posed a challenge, how was this addressed by the multitude of agencies?

- There was a Service Reorganisation going on – did this have an effect on Mr I?
- Was the Care Home going to be moved?
- Who had the ultimate responsibility for Mr I's care?
- If I could pick up the trigger points why could the professionals not?

18. Mr J's family's view of the earlier meeting with the Trust on the 18th March 2011 was that the Trust's attitude was cold, "there was a coldness in their words and a lack of information".

19. Mr J's family feel the Trust did not engage with them, there was a "lack of openness". The Independent Investigation Panel's view is that reasonable notes were taken and shared with the family at both meetings and that the Trust did give an assurance to the family that questions not addressed at the meeting would be via their Internal review process.

20. The Independent Investigation Panel sent the family a copy of the high level notes made at the meeting and received a response from this.

21. Following this, a set of questions and observations was sent to the Chair of the Independent Investigation Panel, by the legal representative for the family. Those germane to the Independent Investigation Terms of Reference have been addressed as part of this report.

Other Victims

22. Whilst the Terms of Reference do not explicitly cover support to the other three victims, the Independent Investigation Panel would like to commend the school for their swift response in terms of support to the other victims and other young people within the school. The support structures the school has in place to respond to a crisis is to be commended.

Conclusion to 9.3

1. The Internal Investigation Panel were able to meet with Mr I's brother and mother and provided interpreters for them.

2. The Independent Investigation Panel was unable to secure a contribution from Mr and Mrs I Senior, although the Panel did interview Mr I as part of the process, with an interpreter present.

3. Not unnaturally the family of Mr J wanted answers to the incident, however they experienced the Internal Panel as cold and lacking in openness. The Independent Investigation Panel concludes that the Trust did follow process having contacted and met with the family in a timely manner but that a lesson could be learned in understanding a family's experience of meeting with a Panel in a formal manner.

4. The Independent Investigation Panel have accepted the questions and observations made by the family at their interview and will address these within this report. They will also address those questions and observations made by the legal representative which are germane to the Independent Investigation.

9.4 Develop a chronology of the events to assist in the identification of any Care and Service Delivery problems leading to the incident

1997 to 1992: Mr I was the third of 10 children, with four sister and four brothers. It is reported that one brother died at the age of 23 when in the Turkish Army, after serving in Greece and attempting to use traffickers come to the UK.

He attended local school from the age of 6 to 12 and left because his parents could not afford the bus fare to the secondary school. His mother did not recall him to be a slow learner and he had good relationships with school staff. He had many friends and no significant problems at school. He worked on the farm before claiming asylum in the UK at the age of 15.

1992: He came to the UK at the age of 15 and his parents separated around this time. His father was in a new relationship and did not support the family, although he has subsequently had contact with Mr I.

1992 to 1997: Reported his personality changed on coming to the UK and his father leaving the family home. There were arguments between him and his mother and on one occasion he attempted to hit her with a pan. He attended a Kurdish centre and Enfield College where he enrolled for a basic English course which he did not complete.

An unspecified male member of the family physically assaulted his sister by punching her in the face when she returned home late one night. Children and families social services became involved and the two youngest sisters were placed in care for physical abuse, with their mother and elder sister, in a safe house. However, they were subsequently placed in foster care when followed home by an unnamed male member of the family.

It is stated Mr I came to the attention of social services at this time because he was sexually inappropriate towards his sister in the form of inappropriate kissing.

Mr I never had an intimate adult relationship.

Two of Mr I's brothers were also treated for mental illness and he subsequently kept in contact with his elder brother.

25 May 1997: Mr I committed a robbery, he was aged 19.

13 November 1997: Mr I was convicted of the actions of 25th May 1997 and sentenced to two years at a young offender's institute.

13 April 1999: Mr I committed burglary and theft, he was aged 21.

9 June 1999: Mr I was convicted of the actions of 13th April 1999 and sentenced to 12 months' probation.

22 July 1999: Mr I was convicted of being in possession of cannabis and fined £50.

November 1999: Mr I failed to surrender to custody at the appointed time.

17 November 1999: Mr I committed theft by shoplifting, he was convicted and fined £25 with £69 compensation.

8 February 2000: Mr I approached a 15 year old girl at a bus station in Peterborough, asking her for a cigarette. He sat next to the victim and placed his hand on her thigh stroking the area "very close to her crotch".

6 April 2000: Mr I was convicted of indecent assault on a female under 16 and failing to surrender to custody. He was sentenced to 6 months in prison and required to register as a Sex Offender.

13 June 2000: Mr I was found in possession of an offensive weapon in a public place. He was fined £25.

14 August 2000: Mr I was fined £15 for attempting to travel without paying a rail fare.

3 November 2000: Mr I allegedly stole a mobile phone belonging to a female cafe owner in North London. The owner told his brother. It is alleged that Mr I and his brother returned to the cafe where an argument ensued and Mr I withdrew a hammer from his trousers and attempted to attack the woman. His brother restrained him but he continued to make verbal threats until the Police arrived.

April 2001: Mr I was convicted of failing to notify his name and address in the context of the Sex Offenders Act. Mr I was fined £250.

19 April 2001: Mr I was charged with affray and theft at Tottenham Magistrates Court following events of the 4th November 2000. Concern was expressed by his counsel that he was acting suspiciously. Mr I was seen by two Specialist Registrars (Senior Trainees) in Psychiatry. He was found to be unkempt and resistive with a limited attention span. He was easily irritated. No overt evidence of mental illness was found and it was recommended he be seen by a Specialist in Forensic Learning Disability. He was not felt fit to stand trial and was remanded to prison.

22 May 2001: Mr I was seen at HMP Pentonville by a Consultant in Forensic Psychiatry and Learning Disability, at request of Mr I's solicitors. He was suspicious, agitated and markedly incongruous in behaviour. It was felt he may have a psychotic illness along with Learning Disability. Treatment with Olanzapine, an anti-psychotic, was recommended and transfer to prison under Section 48 (MHA 1983). The transfer did not happen as Mr I was not returned to prison at the next court appearance.

14 August 2001: Mr I was accused of assaulting two women, he asked the first women personal questions then grabbed her bottom. Later in the day he snatched a cigarette from the second and demanded a kiss to get it back, she refused and he then told her he fancied her and when she got up to leave he grabbed her and tried to kiss her. The woman resisted and he slapped her on the face twice and knocked her down. Mr I kicked her on the ground and she then managed to escape. Mr I allegedly assaulted the Forensic Medical Examiner (FME) at the Police station.

16 August 2001: Mr I was charged with two counts of sexual assault, following events of 14th August 2001, at Tottenham Magistrates Court. He was seen by a Specialist Registrar, Approved Social Worker (ASW) and Community Psychiatric Nurse (CPN). Mr I was found to be distractible and sexually disinhibited. He could not give an account of his circumstances and was pre-occupied by his physical health. It was not clear if he had a psychotic illness as well as a Learning Disability but he was again found unfit to plead and it was recommended that he be remanded to prison to see the Consultant in Forensic Learning Disability again. He was remanded to HMP Pentonville.

16 August to 15 November 2001: Mr I was on remand at HMP Pentonville. He was seen by a Consultant in Forensic Learning Disability and the Consultant's Specialist Registrar on a number of occasions. Mr I was distracted, easily preoccupied, mildly elated and sexually inappropriate, for instance asking the Specialist Registrar if he could touch her breasts. Mr I was shouting at night and irritating other prisoners, resulting in a fight. He had to be restrained on occasion. Mr I was administered anti-psychotic Medication.

15 November 2001 to 13 February 2006: Mr I became an inpatient under the care of the North London Forensic service (NLFS) He was transferred from HMP Pentoville to NLFS under Section 48/49 (MHA 1983). Appendix 5 gives an explanation of the Mental Health Acts (MHA) within the report). Mr I was initially hostile, threatening and sexually inappropriate and within three days of admission began to express overt grandiose and persecutory delusions. He believed prison officers had stolen his semen in order to sell it to female members of the public and that it was worth £100,000 and that he had over 200 children. He had arrived at the unit with a toothpaste tube in which he was storing his semen. Mr I was administered a depot Medication, against his will.

January 2002: In January Mr I required a period of seclusion (being restricted to a secure room for his own safety and that of others) within the Inpatient unit.

31 January 2002: Mr I was found not guilty of the events of the 14th August 2001, by reason of insanity. A trial of the facts took place (which is the procedure when an individual cannot be convicted due to insanity). Mr I was ordered to be detained in hospital under the Mental Health Act (MHA) 1983 according to Section 5 of the Criminal Procedure (insanity) Act 1964, 1991 (effective Section 37).

March 2002: Mr I was not settling and was prescribed an anti-psychotic, 20mg Olanzapine.

April 2002: Mr I was not responding well and refused to eat for several days. Subsequently he began to settle and was granted ground leave.

August 2002: Mr I absconded for 5 days. He became symptomatic and again this resolved with Olanzapine. It was however felt that Mr I should be on a depot (long acting) injection, the preferred depot anti-psychotic Medication being Risperdal Consta. In August Mr I was thus commenced on oral Risperidone, a necessary prerequisite to starting the depot form.

5 November 2002: Mr I was commenced on Risperdal Consta. However Mr I only remained well when his depot was supplemented with oral Risperidone.

April 2003: The medical team would have liked to prescribe Mr I the anti-psychotic Medication Clozapine, however this was not possible as blood tests are required when taking this Medication and Mr I refused the blood tests. The psychotic symptoms continued.

July 2003: Mr I agreed to start Clozapine. He improved quickly and started playing football with other Service Users as well as participating in Occupational Therapy (OT). He also engaged in psychology sessions and started to discuss the sexual assault offence.

Start of 2004: Mr I was settled with no evidence of psychotic symptoms returning (nor did these recur overtly during the rest of his admission). He did however have limited engagement with OT and some insight into being unwell and that he required Medication.

July 2004: Mr I was noted to have some capacity to explore offending behaviour. There were times when he was noted to be laughing to himself but not thought to be psychotic.

September 2004: Mr I told his Responsible Medical Officer (RMO) he was suffering from a mental illness when the index offence occurred. He was engaging better with OT and Psychology.

Start of 2005: Mr I became disinterested, unmotivated and preoccupied with being discharged. It was felt this was due to improvement in mental state.

10 March 2005: Mr I was seen by the Consultant for the Haringey Forensic Outreach Team, who concluded that Mr I was not yet ready for discharge and so the Community Forensic Team would be “unwilling to provide follow-up for him at present”.

15 March 2005: A MHA Tribunal took place which noted that the Forensic Team had had to reconsider Mr I's risk profile. It was noted that Mr I had been inappropriate with OT's on three occasions; inappropriately touching, invading personal space and making comments such as "darling" at a time when his mental state was felt to be stable.

May 2005: Mr I was referred to a Care Home but was rejected because his daily activities were unstructured and lacked focus. There followed 3 weeks of refusal to engage. After much persuasion Mr I finally accepted the need for OT and his attendance at OT sessions and subsequent enjoyment improved, however he did require bargaining between outside leave and his attendance at OT. When on leave he tended to visit a Turkish cafe and his family

25 May 2005: Mr I was reviewed again by the Forensic Community Consultant from the Forensic Community Outreach team. It was concluded that there had been little change and none was likely so he would need very close supervision in the community, but the Consultant stated that Mr I did not meet the criteria for the Forensic Community Team and it would be appropriate for him to be followed up by a General Adult Community Team. There was no clear rationale for this decision.

14 June 2005: A MHA Tribunal took place which noted that the Psychologist had concluded he had made limited progress and was unlikely to make more, so monitoring of mental state "would be the most realistic component of reducing his risk of offending". However, the Independent Psychiatrist had concluded that his inappropriate behaviour was not solely attributable to mental illness but a combination of Learning Disability, Mental Illness, background and upbringing. Section 25a (MHA 1983) was recommended. All agreed that a 24 hour staffed Care Home in the community was needed.

August 2005: It was noted that Mr I may have used unescorted leave to meet a girl who was the friend of another Service User. It was believed that the other Service User helped him write a letter to this girl in Turkish which was felt to be grandiose and inappropriate stating "if you want me to continue being health, please write to me... women adore my eyes".

Autumn 2005: Mr I was referred to and accepted by a Registered Care Home. He gradually had increasing periods of leave. Mr I was also referred to another Registered Care which appeared to have more intensive input with higher qualified staff. However, it would appear that the choice of placement was made on the basis of Mr I's choice and consensus on the appropriateness of the placement.

25 October 2005: CPA at which the decision was made to place Mr I in the Registered Care Home he resided in for the next five years.

10 November 2005: A MHA Tribunal met and made a recommendation for leave to commence at the Care Home. Gradually increasing periods of leave followed this.

11 November 2005: The Forensic Consultant wrote to the Community Consultant in General Adult Psychiatry who covered the Care Home area proposing six months of co-working prior to full transfer to the General Adult Consultant. In the letter she stated her opinion was that provided his mental state remained stable, the risk of serious offending in the community was low.

20 December 2005: The Community Consultant wrote to Forensic Consultant confirming the above arrangements.

17 January 2006: A discharge Care Programme Approach (CPA) meeting was undertaken. Mr I's history and risks were reviewed. The following is noted as indicators of Mr I becoming unwell:

- He becomes untidy and shows a lack of self-care things he is usually very good at. When well he keeps his room very tidy and has very good self/personal hygiene.
- He appears distracted and vague
- He is sexually disinhibited towards women

When psychotic:

- He becomes preoccupied with having children and many wives
- Stores his own semen
- Irritable and aggressive
- Verbally threatening and hostile
- Non compliant with routine/rules

The CPA form is not quite so explicit regarding relapse indicators, noting:

- Obvious deterioration in personal hygiene
- Grandiose delusions about sexual prowess
- Sexually inappropriate behaviour
- Delusions about his semen

1 February 2006: The final psychology report reviewed the fairly extensive input that had taken place over his stay in the forensic service and concluded he had shown "some ability to engage with psychological work" but that "his insight into his mental illness and the possibility of relapse remain limited". It is noted that neuropsychology assessment showed him to have a performance IQ of 69 (the verbal element of the assessment not carried out due to the fact his first language is not English).

9 February 2006: The Forensic Consultant wrote to Community Consultant to clarify that she had offered an appointment for 28th June 2006 and would join the Community Consultant for his appointment on 25th April 2006. She also requested the name of Mr I's Care Coordinator (CC).

13 February 2006: Mr I was discharged under Section 25a (MHA 1983, Supervised Discharge). The Forensic Consultant was named as the Community Responsible Medical Officer (RMO).

28 February 2006: Mr I was seen by Forensic Consultant at the Forensic Unit. He remained well but carried out little daytime activity and had no motivation to improve this.

3 March 2006: A letter was sent from the Forensic to Community Consultant confirming Mr I was registered for Clozapine locally, the latter named Consultant with the Clozapine service.

28 April 2006: The Consultant Forensic and Community Psychiatrists met with the local Social Work Team but Mr I failed to attend. It transpired there was a misunderstanding of the time and Mr I and the Care Home Team met briefly with the Community Consultant, along with the allocated Social Worker who at the meeting clarified that she was no longer the allocated Social Worker as she was from the area where he had lived and he was due to be allocated to a member of staff from the area to which he had moved. Mr I remained well with good self-care.

8 May 2006: Letter from the Director of Care Home to the Consultant Psychiatrist stating that the Social Worker was no longer Mr I's Social Worker and that her Manager was responsible for reallocating the case.

19 May 2006: A transfer CPA took place and Community Consultant became the RMO and a locum Social Worker became his Mr I's first CC. A CPA was completed in which it was noted that "cannabis no longer a problem".

6 August 2006: The Section 25a (MHA 1983) lapsed due to an administrative error in the MHA Administration Office in that the RMO was not advised the Section 25a (MHA 1983) was due for renewal. It was not possible to reapply the Section as it can only be applied if a person is on a Section 3 or 37 (MHA 1983). Mr I did not meet the criteria for either of these and therefore became an informal Service User.

17 October 2006: A CPA took place with the CC, Community Consultant and the Care Home. Mr I remained well but there was 'lingering doubt' regarding his compliance. There was no evidence of cannabis abuse. A CPA was completed which noted the lapse of the Section 25a, (MHA 1983), although this was not noted in the written notes, or in the letter sent to the GP.

24 October 2006: Mr I was reviewed by the Forensic Consultant at the Care Home.

30 November 2006: Mr I was seen by Forensic Consultant at the Care Home. Mr I was cheerful, clean and casually dressed. He was going to two Turkish cafes but was resistant to other activities, which was thought to be related to the Learning Disability and a fear of the unknown. It is noted that Mr I was keen to self-medicate and to stop Medication.

February 2007: Mr I's CPA was completed, and all risks reported as low (even historical risk, which were known not to be). The CC was at this point the same but there is no further mention of him in the documentation.

13 March 2007: Mr I was reviewed at the Care Home by the Forensic Consultant. He continued to wish to self-medicate and reduce the dose of his Medication. The Care Home was felt to be providing a high standard of care.

4 June 2007: Mr I was reviewed in clinic by the Community Consultant, with the Director of the Care Home. It was noted he remained well and had "no alcohol or cannabis recently".

2 July 2007: Mr I was seen by a second Forensic Consultant, as the first Forensic Consultant was on maternity leave. He remained well with a wish to self-medicate, this was resisted. There was a concern that funding for the continued placement may cease. This was resolved.

1 October 2007: Mr I was seen by the Community Consultant in clinic, he remained well.

October 2007: In October the Community Consultant retired.

18 April 2008: The second Forensic Consultant wrote to a second Community Consultant to confirm the latter was the Responsible Consultant. He had met with Mr I every few months and he had been under the impression that no local Mental Health Professional had been allocated to Mr I, but had 'found out' a second Community Consultant had been. He commented "there have been significant risk issues in the past and he requires, in my opinion, very close supervision".

20 April 2008: A letter from the Director of the Care Home was sent to the Manager of the Community Mental Health Team (CMHT) about Mr I (and another Service User). He expressed concern that he had not been seen by the CMHT.

22 April 2008: A Care Plan was completed which was not signed or dated, the CC was not named.

2 June 2008: Mr I was seen by the second Forensic Consultant. There was a concern that Mr I had been seen smoking cannabis on the street. Mr I also became more insistent on wishing to stop Clozapine. His mental state had not changed significantly on examination but staff at the Care Home had noted that he had been seen staring at women much more than normal in recent weeks. In the Care Home Key Worker records it also notes from 20th March 2008 that Mr I admitted to smoking cannabis.

4 June 2008: There was a letter from the second Community Consultant stating that the arrangement agreed with the Associate Medical Director was that the Associate Specialist Doctor would see the Service Users of the retired first Community Consultant. This doctor had not done so as the Service User did not have a CC.

24 June 2008: A blood test showed Mr I's Clozapine levels to be; Clozapine level 0.57, Norclozapine 0.35. This is satisfactory.

3 July 2008: A review meeting was held with the second Community Consultant, second CC and Director of the Care Home. It was noted that Mr I remained well, his personal hygiene was good and cannabis – seen on street. Also regarding risk to women that he had been seen on occasion attracting female attention on the street, whistling and starring at them but no physical contact. Also noted that his Section 25a (MHA 1983) lapsed.

18 August 2008: Mr I was seen by staff at the Care Home from a window trying to talk to a girl in her mid-teens. She was trying to avoid conversation. Staff shouted and he quickly walked away, later saying he just wanted to talk to her.

8-11 September 2008: Mr I went on holiday with Care Home staff to Dorset. On the 10th September 2008 Mr I separated himself from the group and was seen staring at young children in swimming costumes. Staffed stopped him but he was unclear why this was necessary. The main concern was that he would be attacked by parents or others. He was later seen looking at a group of teenagers.

Week of 6 October 2008: Mr I was taken by a Key Worker to a football match at Arsenal (against Fenerbahce, a Turkish team). Mr I was seated with the Arsenal supporters but revealed his Fenerbahce shirt, against advice. This drew abuse but Mr I could not understand why he should cover the shirt, denied there was any danger and appeared confused at the increasing abuse. He made matters worse by cheering the opposition players and had to be moved. He did the same again on leaving.

17 October 2008: A letter was sent from the Director of the Care Home to a third Community Consultant. The letter discussed the holiday and football match above and also noted he "has admitted that he is now smoking cannabis regularly". It was recognised that Mr I was afraid of the Police but concern was expressed that he would cease to be on the Sex Offender Register as of January 2009.

27 October 2008: There was a meeting of the third Community Consultant and third CC with the Director of the Care Home. Concern was expressed that Mr I's compliance with Medication might change when his supervision on the Sex offender Register came to an end. The issues from the letter of 17th October were noted.

On the same day, whilst on a shopping trip to a supermarket with staff, Mr I tried to engage in discussion with a girl of school age. When challenged by staff Mr I said it was a joke but also commented he would no longer be on the Sex Offender Register after January.

17 November 2008: Mr I was seen looking at some young women in a shop who asked him if he had never seen a woman before. He said it was a joke, because they are beautiful.

20 November 2008: A CPA was carried out with Mr I, the Director of the Care Home, his Key Worker of the Care Home, the Community Consultant and CC. Concern was expressed regarding the ending of the supervision register and the fear that the removal of formal supervision might affect his compliance with Medication, as he would no longer perceive there being any authority to compel him. Mr I was also noted to have “resumed smoking cannabis” and to stare at women and children. He denied past aggression or inappropriate interest in children.

The CPA was handwritten, and a Risk Assessment completed by the CC.

28 November 2008: Mr I was seen whistling from his window at passing girls and smoking cannabis in the community.

2 December 2008: There was a MAPPA[6] meeting at Highgate Police station. Mr I was subsequently visited by the JIGSAW [7] team and informed his name would be taken off the Sex Offenders Register. MAPPA had considered him to be level 3 (high) risk to women and so Police would apply for a Sexual Offences Prevention Order (SOPO)[8]. This was not taken forward as Police advised that Mr I did not meet the criteria for a SOPO

15 December 2008: On a weekly shop to a supermarket Mr I was seen staring at young women and girls and trying to engage them in discussion. Those who saw him were uncomfortable, but he was oblivious to this. On the way home Mr I was again starring at three young women, one of whom was pregnant. This was addressed with him by the Care Home but he again dismissed it.

5 January 2009: Mr I caused the same problems on a trip to a supermarket. Also on this day a letter was sent from the Care Home stating that Police will be applying for a SOPO as a containing measure to enable JIGSAW team to manage him

26 January 2009: Detailed letter sent to third Consultant, for his record, from the Director of the Care Home setting out Mr I’s recent concerning incidents for the last six months.

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[6] MAPPA – Multi Agency Public Protection Arrangements – Criminal Justice and Courts Service Act 2000.

[7] Borough Jigsaw officers are responsible for the day to day management of Registered Sex Offenders (RSOs) ensuring notification takes place upon conviction or release from sentence, conducting RSO home visits and any other pro-active Police activity deemed necessary to manage the risk presented.

[8] A sexual Offenders Prevention Order (SOPO) is a civil order created by the Sexual Offences Act 2003 to replace Restraining Orders and Sex Offender Orders available through the Sex Offenders Act 1997.

May 2009: A CPA review was held with the second Community Consultant. This was also attended by Mr I, the Director of the Care Home, the CC from the CMHT and the CC from the new Placement Review Team, which was set up following another of a series of community service reconfigurations. Mr I would now be care coordinated by the CC from the Placement Review Team, this would become his fourth CC. The review was documented on the Social Work IT system, Framework-i, with entry in RiO notes (Trust electronic care records system). Mr I's history and current issues were comprehensively reviewed. It was noted that Mr I normally treats his personal hygiene as a priority but had recently left his hair to grow long and had not been shaving. He was also staying later than normal at the local Turkish café.

The entry in the Trust electronic notes focuses on concern regarding reluctance to take Medication and his no longer being on any restriction.

It was noted that a SOPO was in place, which is incorrect as it was never applied. Mr I was at that time on MAPPA but had never been accepted for a SOPO. Also that Mr I was using cannabis, needed regular encouragement to take his Medication and was refusing to take it in front of support staff. It was also stated the Forensic Service was no longer reviewing him.

13 May 2009: Mr I was visited by his fourth CC for a full review of his current service.

14 May 2009: Mr I was seen by the Consultant for the Placement Review Team, with the CC from the same team. It is stated he had been stable for some time. Hyoscine was recommended for hyper salivation. It is also noted that cannabis lowered his inhibitions and increase offending risk and that he was on a SOPO (again an incorrect statement of fact).

20 May 2009: Mr I was visited by his CC to escort him to a Day Centre as previously agreed, but he stated he had changed his mind and did not want to go to the Centre.

9 June 2009: The CC completed a referral to the Learning Disability team. Nothing ultimately came from this referral as it was deemed inappropriate by the Learning Disability Service and did not meet the eligibility criteria. Whilst the Independent Investigation Panel concurs with this view, Mr I was under the Learning Disability Forensic Service for five years and it is not surprising that staff felt they could refer Mr I to the Learning Disability Community Team. Staff need clarity on the role and function of team. This has been addressed by the Internal Investigation (recommendation 10).

14 July 2009: Mr I's blood levels were tested, it was; Clozapine level 0.59, Norclozapine 0.34. This is satisfactory.

16 September 2009: The Care Home called the CC to report Mr I had become challenging after returning from a week's holiday in Cornwall. Cannabis and a bladed article and illegal substances were found "on him". Care Home documentation shows an appropriate action on their part in informing the Police, who then visited Mr I at the Care Home and gave him a written warning. The Consultant later noted "found to have several knives in his room".

October 2009: CC notes she had received information of a plan to take Mr I off the MAPPA list, which the home thought would be a very bad idea as the SOPO had been a safety net for him.

23 October 2009: A letter was sent from the CC of the Trust to the Assistant Director of the Acute and Community Services (East Haringey) advising on the concerns that Mr I might be taken off MAPPA. Also noted there was a concern he might be attacked because of his behaviour but is stated that there had not been any problems in this area in the last 5 months, believed to be as a result of the SOPO (which was not in place).

10 November 2009: Mr I's case was discussed by MAPPA and it was decided that he no longer met the criteria for supervision by MAPPA. Interviews from the Internal Investigation indicate that there were no apparent issues which warranted Mr I's continuance on MAPPA as a category 3 which is categorised as 'a person who poses a "risk of serious harm to the public" who has received a conviction and whose risk would be better managed in a multi-agency setting' .

13 November 2009: A letter was received from the Assistant Director to the CC to inform her of MAPPA decision.

16 November 2009: A letter was sent from the CC to the Assistant Director acknowledging the decision and stating she would inform the Director of the Care Home.

30 November 2009: A CPA was arranged, an interpreter had been engaged for Mr I's mother but she did not attend. It is stated that a full report will follow but this does not appear to be in the notes.

9 December 2009: A Moving-on Project Review Form was completed (seemingly for the Community Rehabilitation Team (CRT), which replaced the Placement Team. The review was carried out by a locum Review Officer. The form notes poor hygiene and "the Care Home makes frequent room checks and searches for weapons and regularly finding knives". Also "Mr I is an enduring severe high risk predator" and the risk to others is "Enduring Severe High". The form does not represent the facts as it is not documented either by Health or the Care Home notes that they 'regularly' find knives. Knives were found at the Care Home on two occasions.

26 March 2010: A CPA took place with a new Consultant and a fifth CC who was from the Community Rehabilitation Team (CRT), along with the fourth CC, Mr I and the Care Home staff. It was noted some sexually inappropriate behaviour observed e.g. beckoned to a young female child, approximately aged six, in a supermarket in September 2009; Knives found in September and confiscated with the Police informed who told Mr I if he carried a knife he would be arrested; irritable when smoking a lot of cannabis; managing his personal hygiene reasonably well. The impression was that his mental state and presentation had altered little in recent years.

14 April 2010: A blood test showed his Clozapine levels to be; Clozapine level 0.49, Norclozapine 0.27. Although a slight reduction from previous levels, the difference is not significant and the levels remain satisfactory.

3 June 2010: Seen by a Dual Diagnosis worker but not by the regular member of staff who worked with the CRT as it had been agreed a male worker should see him, given his known behaviour towards women. Mr I stated he had not used cannabis in years and the Key Worker was unaware of recent use. It is noted in the Care Home Key Worker notes that Mr I admitted to smoking cannabis from March 2008 onwards through to November 2010 when he became mentally unwell. The Key Worker felt he had been behaving very well of late. Felt by the Dual Diagnosis worker to be an inappropriate referral. This will be covered more in section 9.8.

8 June 2010: A CRT team meeting was held. It was noted there was a need to clarify why Mr I and the Key Worker were stating he had not smoked cannabis in a long time.

27 August 2010: The CC was informed that Mr I had received a fixed penalty for throwing a cigarette butt on the floor.

1 September 2010: Mr I was visited by his CC. It was noted that since the last contact in March Mr I had had his hair cut and that this had been paid for by the local cafe patrons. It is stated that Mr I was distracted and challenging to have a conversation with. A letter would be sent regarding the fine for the fixed penalty notice.

2 September 2010: Mr I's Care Plan was updated, this is comprehensive and includes the issue of knives being found but is quite reliant on the Care Home to implement the Care Plan.

27 September 2010: The fixed penalty notice was withdrawn.

30 November 2010: There was a deterioration in Mr I's mental state as noted by the Care Home. Mr I believed his brain was very powerful so people wanted to take it over and that black magic was being done on him and that he would be stabbed and chopped up. He was hearing voices threatening to cut him up. There was a concern he may not have been taking Clozapine properly over the previous week as he ran off after taking it a couple of times. He was also thought to be having one spliff of cannabis a day. Diazepam was advised and the Consultant Psychiatrist arranged a prescription for this.

1 December 2010: Mr I was **s**een by the CRT Consultant and CC. Mr I was frightened but maintained good eye contact and interacted appropriately. Psychotic symptoms noted to be not so clear cut. The impression was of a clear relapse of psychosis, the past risk of sexual assault and knives was noted. It was planned to carefully supervise the Clozapine, get a Clozapine blood level (to ensure compliance) and consider liquid and to have Diazepam as required. He was to be monitored closely and limit his time at the Turkish cafe. Planned for the Consultant to request a Clozapine level and consider liquid administration. The CC completed a CPA review form on RiO noting that Mr I may have been having a more potent form of cannabis and that there had not been any incidents of staring or looking at women over the last few months.

7 December 2010: A CRT clinical meeting was held. Mr I's relapse was discussed.

An email was received from the Director of the Care Home to the Consultant Psychiatrist stating that Mr I remained psychotic and was frightened to the point he was asking for Police protection. Earlier that day he was seen starring at two young women, who asked him what he was doing. He was not thought to be carrying a knife and none was found in his possession. Mr I had been observed to be swallowing Clozapine tablets. The cause of the relapse was unclear but it was suggested Mr I may have changed his supplier of cannabis which could have been contaminated with more potent drugs (although there is little direct evidence of this). It was noted that for a year he did not cut his hair as he believed washing it would make it fall out but the belief "went as quickly as it came". Formulation by the Director of the Care Home was that "it may be that the psychotic features of his mental health problems alongside his borderline Learning Disability combine to make casual thoughts and fantasies seem real and persistent for a period of time".

Mr I was later seen at the Care Home by the Consultant Psychiatrist. It was noted that Mr I remained similar or possibly slightly improved. Regular Diazepam was advised for a few days and a visit by the CC in a couple of days. There was a consideration regarding contacting the Mental Health Liaison Police to speak to Mr I but Mr I contacted the Police himself and they agreed to visit.

14 December 2010: A CRT clinical meeting notes that Mr I was being monitored by the Care Home.

No further CRT entry in RiO prior to incident on the 20th January 2011.

17 December: The CC went to see other Service Users at the Care Home but did not see Mr I, he was told by the Director that Mr I was settled. The CC was informed by the Director of the Care Home that Mr I was responding to the Medication.

20 December: the CC spoke to the Director of the Care Home again and clarified that Mr I was responding to the Medication. On neither this occasion nor on 17th December did the CC assess Mr I in person.

22 December 2010: Mr I **a**ttended the Clozapine clinic, it is noted that he presented as stable.

19 January 2011: Mr I **a**ttended the Clozapine clinic, it is noted that he presented as stable.

19 January 2011: Mr I met with his Key Worker at the Care Home. The session notes from this describe Mr I as stable.

20 January 2011:

At approximately 15.45 a fatal incident took place between Mr I and four young people. Mr I harmed all four victims with a knife.

At 16.32 one of the victims, Mr J was pronounced dead.

Mr I was arrested and searched, the Police found a black handled knife located in some tissue inside the left arm of his jacket.

The Director of the Care Home informed the Assistant Director of Adult Services, Haringey of the Trust.

The BEH Trust Senior Manager and Director on call were informed by the Police Psychiatric Liaison Officer, that a Service User known in this report as Mr I had been arrested for murder and is being held at Tottenham Police station.

At 18**.**43 Mr I had a blood sample taken for evidence of illicit substances, none found.

22 January 2011: The Director of the Care Home was present during the Police interviews.

24 January 2011: Mr I was remanded to HMP Pentonville. On reception his behaviour was described as "mildly abnormal". Mr I was seen in the prison healthcare wing by a Staff Grade Doctor. Mr I presented as being preoccupied by internal stimuli and hearing voices, felt to be "very mentally disturbed".

25 January 2011: Mr I was seen in healthcare wing by the same Staff Grade Doctor as on 24th January and by a Consultant Forensic Psychiatrist. He was fairly fluent in his conversation and described magic being put on him causing his body to hurt, a delusion he had expressed previously. The impression was of a picture of chronic schizophrenia with predominantly negative symptoms but some active positive symptoms.

27 January 2011: Mr I was transferred to HMP Belmarsh.

February 2011: Mr I was seen at HMP Belmarsh by the Consultant Forensic Psychiatrist who had last treated him at NLFS. He was noted to currently believe magic was being done on him and talked about issues that had brought him into NLFS in the past. He also stated that he had had a knife with him when he was attacked because he believed he was going to be kidnapped and killed when outside the Care Home.

28 February 2011: Mr I's blood sample was analysed, and the Clozapine level was found to be low (0.1). As this test was carried out 39 days after the sample was taken the validity of the result has been questioned by those who were treating Mr I. The Panel have not been able to obtain a definitive opinion on this matter.

Conclusion to Section 9.4

1. This section sets out a pathway of involvement since Mr I became known to the Mental Health Services and underpins and informs the Independent Investigation Panel findings.

9.5 What were the Mental Health Services provided to Mr I and were relevant documents in place?

- Section 1 describes the services Mr I received from the Mental Health Services.
- Section 2 details the involvement of each service, the detail is found in section 9.4.

Section 1:

North London Forensic Services (NLFS) – Medium Secure Services (MSU)

1. The MSU provides assessment and treatment for people who pose a forensic level of risk, where assessment and treatment within low or General/Community services is not appropriate. The staffing establishment for each part of the MSU takes account of safety and therapeutic requirements. Each staffing team will include Consultant and a Medical Team, Ward Manager, Senior Staff Nurses, Staff Nurses, Clinical Support Workers, Occupational Therapists, Therapeutic Workers, Clinical Psychologist, Social Workers and Art Therapists.

Forensic Outreach Service

2. The Forensic Outreach Service provide specialist forensic multi-disciplinary follow-up for male and female forensic outpatients. The majority of Service Users have a primary diagnosis of mental illness, but the Outreach Service also manage Service Users with Learning Disability and Personality Disorder. The Service Users are managed solely by the Outreach Service, and the NLFS provides a 24-hour on-call service. The majority of Outreach Service Users have been discharged from the NLFS, although sometimes Service Users are discharged directly by Specialist Placements. The majority of the Service Users are also subject to restriction orders or other legal frameworks such as life licenses. Service Users will generally be referred onto

General Adult Mental Health Teams when they move into independent or semi-independent accommodation.

Registered 24 Hour Residential Care Home

3. The Care Home is one of two small 24 hour supported Care Homes, run by the same Company. The aim is to develop Service User's potential, practical and coping skills and support them to move on, where possible from 24 hour residential support, to their optimum level of independence. The Service Users all have mental health problems and may have come through the criminal justice system but can also be referred through General Psychiatry. The Care Home has an additional registration to provide domiciliary care. This means they also provide support to people living in their own homes. The Proprietor and Director of the Care Home is very well qualified to work with mentally disordered offenders having trained as an Approved Social Worker under the Mental Health Act 1983, worked as an Approved Social Worker and Manager within Mental Health Settings and undergone post graduate training in both mental disorder offending and criminology.

Community Mental Health Teams (CMHTs) prior to service re-configuration in 2007

4. CMHTs provided local specialist Mental Health Services for adults aged 18 to 65 living in the boroughs of Barnet, Enfield and Haringey. The CMHTs were multidisciplinary teams of Community Psychiatric Nurses, Social Workers, Occupational Therapists, Psychiatrists and Psychologists who delivered Health and Social Care Services to people in the community, who were experiencing acute and enduring mental health problems.

Complex Care CMHT following service re-configuration in 2007

5. The Complex Care CMHT (referred to as the Complex Care Team) consists of a multidisciplinary team of Psychiatrists, Community Psychiatric Nurses, Social Workers, Occupational Therapists, Support Workers and Psychologists, who provide assessment and treatment. The team develop Care Plans delivering Health and Social Care Services both for the Service User and if appropriate Carers, for people with severe and enduring mental health problems. The Complex Care Teams provide treatment and care coordination to people with complex needs who meet the criteria for enhanced level of the CPA and Local Authority FACS[9] criteria at the critical level.

Community Rehabilitation Service (previously known as the Placement Review Team)

6. The Community Rehabilitation Team (CRT) is a community based service with responsibility for coordinating the care of adults with mental illness living in 24 hour Supporting Peoples Placements. The service is responsible for reviewing residential and high supported placements, and using recovery principles to move on appropriately assessed Service Users to less institutionalized forms of care. The Team is multidisciplinary and consists of a Consultant Psychiatrist, a Team Manager, a Senior Practitioner, a Staff Grade Psychiatrist, two Social

[9] FACs – Fair Access to Care Services (2003) superseded by Prioritising Need In The Context of Putting People First (2010).

Workers, an Occupational Therapist, two Community Psychiatric Nurses, two Support Workers and two Administrators.

Mental Health Act Team

7. MHA administration service which delivers compliance with mental health related legislation, policy and guidance. The team consists of 16 staff across the three main hospital sites including the North London Forensic Service and St Ann's Hospital.

The Wellbeing and Clozapine Clinic

8. The Wellbeing and Clozapine Clinic, located in the grounds of St Ann's Hospital, offers a range of services to Service Users who fulfill the criteria for both Clozapine treatment and who are prescribed depot forms of antipsychotic Medication. All Service Users receive a comprehensive assessment of their physical and mental health, this includes full blood investigations.

9. The clinic closely monitors Service Users mental health and the impact of depot Medication on their physical health. Clinic Staff have responsibility for ensuring information, results of investigations, clinical interventions and treatments are recorded onto RiO and that all parties involved in the care of Service Users, are informed.

10. The Clinical Team consists of a full time Specialist Nurse Manager, a full time Nurse and a full time Nursing Assistant. Staff within the clinic are not responsible for care coordination for Service Users under the CPA.

The Dual Diagnosis Network – An Integrated Service

11. The Dual Diagnosis Network works to a Hub and Spoke Model. The spokes are the Dual Diagnosis Workers based on the wards, in the CMHTs and the Community Rehabilitation Team, and Early Intervention in Psychosis Team, and the Complex Needs Team. The Hub Workers provide mental health support to Advisory Groups on Alcohol and/or Substance Misuse. Another aspect of their role is to train the generic staff in the skills and knowledge required to meet the needs of people with a Dual Diagnosis. The Hub will provide direction, guidance and support to the Dual Diagnosis Workers in the spokes through supervision and teaching sessions to assist them in fulfilling all aspects of their role.

Section 2:

1. From 15 November 2001 to 13 February 2006 Mr I was an Inpatient of the North London Forensic service. He was transferred from Prison under a Section 48/49 (MHA 1983). During 2001 and 2002 he did not settle well, required Medication against his will and had a period of seclusion. During Mr I's detention he was found not guilty of his offences by reason of insanity and was detained under the equivalent of Section 37 (MHA 1983).

2. During his stay Mr I, as can be seen from the chronology was prescribed the anti-psychotic Medication Olanzapine. In 2002 however it was felt by the medical team that Mr I should be on

a depot (long acting) injection, the preferred depot anti-psychotic Medication being Risperdal Consta.

3. Mr I was commenced on oral Risperidone, which is a necessary prerequisite before commencing the depot injection. Mr I however only remained well when the depot injection was supplemented by oral Risperidone.

4. By 2003 Mr I had been commenced on Clozapine in place of Risperidone and his depot Risperdal Consta. Mr I improved quickly following this and engaged much more with the services offered to him.

5. In 2005 a MHA Tribunal took place and it is noted that the Forensic Team reviewed Mr I's risk profile and that Mr I had been inappropriate with staff on three occasions; inappropriately touching, invading personal space and making comments such as "darling" at a time when his mental health was thought to be stable.

6. In 2005 Mr I was being considered for discharge from the Inpatient Services, he was assessed but not accepted into the Forensic Community Outreach Service. This is discussed more in section 9.7.

7. At the end of 2005 Mr I was referred to and accepted as a potential resident by a Residential Care Home. A thorough assessment was carried out by the Director of the Care Home and sent to the Senior Social Worker based within NLFS.

8. In November 2005 the Forensic Consultant wrote to the Community Consultant, based within the CMHT covering the area for the Care Home area proposing six months of co-working prior to full transfer. The Community Consultant wrote to the Forensic Consultant confirming above arrangements.

9. In January 2006 a discharge CPA was carried out by NLFS. Mr I's history and risks were reviewed. This will be detailed more in section 9.7.

10. Mr I was accepted as a potential resident in September 2005 and eventually discharged to the Care Home in February 2006 under Section 25a of the MHA. He also received the benefits of Section 117 of the MHA (1983). The Community RMO was named as the Forensic Consultant.

11. During 2006 the Forensic Consultant remained the Responsible Medical Officer, however she was working with the Community Services to eventually transfer Mr I's care. As part of this a letter was sent from the Forensic Consultant to the Community Consultant confirming Mr I was registered for Clozapine locally, with the latter named as the Consultant for Clozapine Service.

12. In May 2006 a transfer CPA took place and the Community Consultant became the RMO. A locum Social Worker became the CC. A CPA was completed and a further CPA completed in October 2006 in consultation with the Care Home.

13. In August 2006 a letter is sent to Mr I from the Mental Health Act office to inform him that his Section 25a (MHA 1983) had expired.

14. From November 2006 through to June 2007 both the Forensic Psychiatrist and the Community Psychiatrist remained involved in Mr I's care, with a CPA being carried out by the CC from the CMHT in February 2007.

15. In July 2007 Mr I was reviewed by a second Forensic Consultant, as the first Forensic Consultant was on maternity leave and in October 2007 Mr I was reviewed by the Community Consultant, who then retired.

16. From October 2007 through to April 2008 Mr I was not reviewed by the CMHT or a Community Psychiatrist, not only did the second Forensic Psychiatrist write to the Community Psychiatrist to confirm that he was the RMO but also the Director of the Care Home wrote to the Manager of local CMHT regarding Mr I (and another Service User) expressing concern that he had not been seen by members of the CMHT.

17. In June 2008 Mr I was reviewed by again second Forensic Consultant. There was concern that Mr I had been seen smoking cannabis on the street, he also admitted this to the Care Home staff, as documented in his Key Worker records and Care Plan and Risk Assessment carried out by the Care Home. Also Mr I became more insistent on wishing to stop Clozapine. His mental state had not changed significantly on examination but staff at the Care Home had noted that he had been seen staring at women much more than normal in recent weeks.

18. On the 4 June 2008 a letter was sent from the second Community Consultant stating that the arrangement agreed with the Associate Medical Director was that the Associate Specialist Doctor would see the Service Users of the retired first Community Consultant. This, doctor has not done so as the Service User did not have a CC. On the 3 July 2008 there was a review meeting between the second Community Consultant, the CC and the Director of the Care Home.

19. During 2008 several concerning behaviours were observed with regard to Mr I in relation to inappropriate behaviour towards women, smoking cannabis and putting himself in danger without any regard to the consequences. The Director of the Care Home expressed concern that Mr I would cease to be on the Sex Offender Register as of January 2009.

20. In November 2008 A CPA was carried out with Mr I, the Director of the Care Home, his Key Worker of the Care Home, a third Community Consultant and new CC. Concern was expressed regarding the removal of formal supervision which might affect Mr I's compliance with Medication, as he would no longer perceive there being any authority to compel him to take Medication. Mr I was also noted to have "resumed smoking cannabis" and to stare at women and children. He denied past aggression or inappropriate interest in children.

21. In December 2008 a MAPPA meeting was held at Highgate Police station. Mr I was subsequently visited at the Care Home by the JIGSAW team and informed his name would be taken off the Sex Offender Register. MAPPA had considered him to be level 3 (high) risk to women and so Police would apply for a Sex Offences Prevention Order (SOPO). Level 3 category is defined as 'active multi agency management requiring ongoing senior management supervision and use of specialist resources'.

22. In May 2009 a CPA review took place, reverting back to the second Community Consultant. This was also attended by Mr I, the Director of the Care Home, the CC from the CMHT and the CC from the new Placement Review Team. A review was completed and Mr I's history and current issues were comprehensively reviewed. It was noted that he normally treats his personal hygiene as a priority but had recently left his hair to grow long and had not been shaving. He had also been staying later than normal at the local Turkish café.

23. In September 2009 the Care Home found illegal substances and two small kitchen knives in Mr I's room. Care Home documentation shows an appropriate action on their part in informing the Police, who then visited Mr I at the Care Home and gave him a written warning. The Consultant later noted" found to have several knives in his room".

24. In March 2010 a CPA was carried out with a Consultant Psychiatrist and CC from the Community Rehabilitation Team (CRT), previously the Placement Review Team. The impression was that his mental state and presentation had altered little in recent years. This was followed up by another CPA in September when Mr I's Care Plan was updated. The Care Plan and Risk Assessment is comprehensive and includes the issue of knives being found but is quite reliant on the Care Home to implement the Trust Care Plan.

25. In June 2010 Mr I was seen by a Dual Diagnosis Worker following a referral to the Dual Diagnosis Service. He was not accepted to the service as felt to be an inappropriate referral. Mr I had stated he had not used cannabis in years and that the Key Worker was unaware of recent use. It is noted in the Care Home Key Worker notes that Mr I admitted to smoking cannabis from March 2008 onwards through to November 2010 when he became mentally unwell.

26. In November 2010 Mr I became mentally unwell as noted by the Care Home. The Consultant arranged for him to receive Diazepam as required and reviewed Mr I with the CC on the 1 December 2010. The impression was of a clear relapse of psychosis and the past risk of sexual assault and knives was noted. It was planned to carefully supervise the Clozapine, get a Clozapine level (via a blood test) and for Mr I to have Diazepam as needed. Mr I was also to be monitored closely and to limit his time at the Turkish cafe. The CC completed a CPA review form on RiO noting that Mr I may have been taking a more potent form of cannabis and that there had not been any incidents of staring or looking at women over the last few months.

27. Over the next two weeks Mr I was discussed in the CRT Clinical team meeting, and monitored by the Care Home, who had access back to the CC and Consultant should they need it.

28. Mr I was later seen at the Care Home by the Consultant. It was noted that Mr I remained similar or possibly slightly improved. Regular Diazepam was advised for a few days and a visit by the CC in a couple of days. There was a consideration regarding contacting the Mental Health Liaison Police to speak to Mr I but Mr I did this himself and they agreed to visit.

29. On the 17 December the CC went to see other Service Users at the Care Home but did not see Mr I, he was told by the Director that Mr I was settled. The CC was informed by the Director of the Care Home that Mr I was responding to the Medication and on the 20 December the CC spoke to the Director of the Care home again and that Mr I was responding to the Medication. On neither occasion did the CC assess Mr I in person. This will be discussed more in 9.7 and 9.8.

30. Mr I attended the Clozapine Clinic twice after his relapse, the second visit being the day before the incident. On both occasions he is noted as being stable.

Conclusion to section 9.5, sections 1 and 2

1. BEH Trust Mental Health Services were available to Mr I and within these he was appropriately managed from his admission in 2001 until 2007 when the Community Psychiatric Consultant left his post.

2. The Independent Investigation Panel questions the rationale for not accepting Mr I into the Community Forensic Service, however note that this has been addressed in the Internal Investigation (recommendation 2).

3. Mr I was appropriately placed into a Residential Care Home, where it is evidenced that his risks and care needs were well documented.

4. Mr I's Section 25a (MHA 1983) lapsed due to an administration error. The Independent Investigation Panel feel that recommendation 4 of the Internal Investigation should be expanded to cover all Mental Health Act Sections and have addressed this within 9.1 of this report. The Panel also note the work that has been carried out by the Mental Health Act Team to comply with the current recommendation 4.

5. There was no Community Mental Health Service available to Mr I after his Consultant Psychiatrist left in October 2007 until April 2008. This was predominately due to restructuring of the Community Mental Health Teams. Whilst this was addressed within the Internal Investigation (recommendation 6) and a Management of Organisational Change Policy has been developed, the Independent Investigation Panel were informed, during staff interviews for the Independent Investigation that this was not complied with during a potential closure of one ward recently. Whilst assurances were given to the Panel that this issue was addressed the Trust need to ensure full compliance with the Organisational Change Policy by auditable means. This is detailed as a Service Delivery Problem in table 6.

6. Mr I's Care Home throughout his stay communicated well with the Mental Health Services, apart from when there was a gap in Mental Health Service delivery. The Care Home appropriately challenged the Service with regard to this.

7. When the Care Home had a concern relating to Mr I they addressed it quickly and effectively with the Mental Health Services as can be seen from their contact with the Trust when Mr I had a relapse in November 2010.

8. Mr I was not accepted by the Dual Diagnosis Service, though he met the criteria in that he had a severe and enduring mental health illness and a substance misuse problem. This is covered in section 9.8

9. The Mental Health Services initially responded appropriately to Mr I's relapse. However Mr I did not have his blood test carried out to measure his Clozapine levels as intended by the Consultant, and the CC did not actually carry out a face to face assessment of Mr I's mental state, relying instead on the Care Home to confirm that Mr I was responding to treatment.

10. The Independent Investigation Panel consider both to be a gap in provision, however note the Internal Investigation has addressed the monitoring of Clozapine (recommendation 16). Section 9.8 will address the concern in relation to the CC's follow up of Mr I.

Table 6 – Section 9.5 Service Delivery Problem

Service Delivery Problem
The Trust did not conform to the Organisational Change Policy as evidenced in the Independent Investigation interviews. The Trust must ensure full compliance with the Organisational Policy by auditable means.

9.6 Was Mr I's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies?

Mr I's care was provided by a range of services. Many of the National and Local Policies are applicable to all services.

- Section 1 with therefore detail service specific Operational Polices

- Section 2 will detail Policies applicable to all Mental Health Services.

Section 1:

North London Forensic Service

1. The NLFS, as already described, provides a medium secure unit which assesses and treats people who pose a forensic level of risk, such that assessment and treatment within low or General/Community services is not appropriate. The current Operational Policy for the Medium Secure Unit was issued in June 2010 with a review date of June 2011.

2. The Policy states that "it aims to outline the principles set out in the Department of Health (DH) document - Best Practice Guidance: Specification for adult medium secure services" (2007) and also sets out that it should be read in conjunction with other Medium Secure Best practice publications from the (DH).

3. The Policy provides an intranet link to BEH Trust Policies and states that NLFS Protocols are available on the Directorate server.

4. The Policy describes the systems of referral, admission and discharge and the range of clinical interventions. There is also a clear section on clinical Risk Assessment and management.

5. There is a clear ratification date and a review date of 2011. It is unclear if the Operational Policy was reviewed in 2011 as the next review date is not stipulated.

6. Whilst this Policy was not available at the time of Mr I's stay the principles set out within it can be seen to have applied in relation to his care.

The Forensic Outreach Service

7. The Forensic Outreach Service provide specialist forensic multi-disciplinary follow-up for male and female forensic outpatients. The majority of Service Users have a primary diagnosis of mental illness, but the Outreach Service also manage Service Users with Learning Disability and Personality Disorder.

8. Recommendation 2 of the Internal Investigation states that "It is recommended that actions identified in the current review of the Forensic Community Services, which will strengthen the interface between Forensic Community Services and the Psychosis Service should be implemented at the earliest possible opportunity" This in relation to the fact that Mr I did not meet the criteria for the Forensic Outreach service. This has led to the development of a Partnership Working Protocol (2012).

9. The Protocol describes referral from NLFS as well as referral from General Community and Acute Services for assessment, case assisted working or full case management, with criteria set against each which addresses recommendation 2.

Registered 24 Hour Residential Care Home

10. The Care Home is one of two small 24 hour supported Care Homes owned by the same Company. The aim is to develop Service Users potential, practical and coping skills and support them to move on, where possible from 24 hour residential support, to their optimum level of independence.

11. The Care Home works within a standard specification which is given to each resident. This is termed an 'Individual Placement Agreements for the Provision of Service in Care Homes'. Within the specification there are standards set out with regard to the resident's Care Plan and Placement Reviews. The specification also states that the service provider (Care Home) shall comply with all relevant statutory requirements.

12. The Care Home also provides a brochure which describes the Service, and within this statements in relation to supporting residents and service delivery. Documentation shows that, in relation to Mr I, the Care Home were complying with these.

Community Mental Health Teams (CMHTs) prior to service re-configuration in 2007

13. CMHTs provided local specialist Mental Health Services for adults aged 18 to 65 living in the boroughs of Barnet, Enfield and Haringey.

14. The CMHTs had an Operational Policy dated October 2005. Within the Policy the Service is described, as is its core function and the core skill of the Teams. The eligibility criteria is described and Mr I was eligible to receive a service meeting more than one criteria. The Care Programme Approach is described and referenced.

Complex Care CMHT following service re-configuration in 2007

15. The Complex Care CMHT (referred to as the Complex Care Team) provides treatment and care coordination to people with complex needs who meet the criteria for enhanced level of the CPA and local authority FACS criteria at the critical level.

Community Rehabilitation Service (Previously known as the Placement Review Team)

16. The Community Rehabilitation Team (CRT) is a community based service with responsibility for coordinating the care of adults with mental illness living in 24 hour Supporting Peoples Placements. The service is responsible for reviewing residential and high supported placements, and using recovery principles to move on appropriately assessed Service Users to less institutionalized forms of care.

17. There is an Operational Policy which has been reviewed as part of the Internal Investigation in relation to recommendations 7 and 14. The Independent Investigation Panel were concerned that this Policy had been in draft since the inception of the CRT in May 2009, however BEH Trust has now evidenced that it is no longer in draft form.

18. The Operational Policy states:

    - "The team aims to provide excellent quality health and social care needs monitoring, through care coordination and case management for individuals who are suitably placed in high support environments".

    - Additionally the service aims to deliver excellence with regards to reviewing residential and high supported placements, and using recovery principles to move on appropriately assessed Service Users to more choice based and personalised forms of care

19. During the Independent Investigation interviews it became apparent that there were different expectations of the overall function of the team between Trust Board members, Senior Managers and clinical staff. This has raised a concern for the Independent Investigation Panel and a question - Is it a team which concentrates on moving Service Users on, or a team which prioritises clinical care and recovery with the aim of moving Service Users on at an appropriate time. Different views were expressed with regard to this.

20. There is a conflict with recommendation 7 of the Internal Review which states that "a weighting system must be devised to ensure that Service Users in CRTs and residential placements are appropriately prioritised". During the Independent Investigation the Panel have become concerned that different staff have a different expectation of the service being delivered and the weighting system's aim. It is unclear if it has been devised to manage those Service Users most at risk or as a tool to manage Service Users through the system.

21. One standard within the Policy states that all Service Users living in residential Care Homes or supported accommodation schemes will be reviewed every six months or as appropriate by members of the CRT, the Care Home staff, any other agencies involved with the Service User and the Service User's representative (if available). At the time of the Incident there is evidence that Mr I had been reviewed in March 2010 and September 2010.

22. The Policy appropriately cross references to other Policies such as the Care Programme Approach Policy.

Mental Health Act Team

23. MHA service delivers compliance with mental health related legislation, policy and guidance. This work is overseen by the Mental Health Act Committee which is a subcommittee of the Trust Board. It is the Mental Health Act Committee which will ensure the services are compliant against relevant Mental Health Act legislation, through the work of the MHA team.

The Wellbeing and Clozapine Clinic

24. The Wellbeing and Clozapine Clinic, offers a range of services to Service Users who fulfill the criteria for both Clozapine treatment and who are prescribed depot forms of antipsychotic Medication. The Service has a Philosophy of Care dated June 2009 and Operational protocols covering the model of service delivery, eligibility criteria and the remit of the service. Mr I was well known to the Team and attended the clinic regularly. The Policy in relation to Clozapine will be discussed in section 2

The Dual Diagnosis Network – An Integrated Service

25. The Dual Diagnosis Network works to a Hub and Spoke Model. The spokes are the Dual Diagnosis Workers based on the wards, in the CMHTs and the Community Rehabilitation Team, Early Intervention in Psychosis Team, and the Complex Needs Team. The Hub Workers provide mental health support to Advisory Groups on Alcohol and/or Substance Misuse.

Section 2

This section addresses the specific local operational policies pertinent to Mr I's care as follows:

Care Programme Approach (CPA)

1. The Trust CPA Policy was in operation in 2005 and reviewed in 2007 and 2008. The next review was scheduled for 2011. It is unclear if the Policy has been reviewed as there is no current review date.

2. The CPA most recent CPA Policy (2011) Policy gives clear criteria for identifying Service Users who are subject to CPA.

3. The CPA Policy sets out clear roles and responsibilities in relation to the care coordination role. This includes making sure that the Service User has had the opportunity to agree the plan of action should they become acutely mentally unwell.

4. There is a statement within the Policy which states that "any change of CC must be discussed with the Service User, the multi-disciplinary team and the clinical team leader". Mr I had several changes to his CC and Consultant given the reconfiguration of the Community Services but there is no evidence that this was discussed with him, although when a change did happen there was normally a review of his care.

5. The section on Risk Assessment is clear and states that "Clinical Risk Assessment is one that balances care needs against risk needs" and emphasises "the importance of the assessment of dynamic (changing) risks factors, as well as the more well understood static ones".

6. The section on Risk Assessment also sets out standards for documentation in relation to risk and states that a RiO Risk Assessment must be completed and entered onto RiO (Service User care records electronic system). It also states that all decisions must be clearly identified in the Service User's progress notes in RiO.

7. The Policy sets out very good standards in relation to transferring care, this was not complied with in July 2007 when Mr I was reviewed by the Community Consultant, who retired and handed over care to an Associate Specialist Doctor who he did not follow up because he was waiting for a CC to be allocated.

Mental Health Act Section 25a (MHA 1983) amended by the (MHA 2007)

8. This Policy was ratified in 2008 and has a review date of 2010. It is not clear if the policy has been reviewed as there is no current review date.

9. Section 25a (MHA 1983) was superseded in part by Community Treatments Orders (CTOs) in 2007. There is a clear criteria which must be met before a CTO can be made. The criteria is set nationally and in legislation.

Clozapine Operational Policy

10. This Policy was issued in 2010 and has a review date set for 2013. It sets out clear roles and responsibilities for all involved in the service. The Policy is under review in response to the Internal Investigation recommendation 16 which as an action requires the Policy to include as an appendix the procedure that must be followed for communication between the Clinic and the relevant community services.

Dual Diagnosis Operational Policy

11. This Policy was reviewed in 2011 and has a review date set for 2014. There is a clear Strategy for the Dual Diagnosis Service which includes clear roles and responsibilities in relation to the Service, its role with other agencies and expectation of services in terms of partnership working.

12. The Policy states that the "Diagnosis Service will be available to anyone with a substance misuse problem in Mental Health Services". and "the selection of Mental Health Services requiring specialist input will be based on a needs assessment and available evidence relating to the prevalence of Dual Diagnosis problems".

Conclusion to both sections 1 and 2

1. It is unclear what the status is of several Policies as there is no current review date noted. Given that there are recommendations which impact on service delivery and service review within the Internal Investigation, the Independent Investigation Panel would request that a review of the status of Policies is prioritised. This is identified as a Service Delivery Problem – table 7

2. There were at times evidence of non-compliance with Policies. The Trust should ensure that it can evidence compliance and ongoing monitoring of Policies. Whilst the Trust has identified this within the Internal Investigation, the Independent Investigation Panel is of the opinion that the Trust should clearly describe how compliance will be monitored. This is identified as a Service Delivery Problem – table 8

3. Trust Policies do cross reference to other appropriate Policies and make reference where appropriate to relevant National Guidance, as an example Clozapine Policy begins with a description of NICE Guidelines (National Institute for Clinical Excellence).

4. The Trust does not appear to have a universal understanding of the role of the CRT and need to clarify and agree, both clinically and managerially, its purpose and function – table 9 identifies this as a Service Delivery Problem.

5. There are different expectation of the 'weighting system's' aim. It is unclear if it has been devised to manage those Service Users most at risk or as a tool to manage Service Users through the system. This is identified as a Service Delivery Problem – table 10

6. The section on Risk Management within the CPA Policy is worthy of note as it clearly leads the clinicians to review dynamic and static risks.

Table 7 – section 9.6 - Service Delivery Problem

Service Delivery Problem
It is unclear what the status is of several Policies as there is no current review date noted. All Policies should have the next review date clearly identified at the front of the Document to ensure that staff are working to the current policy.

Table 8 – section 9.6 - Service Delivery Problem

Service Delivery Problem
Policies should include a process for ensuring compliance. Policies should clarify how compliance will be achieved to ensure staff work within the requirements of the Policy.

Table 9 – section 9.6 - Service Delivery Problem

Service Delivery Problem
There is not a universal understanding of the role of CRT. There is confusion for the staff delivering the clinical services in terms of what is expected and required of them. This should be clarified.

Table 10 – section 9.6 - Service Delivery Problem

Service Delivery Problem
There is a not a universal understanding amongst the staff/teams of the aim of the 'weighting system' tool. The 'weighting system' tool to be clarified to ensure that all staff/teams have the same understanding of its purpose.

9.7 Was the Risk Assessment and Management of that risk to others adequate?

1. The Chronology set out in section 9.5 raises a number of questions in relation to the management of Mr I's risk from a clinical and operational perspective, as follows:

2. Mr I was appropriately transferred from HMP Pentonville to the NLFS as an Inpatient on a Section 48/49 of the MHA (1983).

3. Over the next four years, Mr I was appropriately managed as an Inpatient by NLFS when he was seen by the Forensic Community Consultant Outreach Team who felt that he was not ready to be managed by the Team, giving the Independent Investigation Panel the impression that in the future he would/could be ready and that the Forensic Team would follow him up in the Community.

4. In May 2005 Mr I was reviewed again by Forensic Community Consultant from the Forensic Community Outreach team. It was concluded that there had been little change and none was likely so he would need very close supervision in the community, but the Consultant stated that Mr I did not meet the criteria for the Forensic Community Team. He further stated "I am of the opinion he could be followed up by the General Adult Psychiatric Services". A few weeks previous to this the Consultant's opinion was that Mr I was not yet ready for the Specialist Community Forensic Service and little had changed in the intervening period. There is no rationale for this change of view stated, or any discussion of the role of the Forensic Community Team. The Independent Investigation Panel remain unclear as to why the Forensic Community Team did not follow him up given the original level of concern identified by the Forensic Community Consultant and the clearly identified risks; past convictions for violence and sexual offences, continued inappropriate behaviour despite stabilisation of his mental state and his being on the Sex Offender Register.

5. In January 2006 a CPA was undertaken in preparation for Mr I's discharge from NLFS. There is a detailed description of his indicators to becoming unwell, but the CPA form is not so explicit when describing the relapse indicators, although the indicators are appropriately described, they are less explicit and detailed. These are set out in detail within Mr I's Chronology in section 9.4.

6. Mr I's Section 25a (MHA 1983) lapsed in 2006 due to an administration error. Mr I started to challenge his need to take Medication as he was now an Informal Service User.

7. Mr I's chronology demonstrates that until the Community Consultant left in October 2007 Mr I continued to be reviewed by both the Forensic Psychiatrist and the Community Consultant. It is concerning however that in February 2007 a CPA was completed and within this the Risk Assessment indicators for his risk status are all scored low, including his historical risks. This is contra-indicated to a Risk Assessment Mr I had at his CPA in preparation for discharge from NLFS.

8. In April 2008 the chronology shows that the Forensic Psychiatrist for Inpatient Services is still reviewing Mr I. This is two years after Mr I had been discharged from NLFS. Whilst it is to be commended that the Inpatient Forensic Service stayed involved for so long after Mr I's discharge, this raises a question about the decision not to accept Mr I into the Forensic Community Outreach Team, as the Forensic Consultant for Inpatient Services felt that his risks were significant and that he required close supervision.

9. There was a lack of clarity and communication between the Forensic Services and General Adult Psychiatry with regard to follow up for Mr I from Adult Psychiatry, following both the departure of the first Community Psychiatrist and a significant reorganisation of the CMHTs which in error left Mr I without an allocated CC. It was not until April 2008 that the Forensic Consultant 'found out' that a Community Consultant had been allocated who had not seen Mr I because a CC had not been allocated. This would have been another factor in the Forensic Consultant's continued involvement, as he would have been prevented from ceasing involvement until there was an Adult Psychiatrist to hand over to.

10. In April 2008 the Director of the Care Home wrote to the Manager of the CMHT as there had been no Community input from the CMHT since Mr I was seen by the first Community Consultant in October 2007, apart from a Care Plan which had been completed in February 2007 which was not signed or dated and where the CC was not named. Mr I had a significant risk history and risk factors indicated on the CPA at point of discharge from NLFS Inpatient Services in January 2006. One of his relapsing indicators was his sexual inappropriateness and it is documented throughout 2008 that this was presenting itself by his staring and whistling at women, trying to talk to a girl who clearly did not want to speak to him and staring at young children whilst on holiday.

11. In October 2008 the Director of the Care Home did write to the allocated Community Consultant Psychiatrist setting out Mr I's behaviour during 2008; that Mr I had now admitted to smoking cannabis; and of his concern when Mr I would no longer be on the Sex Offenders Register.

12. In November 2008 there was a CPA where the Director of the Care Home continued to discuss his concerns in reference to Mr I's behaviour. The clinician who attended from the CMHT with the Consultant Psychiatrist is clear that the primary purpose for her attending the CPA was to do a placement review, as she would be leaving the Team in January 2009 to go back to another CMHT. Mr I was therefore handed back to her Team Manager.

13. It should also be noted that at this time (MAPPA meeting December 2008) Mr I's risk were not considered to be high enough to warrant the Police applying for a SOPO and yet at this time it is not clear who his named CC was, and the Community Services were organising a new team – called the Placement Review Team, which became the CRT. Mr I would be case loaded to this team as he was in a residential placement, but this did not happen until May 2009, this was at a critical time when the Police were making decisions about his MAPPA status and would have relied on the Mental Health Services to provide evidence to aid their decision.

14. A new CC and reverting back, the second Consultant met with Mr I at a CPA Review on the 11th May 2009. This was also attended by the Director of the Care Home, the CC from the CMHT and the CC from the new Placement Review Team (this became the Community Rehabilitation team 6-8 week after it was formed). Mr I's history and current issues were comprehensively reviewed. It was noted that Mr I normally treats his personal hygiene as a priority but had recently left his hair to grow long and had not been shaving. This was potentially another indicator of relapse (personal hygiene) – as stated on the Risk Assessment carried out when discharged from NLFS.

15. The CC was consistent until December 2009 when she went on sick leave. Within this time (October 2009) the CC received notification that Mr I might be taken off MAPPA. Interviews from the Internal Investigation indicate that there were no apparent issues which warranted Mr I's continuance as a category 3 – 'a person who poses a "risk of serious harm to the public" who has received a conviction and whose risk would be better managed in a multi-agency setting'.

16. Whilst the CC did write to express her concerns Mr I was removed from MAPPA in November 2009. The Independent Investigation Panel is of the opinion that if there had been a consistent team in the Community supporting the Care Home staff, information about his behaviour since 2007 would have been more comprehensively available to MAPPA and it is possible that he could have remained on MAPPA.

17. In March 2010 a CPA took place with a new Consultant and new CC from the Community Rehabilitation Team (CRT), along with previous CC, Mr I and the Care Home staff. It was noted some sexually inappropriate behaviour observed e.g. beckoned to a young female child, approximately six years old, in a supermarket in September 2009; knives found in September and confiscated with the Police informed who told Mr I if he carried a knife he would be arrested; irritable when smoking a lot of cannabis; managing his personal hygiene reasonably. The impression from the meeting was that his mental state and presentation had altered little in recent years, though documented evidence and communication from the Care Home shows this not to be the case.

18. In November 2010 there was a deterioration in Mr I's mental state as noted by the Care Home. There was a concern he may not have been taking Clozapine properly over the previous week as he ran off after being given it on a couple of times. He was also thought to be having one 'spliff' of cannabis a day. The Community Service were immediately contacted and they responded appropriately. As part of this the Consultant requested, via email as was normal practice, a blood test to check Mr I's Clozapine level. This did not happen as the Clozapine clinic states that they did not receive the email. The system has now been improved as part of the Internal Investigation Review.

19. The Internal interview with the CC state that on the 17 December the CC went to see other Service Users at the Care Home but did not see Mr I, he was told by the Director that Mr I was settled. The CC was informed by the Director of the Care Home that Mr I was responding to the Medication and on the 20 December the CC spoke to the Director of the Care Home again and that Mr I was responding to the Medication (the Independent Investigation Panel was unable to interview the CC as he had left the Trust and was not contactable). On neither occasion did the CC assess Mr I in person. This is covered in section 9.8

20. On the 19 January 2011, the day before the incident Mr I is seen in the Clozapine Clinic and presented as stable. The Key Worker's session notes from the Care Home also note that on the 19 January that Mr I is stable in mood. When Mr I became unwell in November his symptoms were florid. It is clear that on 19 January the relapse in his mental state had largely resolved. However, since 2008 there had been subtle indicators that his mental state was not as stable as it had been in 2006. It is likely that there had been a subtle deterioration in mental state since 2006 that had become overt in December 2010, had to a significant degree resolved but remained in a manner that was very difficult to detect.

Conclusion to section 9.7

In conclusion to this section there are many factors to address in relation to the adequacy of Risk Assessment and Management. These are both organisational and clinical, as follows:

1. Mr I had been an Inpatient of NLFS under Section 37 of the MHA (1983) for over four years and yet was not followed up by the Forensic Community Service. There is no rationale for this and is potentially a missed opportunity for Mr I to have a more seamless reintegration back into the Community with close supervision, and an eventual seamless hand over to the General Adult Psychiatric Service. This has been addressed via the Internal Investigation (recommendation 2).

2. Mr I's Section 25a (MHA 1983) lapsed in 2006 due to an administration error. Mr I started to challenge his need to take Medication as he was an Informal Service User. Had he continued to remain on a Section 25a (MHA 1983). It is possible that after the amendment to the Mental Health Action 1983 Mr I would have been transferred to a Community Treatment Order (CTO). This has been addressed via the Internal Investigation (recommendation 4) and has been discussed in section 9.1 and 9.5 of this report.

3. The CMHTs were restructured more than once between 2006 and 2010 with the result that Mr I did not always receive a consistent service from the Mental Health Services in terms of professional involvement, timely Care Planning and appropriate Risk Management, though in the year prior to the incident in January 2011 Mr I did have two Care Planning meetings as per the CPA Policy, a consistent CC and Consultant Psychiatrist and an appropriate risk and care management plan. By this time the Care Home also had good access to Mr I's CC and Consultant as demonstrated when Mr I relapsed in November 2010.

4. Communication from General Adult Psychiatry to the Forensic Services with regard to follow up for Mr I following the departure of the first Community Psychiatrist in 2007 was poor. This was compounded by the fact that Mr I, following the restructuring of the CMHTs in 2007 was left without an allocated CC. Whilst the Independent Investigation Panel are satisfied that the Trust now have an Organisational Change Policy in place and impact assessments are carried with regard to change it should be recognised that any restructuring of a clinical service must prioritise the risks to the Service User and mitigate against these before any change is made. Compliance with this should be auditable (see section 9.5)

5. Communication and follow up from the Community Services to the Care Home was lacking in 2008 when communication from the Services was poor between October 2007 and July 2008 which necessitated in the Director of the Care Home having to alert the Community Service to their lack of input. This meant that the Forensic Psychiatrist was the only source of support from the Mental Health Services at this time for a Service User who is described as being a significant risk who needs close supervision.

6. In October 2008 the Director of the Care Home appropriately escalated his concerns about Mr I's increasing risk behaviour to the allocated Community Consultant Psychiatrist setting out Mr I's behaviour during 2008. The Director of the Care Home appropriately continued to discuss his concerns at Mr I's CPA meeting held in November 2008.

7. Communication with MAPPA was poor. The Internal report notes the poor engagement of the Mental Health Services with MAPPA meetings and that there were no issues apparent with Mr I which warranted his continuance as a category 3. Mr I was removed from MAPPA in November 2009. This has been addressed within the Internal Investigation (recommendation 9)

8. Risk assessments were variable, given the number of clinicians involved with Mr I from 2006 to 2011. Whilst Risk Assessments were carried out and his main risks documented the description of the severity of these changed, as did the level of detail describing each risk. It should be noted however that the CC did carry out and document Risk Assessments which were comprehensive and included the issue of knives being found. It was however quite reliant on the Care Home to implement the Trust Care Plan.

9. The Care Home carried out regular reviews of Mr I's care which included risk history, Risk Assessment and a risk management plan and when necessary escalated any risk concerns to the Trust.

10. The Mental Health Services initially responded appropriately to Mr I's relapse. However Mr I did not have his blood test carried out to measure his Clozapine levels as intended by the Consultant, the Independent investigation Panel note that the Internal Investigation has addressed the monitoring of Clozapine (recommendation 16).

11. The follow up plan in relation to monitoring Mr I only happened via conversation from the CC to the Director of the Care Home. Therefore no face to face Risk Assessment was carried out, during this period. This is covered in 9.8

9.8 Was the quality of assessments and Care Planning appropriate?

1. As can be seen from the chronology (section 9.4) Mr I had assessments and Care Plans carried out by many different clinicians from the Community Mental Health Teams throughout his time in the Community from 2006 to 2011. These are variable in content, style and quality of information.

2. CPA reviews are documented although these are variable in quality and content.

3. Letters from Consultants to Mr I's GP are timely, informative and normally give a clear account of the consultation and identify the current problems and the consequent Care Plan.

4. Throughout Mr I's time as a resident the Care Home carried out regular reviews and documented these in Care Plans, Key Worker session notes, placement reviews and Risk Assessments. These were detailed and informative.

5. Care Plans developed by the Trust place a high reliance on the Care Home to deliver against them. The Community Services need to demonstrate that they are actively overseeing the implementation of Care Plans, even for those Service Users in residential placement. Section 9.8 addresses this point in relation to Care Planning.

6. The Dual Diagnosis assessment on Mr I was carried out in June 2010 following an informal referral from the Consultant Psychiatrist to the Dual Diagnosis Specialist Worker for the Community. There was no formal referral via RiO. Due to Mr I's behaviour with women the Dual Diagnosis Team arranged for a male member of the Team to assess Mr I.

7. Mr I attended the Dual Diagnosis assessment and within this stated that he did not know why he was there and denied that he used drugs. The RiO notes state that a Key Worker attended with Mr I. The Dual Diagnosis Worker alluded to recent notes that stated Mr I did use substances but Mr I denied this. The Dual Diagnosis Worker offered Mr I the chance to take a urine test, Mr I declined.

8. In the Dual Diagnosis Operational Policy it states that 'Core Assessment takes place over a four week period and reflects a Bio-Psycho-Social approach. Assessment includes substance misuse profile, physical and mental health assessment, children and families assessment and Risk Assessment. This thorough assessment process results in robust Care Plan agreed by the Service and the client'. The Independent Investigation Panel is unclear why the assessment process came to the conclusion that Mr I was inappropriate based on one meeting, when there was significant documented evidence that he was using substances and that he had told his Key Worker from the Care Home, which is noted in all Key Worker session notes dating back to March 2008. Mr I clearly met the criteria for a Dual Diagnosis Service in that he had a significant mental health problem and was using cannabis. The Independent Investigation Panel also challenge the therapeutic value of offering a urine test so early on in what could have possibly been the start of a therapeutic relationship.

9. Following Mr I's relapse in November 2010 the role of the CC was to monitor Mr I. The CC did this through the Care Home and did not carry out a face to face assessment with Mr I. Whilst it is clear that the Care Home were able to make a good assessment of Mr I's mental health status and escalate concerns appropriately, it is part of the CC's role to assess and review Service Users and best practice would determine that this is carried out via face to face contact, particularly when the Service User is recovering from a recent relapse. As evidenced in section 9.6 there was and remains a mismatch between the role of the CRT, which the Trust Board believe is to manage placements, and the role of the clinicians, one of whom quoted "we have these two jobs, clinical care and move on". Clarification with regard to this will be developed into a recommendation within the Independent Investigation report.

Conclusion to section 9.8

1. Care Plans from 2006 were variable, however from 2010, when there was consistency in terms of clinical involvement, Care Plans and assessments became much more consistent, current and informative.

2. The Dual Diagnosis Service did not offer a reasonable rationale for not accepting Mr I into the Service. The Internal Investigation has two recommendations with regard to the Dual Diagnosis Service which has addressed this conclusion. The CC did not follow best practice in his ongoing assessment of Mr I following his relapse. Whilst it is accepted that Mr I had improved significantly it would always be best practice for a CC to assess a Service User face to face, particularly following such a recent relapse. This is set out as a Care Delivery Problem – Table 11.

3. It is recognised that the Care Home carried out regular detailed and informative reviews throughout Mr I's time as a resident.

4. The Panel remain concerned that the CRT was reliant on the Care Home to implement actions from Care Plans. The CRT must be clear about its remit and ensure that as part of this there is a recognition of the professional accountability clinicians carry when delivering care (section 9.6 table 8 addresses the need for clarity).

5. All Community Services need to demonstrate they are actively overseeing the implementation of Care Plans, even for those Service Users in residential placement, and that this is appropriately supported and auditable. This is set out as a Service Delivery Problem – table 12

Table 11 – section 9.8 - Clinical Delivery Problem

Clinical Delivery Problem
The CC did not assess the Service User via a face to face contact following a relapse. The Trust must ensure that CCs, with appropriate support and clear managerial direction, follow the professional requirements of their role, and that a system is put in place to measure compliance with this.

Table 12 – section 9.8 - Service Delivery Problem

Service Delivery Problem
Too much reliance was placed on the Care Home to implement actions from Care Plans. All Community teams are responsible and accountable for ensuring the implementation of Care Plans, this includes those Service Users in a Residential Care Home. Clinicians must be properly resourced and supported to deliver this.

9.9 Are there any other matters of public interest which need to be considered?

1. The Independent Investigation Panel notes the recommendation made by the Internal Investigation Panel in relation to liaison with the schools. There are however 11 schools in the immediate vicinity of the Care Home, and a Family Centre. Whilst the Panel would not want to exclude any person from living in the Community they would advise that where there are new Services developed which have implication of safety for the public, impact assessments are carried out and risks identified from these mitigated.

2. Under the new commissioning arrangements for Health Services the National Commissioning Board will be responsible for the commissioning of all Forensic Services. This will include Community Forensic services. Whilst it is acknowledged that specialist clinical advice has been sought in order to shape the new arrangements, the Trust Board should ensure that these new arrangements do not cause a gap in services for Service Users who could fall between General and Forensic Psychiatry.

3. The Independent Investigation Panel is aware that the Trust has undergone a significant reconfiguration of its Services and most staff interviewed by the Independent Panel welcomed the changes. However the Independent Panel would like to be assured that Services are now allowed to settle and develop without further significant change.

4. The National Service Framework was a ten-year programme that was completed in 2009. Associated with this programme were a series of Policy Implementation Guidance documents (PIG). There is some confusion as to the current status of these documents. Many commissioners and Trusts are reconfiguring their Mental Health Services to meet new demands in a harsher financial environment including for example, closing Assertive Outreach Services and moving their function back into mainstream Community Mental Health Teams. It is not clear from the current Policy context - “No Health Without Mental Health”; February 2011 – with its focus on well being and prevention, what is the optimum way of delivering care for people with an acute mental illness.

10. Contributory/Associated Factors

1. The National Patient Safety Agency (NPSA) determines “contributory factors as those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to Service Users and hence the likelihood of Care Delivery or Service Delivery problems occurring”. Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. The removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or ‘root causes’ will be expected to prevent or significantly reduce the chances of reoccurrence”.

2. The findings of the Independent Investigation Panel determines that, whilst there is no fundamental root or causal factor for this incident, (this will be addressed in section 11), there are several contributory factors which affected the delivery of safe and effective care to Mr I.

3. These factors are:

   Service User:

1. Mr I was known to local Mental Health Services in Haringey and NLFS. He had been in contact with services since November 2001 when he was admitted to NLF Inpatient Services under a Home Office restriction order – 48/49 (MHA 1983), having been transferred from HMP Pentonville whist on remand for two counts of sexual assault against women. Whilst in NLFS he was placed on Section 37 (MHA 1983). Mr I had a provisional diagnosis of Paranoid Schizophrenia and mild Learning Disability.

2. Mr I was discharged from NLFS in 2006, under Section 25a (MHA 1983) to a 24 hour supported Registered Residential Care Home. Whilst Mr I did not engage in community activities, preferring instead to spend his time in one or two Turkish cafes, until 2008 he was quite settled.

3. Mr I's condition was complicated by use of street drugs in the form of cannabis. In 2008 Mr I admitted to his Care Home Key Worker that he was using cannabis, this is noted in his Key Worker session notes from March 2008 onwards.

4. Mr I had a previous history of offending and of conviction, including violent assaults against family members and members of the public who were unknown to him. He had previously spent time in a young offender's institution and prison.

5. In 2000 Mr I was placed on the Sex Offenders Register following a conviction in 2000 for indecent assault on a female under 16 for which he received a six months prison sentence.

6. When Mr I was discharged from NLFS his Risk Assessment noted that his indicators of becoming unwell are that he becomes untidy and shows a lack of self-care; he appears distracted and vague; he becomes sexually disinhibited towards women.

7. Mr I was resistant to taking Medication and often challenged the need to take it. He had little insight into his mental health illness.

8. Mr I did not understand the impact of placing himself in dangerous situations as an example when he was taken by a Key Worker to the football match at Arsenal.

9. Mr I would behave inappropriately to women by staring at them and trying to engage in conversation with young girls.

10. Mr I was found to be in possession of knives by the Care Home on two occasions. Whilst a management plan was put in place by the Care Home to address this, it remained a concern of the Care Home and the Community Mental Health Services that knives were found in Mr I's possession.

Organisational systems:

1. Mr I's Section 25a (MHA 1983) lapsed in August 2006 due to an administration error, he was however still subject to Section 117 aftercare. Whilst he remained on the Sex Offenders Register at this point he did understand that he was no longer subject to the requirements of Section 25a (supervised discharge).

2. Mr I was not accepted for follow up by the Community Forensic Outreach service and no explicit rationale was given for this. Mr I was on Section 25a (MHA 1983); was a convicted sex offender; was convicted of indecent assault; had previously been convicted of affray and theft; was known to use illicit substances and had a severe and enduring mental health problem and a mild Learning Disability. It remains unclear why he was not accepted for follow up.

3. Mr I received no follow up service from the Community Mental Health Teams between October 2007 and April 2008 and there was no communication to the Care Home from the Service. Mr I had got 'lost' in the system due to service reorganisation. He did however continue to be reviewed by the Forensic Consultant and did receive a consistent service from the Care Home.

4. Mr I had a number of changes to his CC and Consultant Psychiatrist from 2006 until March 2010 most of which was due to several reorganisations of the Community Mental Health Team. This created some inconsistency in his care and risk management, as is demonstrated by the variable care and risk management plans in terms of the quality and consistency of information from the Mental Health Services. It would also have been difficult to establish a baseline to observe and monitor Mr I's behaviour as staff did not remain involved for long enough to identify this.

5. Whilst Mr I's his care was very consistent from the Care Home there was an over reliance on the Care Home to keep the Mental Health Services informed of any change in Mr I's behaviour.

6. There was an over reliance on the Care Home to deliver against Mr I's Mental Health Services Care Plan.

7. Whilst Mr I was initially considered for inclusion onto MAPPA at category 3 level in December 2008, due to poor engagement from the Community Mental Health Services to the MAPPA process no current risk information about Mr I was communicated to MAPPA, such as his ongoing concerning behaviour through 2009. In October 2009 Mr I was removed from the MAPPA process. From this point on Mr I had no formal supervisory structures in place.

8. Mr I was referred to the Dual Diagnosis Service but not accepted, though he met the criteria. The Dual Diagnosis Service did not offer a reasonable rationale for not accepting Mr I into the Service. The Dual Diagnosis Workers are skilled at working with Service Users who have both a mental health and substance misuse issue. Cannabis was being used by Mr I and there is little evidence that this is being actively addressed by the Mental Health Services. Although it should be noted that post incident on the 20 January 2011 at 18.43 a blood sample was taken from Mr I which showed no evidence of cannabis use.

9. When Mr I had a relapse in November 2010 it was thought by the Care Home that he had not been compliant with his Medication, having run out of the room a couple of times straight after having his Medication administered. The Consultant Psychiatrist treating Mr I at the time planned to have his Clozapine levels checked, however this did not happen as the Clozapine Clinic did not receive the email sent by the Consultant. There was therefore no current baseline from which to judge Mr I's Clozapine level following the incident in January 2011.

10. Following Mr I's relapse the CC did not carry out face to face assessments, relying instead on conversations with the Director of the Care Home to inform Mr I's progress. Whilst two clinical records independent of each other show that Mr I is reported as stable on the 19 January 2011, his CC would be unable to judge Mr I's improvement as he had not seen him.

Leadership

1. Whilst it is recognised by the Independent Investigation Panel that Mr I provided a very demanding challenge given his history and behaviour, it is not demonstrated that this was addressed by a clear leadership from the Community Mental Health Services, particularly between 2007 to 2009.

2. Leadership issues include; poor communication, poor liaison, poor documentation, poor care and risk management, poor compliance with operational and clinical policies, excessive reorganisation of the services leading to several changes in CCs and Consultant Psychiatrists.

11. Root Causes/Causal factors

1. The NPSA determines a root cause as "a fundamental contributory factor which if removed would either prevent or reduce the chances of a similar type of incident happening in the future". Whilst there are several contributory or associated factors, which have been identified in section 10, the findings from the Independent Investigation has determined that there is no fundamental contributory or causal factor. On the 20th January 2011 Mr I was described by his Care Home Key Worker as 'being back to normal'. On the previous day he is described as being stable by another Health Professional. This was therefore an act that could not have been predicted, given his presentation at that time.

12. Lessons Learned

1. The Internal report identifies and makes recommendations in relation to:

   - Supervision
   - Reviewing the Forensic Community services
   - Community Consultants attendance at CPA discharging planning meeting from the Inpatient forensic service
   - Monitoring working within the Mental Health Act and Mental Capacity Act within supervision.
   - Handling and Movement of Service User Records
   - Assessing risks in relation to service reorganisation
   - Ensuring care management of Service Users in residential placements identifies those requiring more intensive input from the psychiatric team, and verifies that they receive what is required.
   - Sexual Offences Prevention Order (SOPO), where considered necessary, staff involved with the care of the Service User must ensure that they fully understand the information needed by the Police
   - MAPPA Protocol
   - Staff understanding the workings of Haringey Community Learning Disability Service
   - Care Planning and the Dual Diagnosis Network

- Staff understanding and awareness of Dual Diagnosis
- Record Keeping
- Prioritisation of Service Users by Care Coordinators
- Searching of Service Users
- Communication processes between clinical teams and Clozapine clinical teams
- GP Forum, promoting a greater understanding about the role of the CRT and that the expectations by and of the parties involved are more explicit and better understood.
- Informing Service User's GP following an Serious Incident
- Liaison with the school

2. The recommendations were developed into an action plan (see section 9.1) and the Independent Investigation Panel was able to evidence progress against each recommendation (see section 9.2 and appendix 2)

3. The Independent Panel would also like to commend the inclusion of a recommendation in relation to Whistle Blowing. Whilst the Service was undergoing extensive reorganisation many staff, during their Independent Investigation interviews, commented on their concerns in relation to keeping track of their Service Users and the mismanagement of handing over Service Users when CC roles changed. Since this time the staff have received information in relation to Whistle Blowing and most staff interviewed knew of the Whistle Blowing Policy and would feel empowered to use it.

4. The Independent Investigation Panel note the progress on the action plan and adds the following points for consideration within the action plan:

   - Recommendation 4 should be expanded to include an auditable process for monitoring compliance with all parts of the Mental Health Act and Mental Capacity Act.

   - Recommendation 15 can only relate to the searching of property in a clinical area within BEHT and should specify this more explicitly.

   - The actions relating to recommendations 7 and 14 needs to be clarified in terms of the weighting system so that all staff/teams have the same understanding of its purpose

   - In order to fully meet recommendation 7 and 14 the Trust must agree and clarify the role and function of the CRT and ensure this enables delivery of care in line with clinical and professional requirements.

   - Recommendation 19 does refer to all the schools in the vicinity of Haringey, and the evidence and ongoing action focuses only on the school Mr J attended. The Trust should revisit the original recommendation to ensure it complies with regard to each school.

5. The Independent Investigation Panel add the following areas which were not addressed as part of the Internal Investigation:

Leadership

1. Overall clinical and managerial leadership within the Community Mental Health Teams was not demonstrated as robust and effective, particularly between 2007 to 2009. There is no evidence that compliance with policies, documentation, risk management and clinical interventions were monitored and where appropriate, challenged within a supervision or caseload management framework. The Trust has now reconfigured into Service Lines with clear leadership structures in place, underpinned by strong direction at Board Level. The Trust however should assure itself that leadership development is an ongoing process which leads to effective leadership at both clinical and managerial level.

Governance

1. There was a delay of four months following the presentation of the Internal Investigation Report to the BEH Trust Board in May 2012. Whilst the action plan had been developed from the recommendations the group responsible for ensuring implementation of the actions did not meet until September 2012. The Independent Investigation Panel received no mitigating reason for this and consider this period to be too long. The Trust should gain assurance that findings from Internal reports are implemented in a timely manner.

2. The report does not follow the National Patient Safety Agency Comprehensive and Independent Investigation report format. This means that causal factors and Care/Service Delivery problems have not been clearly identified from the findings. This raises a question for the Independent Investigation l Panel in relation to Trust staff having the appropriate Root Cause Analysis training in order to undertake Investigations. The Trust should assure itself that Root Cause Analysis training is available to any person who is a member of an investigation panel.

3. The recommendations appear to be a statement of fact rather than SMART auditable goals which lead to the development of measurable action plans. The Trust should ensure that all recommendations are SMART and auditable so that learning is effective.

4. One of the panel members for the Internal Investigation did review Mr I in a clinical capacity. Whilst this was some time before the incident there was still a potential conflict which should have been acknowledged within the Internal report. The Trust should ensure that it uses Panel members who have not previously had involvement with the issue being investigated, or where this is not possible declare it within the report.

5. Whilst it will be possible to evidence that actions have been completed there is no overarching stated action to ensure understanding and ongoing compliance with the recommendations.

6. The status of all Policies should be clear with a current review date clearly marked.

7. All Policies should have a section on how the Policy will be monitored to ensure ongoing compliance by staff.

8. An audit and/or process should have been included in the action plan to ensure compliance with each recommendation. Currently there is no clear monitoring process to ensure that each action is taken forward and that learning has taken place.

Organisational Systems

1. The Trust recently did not comply with the Organisational Change Policy. Whilst the Independent Investigation Panel accepts the process put in place to mitigate against this happening again, this process should be audited to ensure ongoing compliance

2. The Trust must ensure that CCs, with appropriate support and clear managerial direction, follow the professional requirements of their role, and that a system is put in place to measure compliance with this.

13. Post investigation Risk Assessment

1. In light of the findings from the Independent Investigation, the post investigation Risk Assessment remains at 15. Whilst it is recognised that there are many lessons to be learnt from this incident, this act could not have been predicted given Mr I's presentation at that time. Table 13 sets out the scoring methodology

Table 13 – NHS Controls Assurance Risk Scoring Methodology

Likelihood (the potential likelihood of the risk occurring)			**Impact** (the potential impact to individuals or the organisation of the risk occurring)
Almost Certain	**5**	Multiplied by	**5** Extremely
Likely	**4**		**4** Very High
Possible	**3**		**3** Medium
Unlikely	**2**		**2** Low
Rare	**1**		**1** Negligible

14. Recommendations

Internal Action Plan

1. The recommendations and action plan to be reviewed to take account of the Independent Investigation Panel additional findings.

2. The Trust to ensure that the action plan continues to be monitored and its progress reported upwards via its governance reporting systems.

3. The Trust should include an audit and/or process within the Internal Investigation action plan to ensure compliance with each recommendation.

Leadership

1. The Trust should assure itself that leadership development is an ongoing process leading to effective leadership at both clinical and managerial level.

Governance

1. The Trust should assure itself that the findings from Internal reports are acted upon in a timely manner.

2. The Trust should assure itself that Root Cause Analysis training is available to any person who is a member of an Internal Investigation Panel.

3. The Trust should ensure that all recommendations from Internal Investigations are SMART and auditable, leading to effective learning.

4. The Trust should ensure that all Policies are current and that there is a process described to monitor compliance with each.

Organisational Systems

1. The Trust should assure itself that the process described in the Organisational Change Policy is audited to ongoing compliance.

2. The Trust must ensure that CCs, with appropriate support and clear managerial direction, follow the professional requirements of their role, and that a system is put in place to measure compliance with this.

3. The Trust should ensure that it does not use Panel members who have had other involvement with the issue being investigated, or where this is not possible it is declared within the report.

New Services

1. The Trust should ensure that where new Services are set up in the community, it carries out impact assessments which identify any implication of safety for the public and put in place plans to these mitigated the risks identified.

Future Commissioning of Forensic Services

1. The Trust must ensure that given the new commissioning arrangements for Forensic Services, no gap is allowed to develop for Service Users to fall between General and Forensic psychiatry.

Acknowledgements

The Independent Investigation Panel would like to express their thanks to:

Mr J's family for taking the time to meet with the panel in what must have been very difficult circumstances

The staff at Barnet Enfield and Haringey Mental Health NHS Trust for their responsiveness and openness to this Independent Investigation process

The staff and Director of the Care Home, for their responsiveness and openness to this Independent Investigation process.

The Head Master of the School the young people attended.

The Deputy Director, Adult and Community Services, Haringey Council

Mr I's current Responsible Clinician

The Police

Appendix 1

Independent Mental Health Investigation into the

Care and Treatment provided to Mr I

Terms of Reference

Commissioner

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

The aim of the Independent Investigation is to evaluate the mental health care and treatment provided to Mr I 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 Investigation:
- Involving the family of both Mr I and the victim's family as fully as is considered appropriate:
- A chronology of the events to assist in the identification of any Care and Service Delivery problems leading to the incident:
- An examination of the Mental Health Services provided to Mr I and a review of the relevant documents:
- The extent to which Mr I's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies:
- The adequacy of the Risk Assessment and management of that risk to others.
- The appropriateness and quality of assessments and Care Planning:
- Consider other such matters as the public interest may require:
- Complete an Independent Investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

Approach

The Investigation team will conduct its work in private and will take as its starting point the Trust Internal Investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

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

If the investigation team identify a serious cause for concern then this will immediately be notified to the Homicide Investigation Manager, NHS London.

The Investigation Team

The Investigation team will consist of appropriate qualified senior professionals.

Consultant Adult Psychiatrist

Mental Health Nurse

Project Chair/Manager

Appendix 2

Evidence of Internal Action Plan Implementation

Recommendation	Actions	Evidence
1. Supervision The Trust should further develop its supervision policy and procedure to facilitate it being used to provide assurance to the Trust Board that Service User care is of the required standard. The supervision process should enable monitoring at every level to ensure clinical practice reflects the requirements of the clinician's professional duties and of prescribed changes in practice such as the recommendations below.	1. The Supervision Policy should be reviewed to ensure the findings identified in the report is reflected in the Policy 2. Following the Policy review the procedures for clinical supervision (both individual and team) should be reviewed to ensure that best practice is maintained and followed	• Supervision Policy reviewed October 2012 • Section on training regarding Clinical Supervision October 2012 • Sample on staff tracking regarding appraisals 2011 and 2012 • Supervision and Appraisal monitoring form • Completed supervision and appraisal monitoring form from six service areas **NHSL Level 2**
2. Forensic services It is recommended that actions identified in the current review of the Forensic Community Services, which will strengthen the interface between Forensic Community Services and the Psychosis Service should be implemented at the earliest possible opportunity. Their progress should be monitored via the action plan monitoring process arising from this report.	1. The current review of Forensic services to be completed. Progress on the outcomes of the review to be monitored via this action plan and quality assurance audit	• Partnership Working Protocol March 2012 **NHS Level 1**

Recommendation	Action	Evidence
3. Attendance at CPA discharge planning Leads in the Psychosis Service should reinforce the need for Community Consultants to attend CPA Discharge Planning Meetings in respect of Service Users who are being discharged from Inpatient Forensic Services, in order to ensure that they are involved in all aspects of care planning, and in order to ensure that follow-up in the community is robust. The change in practice resulting from the effective implementation of this recommendation can be monitored by including this aspect of CPA process in the clinical supervision of those teams involved with this Service User group.	1. Memo to be sent to Team managers and all Community Consultants advising them of the need to attend CPA Discharge planning meetings regarding Service Users discharged from NLFS. The change in practice resulting from the effective implementation of this recommendation to be monitored to include this aspect of the CPA process in clinical supervision of the teams involved in this Service User group	• Memo sent 14 September 2012 • Care Plan Competency Audit – Quality Assurance Tool Trust (seven months period 2012) • Forensic Service Results for Contents of care Planning Competency of Quality Audit (six months period 2012) **NHS Level 3**

<table>
<tr><th>Recommendation</th><th>Actions</th><th>Evidence</th></tr>
<tr><td>4. Reminder Process re CTOs

The Panel welcomes the assurance that there are systems in the MHA Offices to remind Responsible Clinicians at 2 months before expiry of the Supervised 'Community Treatment Order' (CTO). However it is recommended that those procedures should be reviewed to ensure they are sufficiently robust during significant degrees of service changes within the Trust. The change in practice resulting from the effective implementation of this recommendation can be monitored by including working within the Mental Health Act and Mental Capacity Act in the clinical supervision of those individuals and teams involved with these Service User groups.</td><td>1. Procedure for reminding Responsible Clinicians of the expiry of Supervised CTOs to be reviewed

2. Once review completed a memo should be sent to all Consultants reminding them of the process for renewal of CTOs.

3. The change in practice resulting from the effective implementation of this recommendation to be monitored via the clinical supervision of clinicians and teams who may be involved with these Service User groups. Supervision to include the use of and consideration of the Mental Health Act and Mental Capacity Act.</td><td>1. Memo May 2012 to Psychosis Service Line and Consultants

• Community Treatment Orders (CTO) Data Reports, 2009, 2010,
• CTO Activity Reports, 2008-2010, 2011, 2012
• Two Reports to the Mental Health Act Committee 2011
• Guidance for Care Coordinators on Hearings, Reviews of Service Users on CTOs.
• Admission and Discharge CTO checklist
• Mental Health Act Related Incidents Report 2011/12
• Associate Hospital Managers Guidance 2010

NHS Level 2</td></tr>
</table>

Recommendation	Action	Evidence
5. Movement of Service User records The BEHMHT Records Management Information Life Cycle Policy sets out good practice for handling Service User records. This policy should be brought to the attention of all staff involved in the handling and movement of Service User records to ensure they are managed consistently and safely, particularly during times of service change. The change in practice resulting from the effective implementation of this recommendation can be monitored by including the management of clinical records in the clinical supervision of those teams involved with services undergoing significant change.	1. In addition to communication already established 'In the Know' the Trust Communicate, a memo should be sent to all staff advising them of the requirements that must be followed for handling Service User records 2. The change in practice resulting from effective of the recommendation can be monitored by including the management of clinical records in the clinical supervision of those teams involved with services undergoing significant change	• Memo October 2012 to Managers to cascade Trust Records management Life Cycle Policy • Records management Information Life Cycle Policy 2011 – next review 2014 • Evidence triangulated in External interviews that Records are monitored in Supervision **NHS Level 2**

Recommendation	Action	Evidence
6. Re-organisation of Services Before any significant reorganisation of services the Trust should ensure that an assessment of risks arising out of the proposals is carried out and a means to implement a risk management plan to minimise any adverse outcomes identified. In particular there is a need to make provision to deal with the impact of the transfer of large numbers of Service Users between teams and the movement of staff from existing resources to man newly developed services. Without such provision realistically timetabled into the implementation plan the smooth and safe transfer of complex cases is not possible.	1. Prior to any re-organisation of services the Trust must ensure that a risk assessment and risk management plan is implemented. The plan must address in particular, the need to make provision to deal with the impact of the transfer of large numbers of Service Users between teams and the movement of staff from existing resources to man newly developed services. Without such provision realistically timetabled into the implementation plan the smooth and safe transfer of complex cases is not possible.	• Memo October 2012 drawing attention to paper (evidenced) presented to Finance Committee in March 2012 regarding each service change must be quality assessed. • Management of Organisational Change Policy 2011 – next review 2014 **NHS Level 2**

Recommendation	Action	Evidence
7. **Care Management of Service Users in Residential placements** The Trust should ensure that the arrangements for the care management of Service Users in residential placements identifies those requiring more intensive input from the Psychiatric Team, and verifies that they receive what is required. The change in practice resulting from the effective implementation of this recommendation can be monitored by including relevant factors in the clinical supervision of those teams involved with this Service User group.	1. Associate Director with input from the Service Managers to devise a weighting system which ensures that Service Users in residential placements are appropriately prioritised 2. Procedures once agreed to be written up and circulated to team members and audited via supervision of staff who may be involved with this Service User group.	• Productive Community Rehabilitation meeting (May 2012) • Memo from Team manager setting out RAG rating system in relation to prioritisation • Operational Policy - next review 2014 • Staff caseloads are audits as described in interviews with staff • Template regarding weighting tool **NHS Level 2**
8. Sexual Offences Prevention Order (SOPO) The Service Director of the Psychosis Service should issue a directive to all clinicians that in cases where a Sexual Offences Prevention Order (SOPO) is considered necessary, staff who are involved with the care of the Service User must ensure that they fully understand the information which is needed by the Police in order to define the specific restriction to be imposed. They must be given advice as to where this and similar information is available.	1. The Service Director of the Psychosis Service to send a memo to all clinicians advising them of the requirements and the information that is necessary for effective implementation of Sexual Offences Prevention Order (SOPO)	• MAPPA Policy Draft – August 2011 • Memo November 2012 briefing paper in relation to Sexual Offenders prevention Order (SOPO) • Memo 2012 Advice on the requirements and information that is necessary for effective implementation of SOPO • Briefing paper on Sexual Offenders Register September 2012 **NHSLA Level 1**

Recommendation	Action	Evidence
9. MAPPA Protocol The Trust MAPPA Protocol which is currently under revision, should be ratified, and cascaded on a Trust-wide basis as soon as possible, in order to clarify the MAPPA Leads in each area, and to ensure there is a wider understanding about the circumstances where a referral to MAPPA should be contemplated.	1. MAPPA Protocol should be ratified and circulated to all staff. Protocol to include referral criteria and names of MAPPA Leads for each area	• MAPPA Policy Draft – August 2011 **NHSLA Level 1**
10. Staff Understanding the workings of HLDP In order to promote a greater understanding of the work carried out by Haringey Community Team for Learning Disabilities (HLDP) it is recommended that information about HLDP Eligibility for Services, and HLDP Eligibility Assessment Flowcharts for Health and Social Care should now be widely cascaded to all clinical teams.	1. Information regarding the work of Haringey Community Team for Learning Disabilities (HLDP) to be sent to the Patient Safety Department for circulation 2. Once information has been prepared and circulated issue to be discussed with teams via the Trust Governance Processes	• HLDP Eligibility Criteria • Review Group Minutes of meeting where Criteria and Operational Policy Discussed **NHSLA Level 1**

Recommendation	Action	Evidence
11. Care Planning/Dual Diagnosis Network In cases where a service user refuses to engage with the Dual Diagnosis (DD) Network, and their mental health is being severely affected by substance misuse, every effort must be made to ensure the CC is aware that a collaborative approach can be taken by way of ongoing support from the DD Network. A specific item in the Care Plan should identify the response of the clinical team to this issue. The change in practice resulting from the effective implementation of this recommendation can be monitored by including relevant factors in the clinical supervision of those teams involved with these Service User groups.	1. Memo to be sent by Manager of Dual Diagnosis Network to all team managers to remind them of the work and support to service users that can be provided by the service. 2. The change in practice resulting from this recommendation to be monitored by including relevant factors in the clinical supervision of those teams involved with these Service User groups	• Memo regarding Dual Diagnosis Guidance • Not evidenced, however addressed under recommendation 12 **NHS level 3**
12. Staff understanding and awareness of Dual Diagnosis In order to raise awareness in the skills and knowledge required to meet the needs of people with Dual Diagnosis, it is recommended that every effort should be made by Service Managers to ensure that staff attend the Dual Diagnosis Best Practice Training.	1. Service Managers to undertake with the input of team leaders an audit to establish a base line as to how many of their staff have accessed this training. 2. Going forward training to be mandatory for designated staff 3. Overall figures within teams to be monitored via team and service line clinical governance meeting and submitted at end of year as evidence of implementation	• Dual Diagnosis Presentation • Dual Diagnosis Forum Information September and November 2012 • Staff numbers submitted regarding training on Dual Diagnosis – November 2012 **NHSLA Level 2**

Recommendation	Actions	Evidence
13. Record Keeping Service Leads in all Service Lines should reinforce to staff in their areas that RiO Records must be contemporaneous in accordance with the Trust Record Keeping Policy. The change in practice resulting from the effective implementation of this recommendation can be monitored by routinely including an examination of the RiO record in the clinical supervision of individuals and teams.	1. Associate Directors to send a memo to their Service Managers/Teams advising them of the importance of adhering to the requirements of the Trust's Record Keeping Policy in regard to contemporaneous record keeping 2. The change in practice resulting from this recommendation can be monitored by routinely including an examination of RiO record in the clinical supervision of individuals and teams	• 1 memo sent to staff in 2011 and 4 memos sent to services in October/November 2012 regarding adherence to Record keeping Policy • Papers to Quality Committee regarding compliance with CQC 16 • Interviews confirm discussion at Clinical supervision sessions **NHSLA Level 3**
14. Prioritisation of Clients by Care Co-ordinators Psychosis Service Line Managers must ensure that the individual case load of all CCs are now reviewed to ensure there is appropriate prioritisation of clients, and to ensure that there is a clear understanding about the frequency of contact which is required. The change in practice resulting from the effective implementation of this recommendation can be monitored by including an examination of case load priorities in the clinical supervision of individuals acting as Care Coordinators.	1. A system for the weighting of cases held within the CRT to be developed. Weighting system/procedure to reflect appropriate prioritisation 2. Once developed Procedure to be used in the allocation of all cases and monitored via supervision of staff who may act as care co-ordinators for this Service User group	• See Recommendation 7 – work on the weighting system is still ongoing • As above **NHSLA Level 1**

Recommendation	Actions	Evidence
15. Searching of Service Users All clinical teams must be made aware that when they are working with informal Service Users and there may be clinical or safety reasons to wish to search them or their belongings, the circumstances should be explored with senior clinical colleagues, if necessary legal advice should be sought and an explicit acknowledgment of the issues and consequent plan should be documented into the Care Plan.	1. The Trust's Searching of Patients Policy to be reviewed to ensure that the recommendation is included. Procedure to be developed to be added as an appendix to the Policy of the steps to be taken by staff when it is felt that more senior advice is required to undertake the search of the Service User	• Memo progressing relevant part in Search Policy (October 2012) • Search Policy version 3 **NHSLA Level 1**
16. Communication processes between clinical teams and Clozapine clinical teams Service Leads in the Psychosis Service should now review their policies and procedures to establish that lines of communication between Clinical Teams and the Clozapine Clinic are sufficiently robust, to ensure that any concerns about a Service User's deteriorating mental state, can be brought to the attention of all clinical teams involved as quickly as possible. The change in practice resulting from the effective implementation of this recommendation can be monitored by including an examination of cases where this is an issue in the clinical supervision of individuals within the Clozapine clinic.	1. Operation Policy of Well Being Clinic to be reviewed. Policy to include as an appendix the procedure that must be followed for communication between the clinic and the Services. Once completed the procedure to be circulated to all teams. 2. The change in practice resulting from the effective implementation of this recommendation to be monitored by including an examination of cases where this is an issue within the clinical supervision of individuals within the Clozapine/Wellbeing Clinic.	1. Operational Policy under Review 2. Clozapine Clinic Policy 2013 **NHSLA Level 1**

Recommendation	Actions	Evidence
17. GP Forum The Acting Manager and the Clinical Lead of the CRT should facilitate a Haringey GP Forum Meeting in order to promote a greater understanding about the role of the CRT and that the expectations by and of the parties involved are more explicit and better understood.	1. Acting Manager of CRT and Clinical Lead to facilitate a GP Forum meeting. Report of outcome to be presented to the Clinical Quality Review Group	• GP News letters x 2 in 2012 from the Trust • Task group meetings and agendas x 4 in 2012 **NHSLA Level 3**
18. Informing Service User's GP following an Serious Incident Service Leads should issue a directive to staff in their areas that if a severe incident involving one of their Service Users has occurred, the GP must be informed by telephone and subsequently by letter in accordance with the BEHMHT Serious Untoward Incidents Management Policy.	1. Memo to be sent to team leaders reminding them of the action to be taken following a serious incident, including informing the Service User's GP. 2. Memo to be drawn up with input from the Patient Safety Team	• Memo not evidenced, but information within Serious Untoward Incidents Policy - 2009 **NHSLA Level 1**

Recommendation	Action	Evidence
19. Liaison with the School Representatives from the Trust should liaise with Local Head Teachers in Haringey in order to provide advice with regard to ways of incorporating mental health subjects into the curriculum, so that student understanding of adult mental health issues is increased and student concerns in this area are better understood.	1. Recommendation to be discussed at Clinical Quality Review Group with a view of determining action for implementation.	• Meeting following incident was arranged with headmaster of school for week commencing 31st January 2011. • Future work in this area to be determined. • Waiting on school to confirm meeting dates when they are ready to hold a meeting (22 November 2012) **NHSLA Level 1**
Added since Incident as general Recommendation **Whistle Blowing** How is this being Communicated across the Trust	1. Director had request from External Panel to demonstrate process in relation to Whistle Blowing.	• Confidential Hotline communicated out to all staff June 2011 • Staff concerns and the Disclosure of Information Whistle Blowing Policy 2011 • Whistle Blowing data evidenced • In external investigation interviews all staff bar 1 knew and would feel able to whistle blow if needed to **NHSLA Level 3**

Appendix 3

Documents reviewed by the Independent Investigation Panel

Documents relating to the recommendations of the Internal Investigation

- Supervision Policy reviewed October 2012
- Section on training regarding Clinical Supervision October 2012
- Sample on staff tracking regarding appraisals 2011 and 2012
- Supervision and Appraisal monitoring form
- Completed supervision and appraisal monitoring form from six service areas
- Partnership Working Protocol March 2012
- Memo sent 14 September 2012
- Care Plan Competency Audit – Quality Assurance Tool Trust (seven months period 2012)
- Forensic Service Results for Contents of Care Planning Competency of Quality Audit (six months period 2012)
- Memo May 2012 to Psychosis Service Line and Consultants
- Community Treatment Orders (CTO) Data Reports, 2009, 2010,
- CTO Activity Reports, 2008-2010, 2011, 2012
- Reports to the Mental Health Act Committee x 2 2011
- Guidance for Care Coordinators on Hearings, Reviews of Service Users on CTOs.
- Admission and Discharge CTO checklist
- Mental Health Act Related Incidents Report 2011/12
- Associate Hospital Managers Guidance 2010
- Memo October 2012 to Managers to cascade Trust Records Management Life Cycle Policy
- Records Management Information Life Cycle Policy 2011 – next review 2014
- Memo October 2012 drawing attention to paper (evidence) presented to Finance Committee in March 2012 regarding each service change must be quality assessed.
- Management of Organisational Change Policy 2011 – next review 2014
- Productive Community Rehabilitation meeting (May 2012)
- Memo from Team Manager setting out Red Amber Green (RAG) rating system in relation to prioritisation
- CRT Operational Policy - next review 2014
- Template regarding weighting tool
- MAPPA Policy Draft – August 2011
- Memo November 2012 briefing paper in relation to Sexual Offenders Prevention Order
- Memo 2012 Advice on the requirements and information that is necessary for effective implementation of SOPO
- Briefing paper on Sexual Offender Register September 2012
- MAPPA Policy Draft – August 2011
- HLDP Eligibility Criteria
- Memo regarding Dual Diagnosis Guidance
- Dual Diagnosis Presentation
- Dual Diagnosis Forum Information September and November 2012
- Staff numbers submitted regarding training on Dual Diagnosis – November 2012
- 1 memo sent to staff in 2011 and 4 memos sent to services in October/November 2012 regarding adherence to Record Keeping Policy
- Papers to Quality Committee regarding compliance with Care Quality Commission (CQC)

- Memo progressing relevant part in Search Policy (October 2012)
- Search Policy version 3
- Wellbeing and Clozapine Operational Policy 2009
- Clozapine Clinical Policy 2013
- GP Newsletters x 2 in 2012 from the Trust
- Task group meetings and agendas x 4 in 2012
- Serious Untoward Incidents Policy - 2009
- Information Whistle Blowing Policy 2011
- Whistle Blowing data evidenced
- Review Group Minutes of meeting where criteria and Operational Policy discussed

Additional documentation reviewed by the Independent Investigation Panel

BEH Trust

- 24 hour incident report - 20/01/11
- Rapid response meeting - 23/01/11
- Desktop Review - 04/02/11
- Board level Inquiry Terms of reference
- Internal Investigation report – Board Level Inquiry – 29/11/11
- Tabular Timeline
- Crisis meeting plan
- Report regarding Strategic Response to the school 25/01/11
- Interview Statements from Internal Investigation
- Trust Updated Serious Incident Action plan - 30/11/2012
- Discharge Report
- Various clinical reports and letters,
- Tribunal Report 15/03/05, 09/11/05
- Tribunal decision 14/06/05, 10/11/05
- Social Circumstances Reports
- Various minutes of CPA meetings plus CPA and Risk Documentation
- Section 25a application 07/02/06
- Letters to Mr I regarding Section 25a lapse 13/02/06, 22/09/06
- Clinical progress notes
- Moving on Project review form – 09/12/10
- Letter to street enforcement – 17/09/10
- Email from Mental Health Act Manager – 23/11/12
- Email from Director of Nursing – 08/11/12
- Previous version CRT Operational Policy
- Care Programme Approach Operational Policy 2005/2006, 2008, 2011
- North London Forensic Operational Policy – Medium Secure – June 2011
- North London Forensic Operational Policy – Low Secure – June 2011
- CMHT Operational Policy – 2005
- Policy regarding Section 25a – 2008
- Serious Incident Policy 2010 – next review 2013
- Independent Homicide investigation Presentation
- Dual Diagnosis Strategy – 2011 – 2014 and Dual Diagnosis Operational Policy – 02/2010
- Trust Board Structure and Board reports 2007 - 2008

Adult Services – Haringey Council

- Letter from the Director of Adult Services – 28/11/12

Care Home

- Individual Placement Agreements
- Care Home brochure and Care Home Statement of Purpose
- Serious Incident report 08/02/11
- Report to Internal Investigation Panel
- Statements to Internal Investigation Panel
- Letters to Trust, Social Workers, MHA Administrator, and Disabled Benefits Centre
- Letter to Queens Counsel presiding over Court proceedings – regarding sentencing remarks
- Copies of email response from Judge
- Research Paper on Clozapine
- Residents progress reports
- Completed Community Care Review Forms
- Various Care Plans and Risk Assessments throughout Mr I's stay
- Key Worker session notes and Daily Records Sheets
- Resident Profile report
- Notes of meeting between Key Worker and Mr I

Police

- Internal Investigation Statement
- Statements made to Police Officers from those involved
- Statement from Forensic Scientist 31/03/11
- Police report 14/02/11

School

- Letter to Chief Executive of the Trust 14/02/11 and Response letter 21/02/2011
- Statement – Independent Investigation
- Notes from meeting with a surviving victim
- Letter commenting on Desktop Review – 14/02/11

Mr J's family

- Minutes of meetings with the Trust
- Independent investigation interview statement
- Map showing the number of schools in the vicinity

Mr I's family

- Independent Investigation interview statement
- Notes of meeting with Mother, Brother and BEH Trust

Others

- Judges Summing Up

Appendix 4

Internal Report Recommendations

1. The Trust should further develop its supervision policy and procedure to facilitate it being used to provide assurance to the Trust Board that Service User care is of the required standard. The supervision process should enable monitoring at every level to ensure clinical practice reflects the requirements of the clinician's professional duties and of prescribed changes in practice such as the recommendations below.

2. It is recommended that actions identified in the current review of the Forensic Community Services, which will strengthen the interface between Forensic Community Services and the Psychosis Service should be implemented at the earliest possible opportunity. Their progress should be monitored via the action plan monitoring process arising from this report.

3. Leads in the Psychosis Service should reinforce the need for Community Consultants to attend CPA Discharge Planning Meetings in respect of Service Users who are being discharged from Inpatient Forensic Services, in order to ensure that they are involved in all aspects of Care Planning, and in order to ensure that follow-up in the community is robust. The change in practice resulting from the effective implementation of this recommendation can be monitored by including this aspect of CPA process in the clinical supervision of those teams involved with this Service User group.

4. The Panel welcomes the assurance that there are systems in the MHA Offices to remind Responsible Clinicians at 2 months before expiry of the Supervised 'Community Treatment Order' (CTO). However it is recommended that those procedures should be reviewed to ensure they are sufficiently robust during significant degrees of service changes within the Trust. The change in practice resulting from the effective implementation of this recommendation can be monitored by including working within the Mental Health Act and Mental Capacity Act in the clinical supervision of those individuals and teams involved with these Service User groups.

5. The BEHMHT Records Management Information Life Cycle Policy sets out good practice for handling Service User records. This policy should be brought to the attention of all staff involved in the handling and movement of Service User records to ensure they are managed consistently and safely, particularly during times of service change. The change in practice resulting from the effective implementation of this recommendation can be monitored by including the management of clinical records in the clinical supervision of those teams involved with services undergoing significant change.

6. Before any significant reorganisation of services the Trust should ensure that an assessment of risks arising out of the proposals is carried out and a means to implement a risk management plan to minimise any adverse outcomes identified. In particular there is a need to make provision to deal with the impact of the transfer of large numbers of Service Users between teams and the movement of staff from existing resources to man newly developed services. Without such provision realistically timetabled into the implementation plan the smooth and safe transfer of complex cases is not possible.

7. The Trust should ensure that the arrangements for the care management of Service Users in residential placements identifies those requiring more intensive input from the psychiatric team, and verifies that they receive what is required. The change in practice resulting from the effective implementation of this recommendation can be monitored by including relevant factors in the clinical supervision of those teams involved with this Service User group.

8. The Service Director of the Psychosis Service should issue a directive to all clinicians that in cases where a Sexual Offences Prevention Order (SOPO) is considered necessary, staff who are involved with the care of the Service User must ensure that they fully understand the information which is needed by the Police in order to define the specific restriction to be imposed. They must be given advice as to where this and similar information is available.

9. The Trust MAPPA Protocol which is currently under revision, should be ratified, and cascaded on a Trust-wide basis as soon as possible, in order to clarify the MAPPA Leads in each area, and to ensure there is a wider understanding about the circumstances where a referral to MAPPA should be contemplated.

10. In order to promote a greater understanding of the work carried out by Haringey Community Team for Learning Disability (HLDP) it is recommended that information about HLDP Eligibility for Services, and HLDP Eligibility Assessment Flowcharts for Health and Social Care should now be widely cascaded to all clinical teams.

11. In cases where a Service User refuses to engage with the Dual Diagnosis (DD) Network, and their mental health is being severely affected by substance misuse, every effort must be made to ensure the CC is aware that a collaborative approach can be taken by way of ongoing support from the DD Network. A specific item in the Care Plan should identify the response of the clinical team to this issue. The change in practice resulting from the effective implementation of this recommendation can be monitored by including relevant factors in the clinical supervision of those teams involved with these Service User groups.

12. In order to raise awareness in the skills and knowledge required to meet the needs of people with Dual Diagnosis, it is recommended that every effort should be made by Service Managers to ensure that staff attend the Dual Diagnosis Best Practice Training.

13. Service Leads in all Service Lines should reinforce to staff in their areas that Rio Records must be contemporaneous in accordance with the Trust Record Keeping Policy. The change in practice resulting from the effective implementation of this recommendation can be monitored by routinely including an examination of the RiO record in the clinical supervision of individuals and teams.

14. Psychosis Service Line Managers must ensure that the individual case load of all CC's are now reviewed to ensure there is appropriate prioritisation of clients, and to ensure that there is a clear understanding about the frequency of contact which is required. The change in practice resulting from the effective implementation of this recommendation can be monitored by including an examination of case load priorities in the clinical supervision of individuals acting as Care Coordinators.

15. All clinical teams must be made aware that when they are working with Informal Service Users and there may be clinical or safety reasons to wish to search them or their belongings, the circumstances should be explored with senior clinical colleagues, if necessary legal advice should be sought and an explicit acknowledgment of the issues and consequent plan should be documented into the Care Plan.

16. Service Leads in the Psychosis Service should now review their policies and procedures to establish that lines of communication between Clinical Teams and the Clozapine Clinic are sufficiently robust, to ensure that any concerns about a client's deteriorating mental state, can be brought to the attention of all clinical teams involved as quickly as possible. The change in practice resulting from the effective implementation of this recommendation can be monitored by including an examination of cases where this is an issue in the clinical supervision of individuals within the Clozapine clinic.

17. The Acting Manager and the Clinical Lead of the CRT should facilitate a Haringey GP Forum Meeting in order to promote a greater understanding about the role of the CRT and that the expectations by and of the parties involved are more explicit and better understood.

18. Service Leads should issue a directive to staff in their areas that if a serious incident involving one of their Service Users has occurred, the GP must be informed by telephone and subsequently by letter in accordance with the BEHMHT Serious Untoward Incidents Management Policy.

19. Representatives from the Trust should liaise with Local Head Teachers in Haringey in order to provide advice with regard to ways of incorporating mental health subjects into the curriculum, so that student understanding of adult mental health issues is increased and student concerns in this area are better understood.

Appendix 5

Mental Health Act 1983 Section Descriptions

Introduction:

The purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they may need for their own health and safety, and for the protection of other people. it sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for Service Users.

Section 25A: was inserted by the Mental Health (Patient in the Community) Act 1995 which came into force on 1st April 1996.

The people for whom 'aftercare under supervision is targeted have been described as 'the small group of so called revolving door Service Users'. Typically such a Service User will be someone who:

- Is compulsorily admitted to hospital for treatment for mental illness;
- Responds to the treatment and improves;
- Is discharged into the community with a Care Plan
- Fails to continue to comply with the Care Plan and consequently deteriorates;
- Is formally re-admitted to hospital where the whole cycle begins again.

Section 37: This is a court order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation. It has the same duration as a Section 3, and in many ways operates exactly the same way.

Section 48: allows the Secretary of State the power to transfer prisoners with mental health disorders to appropriate hospital settings

Section 49: Refers to special restrictions which can be applied by the Secretary of State on the advice of the Responsible Medical Officer to prisoners who have been transferred to hospital settings.

Section 117: concerns aftercare and places a legal duty on the NHS and Social Services to provide aftercare, free of charge, to people who have been detailed under Sections 3, 37, 45a, 47 and 48 of the Mental Health Act. Aftercare lasts as long as someone requires if for their mental health condition and only ends when Health and Social Care authorities have assessed that someone is no longer in need of aftercare services.

Mental Health Act Tribunal: exists to protect the rights of persons subject to the Mental Health Act 1983 (amended 2007). Essentially, it provides for consideration of appeals against detention in hospital made by people thus detained.