An independent investigation into the care and treatment of Mr SU

February 2012

A report for NHS London
Undertaken by Consequence UK Ltd

NHS
London

This is the report of an independent investigation commissioned by NHS London to conform with the statutory requirement outlined in the Department of Health (DH) guidance *"Independent investigation of adverse events in mental health services"*, issued in June 2005. The guidance replaces paragraphs 33-36 in HSG (94)27 (LASSL(94)4) concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

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- the mental health service user (Mr SU) whose care and treatment is the focus of this report;
- the mother of Mr SU;
- the administrative and clinical staff employed currently and/or at the relevant time by East London NHS Foundation Trust; and
- the Metropolitan Police for their efforts in trying to locate the next of kin for the deceased.

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ACRONYMS USED IN THIS REPORT

Acronym	Full Title
A&E	Accident and emergency
CPA	Care Programme Approach
DoH	Department of Health
GP	General practitioner
NHS	National Health Service
NPSA	National Patient Safety Agency
SHA	Strategic Health Authority

EXECUTIVE SUMMARY

Incident overview

On 19 April 2007 a Mental Health Service User (Mr SU) spent the evening with his girlfriend. At one point in the evening an incident occurred as a consequence of which Mr SU's girlfriend died. Mr SU was arrested and was subsequently sentenced to life imprisonment with a minimum term of 22 years.

Reason for and purpose of the investigation

Whenever a patient of specialist mental health services is involved in a homicide and it can be identified that they have received care and treatment in the six months preceding this, there is a requirement that the care and treatment provided is independently assessed to determine whether or not the care and treatment was reasonable, and also to determine whether or not the homicide was predictable by mental health services and/or preventable by different and/or better care and treatment.

Such investigations are expected to be proportionate and to take note of any internal investigation already conducted by the mental health trust that provided the care and treatment to the mental health service user prior to the incident.

Terms of Reference

The following terms of reference were provided by NHS London and agreed with the East London Foundation NHS Trust and its commissioners.

- A review of the East London NHS Foundation Trust's (the Trust) Internal Investigation to assess the adequacy of the findings, recommendations and action plans;
- A review of the progress made by the Trust in implementing the action plan from the Internal Investigation;
- Involvement of the families of both the Service User and the victim as fully as is considered appropriate;
- A chronology of 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 the Service User and a review of the relevant documents;
- An assessment of the extent to which the care provided to the Service User was in accordance with statutory obligations and relevant national guidance from the Department of Health (DoH), including local operational policies;
- An assessment of the extent to which the Service User engaged with the Substance Misuse Service (not applicable to this case);
- An assessment of the appropriateness and quality of assessments and care planning;

- Consideration of the effectiveness of inter-agency working with particular reference to the sharing of information between the neurological medical service and the Community Mental Health Services;
- Consideration of such other matters as the public interest may require;
- Completion of an Independent Investigation Report for presentation to NHS London within 26 weeks of commencing the investigation and assistance in preparation of the report for publication.

These terms of reference were translated into the following questions the Independent Investigation Team considered of relevance to the conduct of the work required:

- Was the care and treatment provided by the Psychological Therapies Service reasonable?
- Was it reasonable not to seek a specialist neuropsychiatric opinion for Mr SU?
- Was it reasonable to delay acceptance of Mr SU on to the Community Mental Health Team caseload until 29 September 2006?
- Once accepted on the caseload, did the community mental health team:
    - Appoint a care co-ordinator appropriate to Mr SU's needs?
    - Conduct an appropriate assessment of the Mr SU?
    - Devise and implement a care plan appropriate to Mr SU's needs?
- Did the community mental health team communicate appropriately with other agencies and professionals to enable:
    - A sufficient understanding of Mr SU's brain injury and diagnosis?
    - An informed awareness of the ancillary support other agencies could offer and/or were offering Mr SU, and any limitations?
    - Care co-ordination responsibilities to be fulfilled?
- Was there appropriate communication with Mr SU's mother?
- Was the incident predictable on the basis of information known, or that should reasonably have been known, by the mental health services at the time?
- Was the incident preventable by different actions/care/treatment by the mental health services, on the basis of what was known, or should reasonably have been known, by them at the time?

It was determined early on that the content of the Trust's internal investigation report was not sufficient to provide the answers to the above. Consequently, the Independent Investigation Team conducted a targeted investigation to ensure that the principles of Health Circular Guidance (94)27 and the required terms of reference were delivered.

Conclusions of the Independent Investigation Team

The incident in which Mr SU was involved was tragic and its impact has been enormous for all concerned. The Independent Investigation Team's conclusions are based on an objective and detailed analysis of his care and treatment in the then East London and the City Mental Health Trust in the 28 months preceding the incident, with consideration of the previous medical history in relation to his traumatic brain injury with frontal lobe damage in 1998 and his subsequent period of rehabilitation.

With regard to the question "Was it predictable that Mr SU would show physical violence towards another person, including his girlfriend?", the Independent Investigation Team has concluded that it was not predictable. There was no previous history of aggression or violence towards others. All the evidence supported the clinical assessments that Mr SU was at risk or harming himself rather than others.

With regard to the question "Was the death of the victim preventable by virtue of different mental health care and treatment?", the Independent Investigation Team has concluded that the incident was, on the balance of probabilities, not preventable. The only caveat to this conclusion is whether mood stabilising medication might have altered the course of events, had Mr SU agreed to take it as repeatedly recommended. Even with the benefit of hindsight, however, it is not possible to know whether that would or would not have made any difference to the outcome.

The Independent Investigation Team identified aspects of Mr SU's care and treatment that could have been better. However, there are no grounds to suggest that, even had they been optimal, the incident would not have happened.

With regard to the specific terms of reference, these have been addressed throughout the findings section of this report (section 4). To summarise:

- For the most part there was an acceptable level of compliance with core policies and procedures (for example, the CPA policy and risk assessment policy) in terms of frequency of contact, treatment recommendations and performance of risk assessments;
- There was insufficient compliance with local and national policy expectations in relation to the involvement of carers and the offer of a carer's assessment for the period after January 2007;
- Insufficient attention was given to the requirement to work effectively with other agencies, which may usefully have been, or were actually involved in, Mr SU's care.

The Independent Investigation Team noted that, in the aftermath of the incident, some community mental health team staff considered themselves insufficiently skilled in the area of acquired brain injury to have been able to provide adequate care and treatment to Mr SU. The Independent Investigation Team disagrees with this. The Independent Investigation Team considers that the community mental health team was ideally placed to provide the effective care co-ordination service Mr SU required.

The Independent Investigation Team considers that the community mental health team did provide a caring and compassionate service to Mr SU. However, the quality of this service would have been enhanced by appropriate initiatives to access specialist expertise and advice in relation to persons with acquired brain injury, which were readily available within the Trust's own psychological therapies service and from specialist brain injury rehabilitation organisations in the local community.

Recommendations

The recommendations that the Independent Investigation Team would have made following its analysis of the care and treatment provided to Mr SU have been largely implemented as a consequence of the Trust's own community services review. This resulted in the complete reorganisation of community mental health teams, their operation and clinical leadership. The present picture is not at all as it was between 2005 and 2007.

Consequently, the Independent Investigation Team has only five largely practical recommendations:

Recommendation 1: Audit of CPA documents

Effective care co-ordination depends on effective communication with all agencies engaged with a mental health service user. This did not happen in this case. The limitations of the independent investigation mean that the Independent Investigation Team does not know if the lapse that occurred in this case was an isolated occurrence or if there is a culture of non-communication with other teams, services and agencies. It is incumbent on East London Foundation Trust to determine whether or not its staff reliably communicates with involved third parties in the delivery of effective care and treatment to its service users.

Consequently, the Independent Investigation Team recommends that, within the context of existing activities, namely:

- management supervision;
- CPA audit; and
- Record-keeping audit,

East London Foundation Trust determines:

- Whether it is possible from the existing design of its documentation tools to identify those service users engaged with other services and agencies; and
- Whether the records evidence:
    - Consent reliably being sought from service users to engage with third party services/agencies;
    - Direct communication from the community mental health team to identified third party services/agencies;
    - Invitation of third parties/agencies to CPA reviews.
    - Appropriate exception reporting, i.e. if no communication where third party service/agencies are involved, why this decision has been made.

If it is possible with the current design of documentation to assess the above, then East London Foundation Trust must ensure that evidence of appropriate communication with relevant third parties involved in a service user's care and treatment is included in contemporary activities such as:

- CPA audit;
- Record-keeping audit;
- Peer review; and
- Management supervision.

Evidence of such audit will need to be provided to the relevant commissioners of its services.

If it is not possible to assess the above activities on the basis of the current design of documentation tool(s), the Independent Investigation Team recommends that the Trust considers amending the documentation tools at the time of next review to enable the assessment of the above, or alternatively devising another method of conducting the audit.

Target audience: The Medical and Nursing Directors, the Director of Governance and Locality Managers.

Timescale: The Independent Investigation Team suggests that East London Foundation Trust make provision for addressing the above in line with its existing audit timetable.
All community mental health team leaders should be directed to raise the issue on a periodic basis during clinical team meetings and to address the same issue during management supervision as a form of local self-assessment. The provision (by the Trust) of a common, but simple, audit tool for managers may assist this process.

Recommendation 2

The minutes of the community mental health team weekly clinical team meetings were uninformative, consisting only of a list of service users discussed/for discussion. Consequently, the Independent Investigation Team recommends that it would be prudent to develop a minutes template that enables accurate and appropriately detailed minutes to be taken of the weekly clinical team meeting. The advantages of doing so are that:

- All services providing the 'same service' are working to a common set of standards;
- It is easier for these important documents to be audited when required;
- When staff move from team to team, the core systems and processes that are not 'service dependent' are uniform.

Suggested headings for a 'minutes template' are:

- Persons present and designation;
- Business matters;
- Case discussions:
  - Patient ID and traffic light rating;
  - Assigned care co-ordinator;
  - Key features presented;
  - Key decisions made and/or advice given;
  - Date for review.

Target audience: The Director of Governance and the Director of Operations at East London Foundation Trust.

Timescale: This is a simple, practical recommendation that should be readily addressed and implemented not later than three months after the publication of this report. If East London Foundation Trust decides not to implement this recommendation, it must provide a reasoned rationale for this to its commissioners.

Recommendation 3

In this case the quality of medical record-keeping by community mental health team medical staff was not of an acceptable standard. There was an over-reliance on the care co-ordinator to make accurate records of assessments conducted by medical staff.

In this case the staff-grade doctor did not consider that the service user's presentation in April 2007 was such that an assessment under the Mental Health Act (1983) was required. However, there was no evidence in the clinical records of the medical assessment on the basis of which this decision was made. This was not acceptable.

The Independent Investigation Team recognises that the approach to, and philosophy of, care and treatment within the community mental health teams within East London Foundation Trust has altered significantly since 2007. However, it recommends that the Trust provides assurance to its

commissioners about the current record-keeping standards required of medical staff and provides evidence of how those standards are currently audited in relation to:

- The making of records by doctors following contacts with and assessments of service users;
- The quality of the records; for example, consistent methodology for recording a mental state examination and to a sufficient level of detail.

Note: The Independent Investigation Team is aware that East London Foundation Trust has a detailed records audit tool of a quantitative nature. However, this tool does not necessarily assess the quality of record-keeping, or differentiate between the standards required of medical staff and non-medical staff.

Target audience: The Medical Director and Clinical Leads.

Timescale: It should be possible to incorporate this recommendation into the standardised approach the Trust takes to records audit and peer review, including for medical staff. On this basis, East London Foundation Trust should be able to incorporate this recommendation into its next timetabled notes audit. The Trust's supervision framework for medical staff should also provide opportunity for the ongoing assessment of the quality of medical record-keeping.

The time period for the audit of medical record-keeping quality should be notified to the Trust's commissioners at the action planning meeting prior to publication of this report.

Recommendation 4

It was clear to the Independent Investigation Team that the care co-ordinator to Mr SU, whose care and treatment was the subject of this investigation, does appreciate the importance of offering carers a Carer's Assessment. The commitment to the provision of a Carer's Assessment was endorsed by the then, and current, community mental health team leader. However, in this case the mother of Mr SU was not offered such an assessment because of a perceived conflict of interest for the care co-ordinator.

The Independent Investigation Team considers that East London Foundation Trust must assure the commissioner of their services that:

- Carers' Assessments are offered to all carers and family members who are providing support to a Service User, regardless of whether the service user wants their care co-ordinator to be in communication with the care/family member or not.
- That the Trust has a system in place to enable a Carer's Assessment to be offered in circumstances where there is a conflict of interests that would prevent a Service User's care co-ordinator from doing so; for example, a threat to the therapeutic relationship between care co-ordinator and service user.

- That where a Carer's Assessment is identified as being required and is subsequently not provided then the reason(s) for the non-provision are clearly documented, aiming for a 100% documentation rate.

Target audience: The Director of Nursing and Service/Operational Managers.

Timescale: The audit component of this recommendation can be absorbed into the Trust's existing audit framework and timetable.

The issue of how the conduct of a 'local' Carer's Assessment is progressed, where it is not appropriate for the care co-ordinator to do so, needs to be determined within the Trust. The process agreed will need to be reflected in relevant Trust policy and also in Community Mental health Teams operational policies. Because the Independent Investigation Team recognises that this is a complex issue it recommends that the Trust agrees the timeframe and process within which this issue is to be addressed at the action planning meeting with its commissioners prior to the publication of this report.

Note: The Independent Investigation Team is referring to the assessment of a carer's needs as it can be delivered within mental health services, and not the more far-reaching assessment which is the responsibility of the local authority.

Recommendation 5:
Although it was clear to the Independent Investigation Team that East London Foundation Trust has taken action on the recommendations it made following its own internal investigation into the care and treatment of Mr SU, whose care and treatment is subject to this independent investigation, the Trust was not able to provide any information showing that it had subsequently tested out the impact (or benefit) of the actions taken with regard to practice, quality or safety improvement.

It is therefore a recommendation of the Independent Investigation Team that East London Foundation NHS Trust devises a process by which it can reliably test the impact of all recommendations made following its internal investigation of its categorised serious untoward incidents, and the impact of implementing the recommendations made following independent investigations such as this one.

The Independent Investigation Team suggests that for all such action plans devised the Trust's serious incident committee does not sign these off unless the action plan identifies:

- How the impact of implementation is to be measured;
- The timetable for 'post-implementation' audit in the short, medium and, where appropriate, the long term.

It is essential that the Trust is aware of actions taken that do not result in the desired level of improvements in practice, quality and safety and that it does not assume that this has been achieved.

Target audience: The Medical Director, Director of Nursing and Director of Operations.

Timescale: The principles of this recommendation need to be implemented with immediate effect.

Recommendation 6

The analysis of the Trust's own investigation did not reveal information consistent with an effective investigation process, or one that evidenced knowledge and competency in information analysis or root cause analysis.

Consequently, it is important that East London Foundation Trust:

- Identify lead investigators for its serious untoward incident investigations who:
    - Understand what constitutes an effective investigation.
    - Have the skills to take comprehensive interview records, or are supported by administration staff competent to do so.
    - Know how to formulate 'care management concerns' and/or critical questions.
    - Know how to conduct a repeatable information analysis using the evidence gathered during the investigation process. Content analysis with affinity mapping would be one such approach.
    - Understand how to differentiate between the contributory factors to a specified problem and the most significant factors, otherwise referred to as root causes.
    - Understand that, for complex investigations following incidents such as homicide and suicides where the service user remained under the direct care of the Trust, applying a contributory factors framework 'to the incident' rather than to the specifically identified problems in the case management is not the correct application of process.
    - Have an understanding of the fail-safe attributes of improvement measures and know how to write S.M.A.R.T. (specific, measurable, achievable, realistic and timely) recommendations.

In addition to the above, it is recommended that the committee quality assuring the Trust's serious untoward incident investigations also have a good understanding of the above.

Target Audience: The Director of Nursing and Quality Assurance and the Associate Director of Governance.

Timescales: All Trust's should have a register of individuals who are competent in the above. However, it is recognised that achieving this has proved challenging for Trusts. The Independent Investigation Team considers that, within 18 months of the publication of this report, East London

Foundation Trust must be able to evidence to its commissioners that it can consistently deliver serious untoward investigation reports that evidence the above.

1.0 INTRODUCTION

This investigation was commissioned by London NHS Strategic Health Authority to determine:

- whether the quality of care and treatment afforded Mr SU was reasonable and in keeping with local and national standards; and
- whether the incident on or about 19 April 2007 could have been prevented by different management and/or actions by the specialist mental health services of the then East London and the City Mental Health Trust.

On 22 December 2008 Mr SU was sentenced in the Old Bailey to life imprisonment with a minimum term of 22 years for the murder of his girlfriend in April 2007.

The circumstances are that late in the evening of 19th April 2007 the victim visited Mr SU at his home. During the course of an argument the victim, according to WI, taunted him as a result of which he "saw red". The homicide then occurred.

On the limited information available there is no information in the days leading up to the incident that there was concern about Mr SU. The incident appears to be spontaneous to the occasion.

Mr SU had been assessed by his community mental health team one week prior to the incident and there were no indicators known to the services that should have alerted them, such that there was a potential for such violence in this service user.

1.1 Brief overview of Mr SU's contacts with specialist mental health services in East London NHS Foundation Trust

In May 1998 Mr SU suffered a traumatic brain injury (frontal lobe damage) as a passenger in a road traffic accident, resulting in hospitalisation for 6-8 months. He subsequently made good progress with an extended period of rehabilitation, including support from Rehab UK for a year.

In June 2001 Mr SU first came into contact with specialist mental health services in East London NHS Foundation Trust when he received counselling and Community House support following a referral by his general practitioner (GP). (The Independent Investigation Team believes that the Community House Support was provided by a local housing provider to assist in community living.)

In May 2004 the GP re-referred Mr SU to the psychiatric outpatients department, where he was diagnosed with depression and anxiety attacks and referred on to Psychological Therapies Services.

On 17 August 2004 the first offer of an appointment with the consultant psychiatrist in psychological therapies was sent to Mr SU. His first attendance was on 22 November 2004.

On 24 December 2004 the consultant psychiatrist in psychological therapies prepared a comprehensive assessment report on the basis of 3 assessment appointments and a review of earlier medical and psychological reports. The diagnoses at this time were organic personality disorder (frontal lobe syndrome) of moderate severity (score 3 of 4) and organic bipolar disorder (current episode moderate depression, severity score 3 of 4).

On 13 January 2005 the consultant psychiatrist in psychological therapies met Mr SU with his mother, who was his principal support person. At this time Mr SU was offered, but declined, antidepressant and mood stabilising medication and his name was placed on the waiting list for cognitive behavioural therapy. He was also referred to an Ophthalmologist to exclude any visual disturbance being an underlying cause of the headaches he was experiencing. It was also recommended to him that he maintain a sleep diary.

Mr SU was offered no further appointments with the consultant psychiatrist in psychological therapies at this time, and therefore had no further contact with mental health services until sessions with a cognitive therapist began in August 2005.

23 September 2005: Mr SU attended a scheduled outpatient's appointment with a consultant psychiatrist. At this appointment it was noted that he had lost his job. It was also noted that he continued to see his girlfriend and had "patched things up" with his mother regarding this relationship. His appetite was noted to be good, and he reported feeling and sleeping well. He was noted to be seeing the consultant psychiatrist in psychology services twice weekly. The record noted that he had continued without medication, but his mental state was stable, with no identifiable psychotic or affective symptoms or thoughts of suicide or homicide.

On 26 October 2005 Mr SU attended an appointment with the consultant in psychological therapies. It was noted that this consultant was now providing Mr SU with his cognitive therapy sessions as his colleague was unwell. Mr SU was noted to be feeling more relaxed at this appointment, having changed his job to a less stressful one. Finance management was noted to be an ongoing concern based on information provided by Mr SU's mother, though he himself reported having no such difficulties.

At this appointment it was noted that Mr SU was looking for more generalised supportive counselling rather than cognitive therapy, and that he did not require this more than every two months. Because of this, the letter to Mr SU's GP from the consultant psychiatrist in psychological therapies suggested that perhaps this could be provided by the practice counsellor as it was not a service normally provided by "a secondary service". The letter also noted that should Mr SU develop a further episode of significant hypomania or depression then he (the consultant in psychological therapies) would be

“happy to review the situation”. A December appointment was, however, agreed for Mr SU.

Mr SU was not in contact with mental health services between 26 October 2005 and 24 February 2006. However, he was offered three appointments during this time by the consultant psychiatrist in psychological therapies.

On 24 February 2006: Mr SU attended for an appointment with the above consultant. He was noted to be clinically depressed and presented with a number of life problems. The consultant psychiatrist in psychological therapies prescribed antidepressant medication and advised Mr SU about contact with outside agencies (Citizens Advice Bureau, Shaw Trust,[1] Headway[2]).

3 March 2006: The consultant psychiatrist in psychological therapies reviewed Mr SU and changed his antidepressant medication from Escitalopram to Reboxetine 2mg twice daily, increasing to 4mg twice daily after 7 days, because of side effects reported by Mr SU. He also wrote referral letters to Headway and a local community mental health team. A different community mental health team linked to Mr SU’s GP subsequently responded to this referral. The following week the consultant psychiatrist in psychological therapies services wrote to the consultant psychiatrist attached to the community mental health team, requesting additional support for Mr SU because he (the consultant psychiatrist in psychological therapies) would be on leave for a month.

On 16 March 2006: Headway advised the consultant psychiatrist in psychological therapies services that Mr SU had been placed on their waiting list for assessment and potential service placement.

On 20 March 2006: Mr SU was assessed by a social worker attached to the referral community mental health team.

On 21 March 2006: Mr SU was seen with his mother. The clinical notes record a comprehensive assessment. It was also noted that Mr SU *“Hates taking any medication”.* Under “Carer’s Comments and Needs”, it was recorded that Mr SU’s mother *“Feels upset as she hasn’t received any financial or emotional support from any other services. She has been fighting the system for the past 8 years for any support. She has contacted Headway and they have finally offered the MHSU an assessment.”*

On 31 March 2006: The student social worker, present at the assessment, contacted Mr SU’s mother to advise that the social worker was away for a number of weeks. Mr SU was not available at this time.

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[1] Shaw Trust is a national charity which supports disabled and disadvantaged people to prepare for work, find jobs and live more independently.
[2] Headway is a charity set up to give help and support to people affected by brain injury.

On 3 April 2006: When the social worker returned from annual leave, it was decided that Mr SU's case did not meet the then criteria for community mental health team input. This was subsequently discussed with the consultant psychiatrist for the community mental health team on 18 April 2006, who agreed that Mr SU should be re-referred back to psychological therapies.

On 3 May 2006: Mr SU did not attend for an outpatient appointment with his community mental health team consultant psychiatrist.

On 19 May 2006: Mr SU attended the community mental health team base, and met with the social worker who informed him of the team's decision. The records noted that Mr SU was content to continue to receive a service from psychological therapies.

On 2 June 2006: the consultant psychiatrist in psychological therapies services reviewed Mr SU and referred him to Employment Support Services and the Day Opportunities Service. He again advised Mr SU to contact Rehab UK. At this appointment he was noted to have *"substantially improved"* and was no longer suicidal or depressed. The letter to Mr SU's GP noted that Mr SU had engaged with the Shaw Trust, *"but found this unhelpful".* Further follow-up was noted to be arranged for eight weeks' time.

11 August 2006: Mr SU attended an appointment with the consultant psychiatrist in psychological therapies. His improvement was noted to continue, and he was noted to continue with his revised medication. A plan was made to review him again in two months.

On Friday 25 August 2006: Mr SU contacted the consultant psychiatrist in psychological therapies services in distress. He was immediately referred to the community mental health team with a request for assessment by the home treatment team. This team assessed Mr SU at home the following day and provided support to him over the bank holiday weekend.

On 1 September 2006: The community mental health team again assessed Mr SU and again did not accept him on to their caseload. He was, however, accepted four weeks later, on 29 September, on the basis of a further urgent referral by the consultant psychiatrist in psychological therapies services, following a reported overdose of Ibuprofen. Mr SU was allocated a community psychiatric nurse as his care co-ordinator working with a student social worker under supervision. Mr SU was not seen by this professional until 26 October.

On 13 October 2006: Mr SU attended his last scheduled appointment with the consultant psychiatrist in psychological therapies services. At this appointment his problems were clarified as relating to his head injury and were noted as: 1. episodes of depression and elevated mood, treated with Reboxetine 4mg twice daily to be continued for another year and then phased out. It was also noted that Mr SU continued to refuse a mood stabiliser. 2. Excessive spending and over-ambitious plans causing substantial stress, loss of confidence and occasional crises.

The consultant in psychological therapies noted that he believed he had progressed with Mr SU as far as he could and had not arranged to see him again.

On 26 October 2006: Mr SU attended at the community mental health team base to meet with his care co-ordinator. A plan for a CPA meeting and medical review was formulated. Mr SU was also noted to be low and that he considered that psychological therapies had not helped him much.

On 8 November 2006: Mr SU did not attend his appointment with his care co-ordinator.

On 15 and 29 November 2006: Mr SU attended the community mental health team base for appointments with his care co-ordinator. He reported feeling better now that he was taking his full antidepressant dose. He was noted to be eating and sleeping well, exercising and attending college.

5 December 2006: A CPA meeting was scheduled. There remains uncertainty about whether it took place or not. Mr SU's care co-ordinator was absent on leave, but the CPA diary was ticked, indicating that it may have taken place.

Between 20 December 2006 and 17 January 2007: Mr SU did not attend a series of rescheduled appointments with his care co-ordinator.

19 January 2007: Mr SU attended to meet with his care co-ordinator. He was noted as saying that his mood was good and that he did not want to be discharged from the service.

On 23 January 2007: the Service User did not attend an outpatient's appointment with the community mental health team consultant psychiatrist.

On 2 February 2007: Mr SU again did not attend for a scheduled appointment with his care co-ordinator.

On 13 February: Mr SU presented himself to the community mental health team distraught in the context of financial and other problems. He was at this time expressing thoughts of self-harm. The staff-grade doctor saw him and prescribed a short course of Olanzapine.[3] The home treatment team supported him through this period and community mental health team staff agreed a plan for debt management. The clinical notes recorded that Mr SU settled quickly with support and when subsequently seen by his care co-ordinator on 20 February and 2 March he was recorded as feeling better.

[3] Olanzapine is an atypical antipsychotic medication that is commonly used for patients with schizophrenia. However, it is also used to treat manic or mixed episodes in patients with bi-polar disorder.

On 20 March 2007: Mr SU telephoned the community mental health team tearful and depressed with thoughts of self-harm because of a range of interpersonal and social problems. In the absence of his care co-ordinator, he was seen later on the same day by a social worker and the student social worker. He was calmed and saw his own care co-ordinator at a follow-up appointment on the following day, 21 March, where he was noted to remain distressed but not suicidal.

Between 21 March and 11 April: There is no evidence that Mr SU was offered any further follow-up by the community mental health team.

On 12 April 2007: In the early hours of the morning, Mr SU attended a local Accident & Emergency Department following a (non-lethal) overdose of painkillers and antidepressants. After medical review and further review by the mental health liaison nursing team, Mr SU was discharged home in the company of a friend.

Later that same day he attended at his community mental health team for a scheduled CPA meeting. He was seen by his care co-ordinator and a staff-grade doctor. It was noted that he was distraught and confused, but it was decided that there were insufficient indications to warrant a Mental Health Act assessment. Mr SU was, however, offered and declined hospitalisation. He agreed to return for an assessment by the home treatment team in the afternoon of the following day.

13 April 2007: Mr SU attended for assessment as planned. This was conducted jointly by his community mental health team and the home treatment team. The assessment of him concluded that there was no evidence of a mental health crisis. Mr SU did not want the home treatment team to visit him subsequently and he also refused medication. He expressed a wish only for someone to talk to. He was given relevant crisis contact numbers and a review appointment with the staff-grade doctor in 7 days' time, on 19 April.

This was the last communication the mental health services had with Mr SU prior to the incident. He did not attend the appointment on 19 April and could not be contacted by phone on 26 April, the day he was remanded in custody. Mental Health Services were not aware of what had happened until after 26 April.

Further details of the Service User's contacts with East London and the City Mental Health Trust are contained in the relevant parts of section 5 of this report, pages 30-79

2.0 TERMS OF REFERENCE

The terms of reference for this independent investigation, set by NHS London Strategic Health Authority (the SHA), were as follows:

- A review of the East London NHS Foundation Trust's (the Trust) Internal Investigation to assess the adequacy of the findings, recommendations and action plans;
- A review of the progress made by the Trust in implementing the action plan from the Internal Investigation;
- Involvement of the families of both the Service User and the victim as fully as is considered appropriate;
- A chronology of 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 the Service User and a review of the relevant documents;
- An assessment of the extent to which the care provided to the Service User was in accordance with statutory obligations and relevant national guidance from the Department of Health (DoH), including local operational policies;
- An assessment of the extent to which the Service User engaged with the Substance Misuse Service (not applicable to this case);
- An assessment of the appropriateness and quality of assessments and care planning;
- Consideration of the effectiveness of inter-agency working with particular reference to the sharing of information between the neurological medical service and the Community Mental Health Services;
- Consideration of such other matters as the public interest may require;
- Completion of an Independent Investigation Report for presentation to NHS London within 26 weeks of commencing the investigation and assistance in preparation of the report for publication.

Following an analysis of East London Foundation Trust's internal investigation into the care and treatment of Mr SU, the Independent Investigation Team determined that to deliver the above terms of reference the following questions needed to be answered:

5.1 Was the care and treatment provided by psychological therapies services reasonable?

5.2 Was it reasonable not to seek a specialist neuropsychiatric opinion for Mr SU?

5.3 Was it reasonable to delay acceptance of Mr SU on to the community mental health team caseload until 29 September 2006?

5.4 Once accepted on the caseload, did the community mental health team:

- Appoint a care co-ordinator appropriate to Mr SU's needs?
- Conduct an appropriate assessment of Mr SU?
- Devise and implement a care plan appropriate to Mr SU's needs?

5.5 Did the community mental health team communicate appropriately with other agencies and professionals to enable:

- A sufficient understanding of Mr SU's brain injury and diagnosis?
- An informed awareness of the ancillary support other agencies could offer and/or were offering Mr SU, and any limitations?
- Care co-ordination responsibilities to be fulfilled?

5.6 Was there appropriate communication with Mr SU's mother?

5.7 Was the incident predictable on the basis of information known, or that should reasonably have been known, by the mental health services at the time?

5.8 Was the incident preventable by different actions/care/treatment by the mental health services on the basis of what was known, or should reasonably have been known, by them at the time?

3.0 THE INTERNAL INVESTIGATION CONDUCTED BY THE THEN EAST LONDON AND THE CITY MENTAL HEALTH TRUST AND REPORTED ON BY EAST LONDON FOUNDATION NHS TRUST

The first term of reference for this independent investigation was to assess the adequacy of East London Foundation Trust's internal investigation report to determine the adequacy of its findings, recommendations and conclusions.

A summary of the Independent Investigation Team's assessment of the above-mentioned report is detailed below:

The Trust's investigation was guided by a terms of reference that was not dissimilar to that provided to this Independent Investigation Team.
The main features were:

- The care Mr SU was receiving at the time of the incident
- The suitability of that care
- The extent to which the care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies
- The exercise of the care plan and its monitoring by the key worker
- The adequacy of the risk assessment
- Clinical leadership as it related to the care and management of Mr SU
- The extent to which concerns by relatives and close friends of Mr SU were taken into account
- To make recommendations
- To examine the clinical effectiveness of treatments and interventions
- To assess the quality of care received within the framework of the care programme approach (CPA)
- To review the adequacy of support provided to team members
- To examine the interface between all relevant agencies prior to the incident.

The investigation report produced by the Trust does attend to each of the above, albeit briefly. It may have been helpful to the Trust investigators if the terms of reference had been streamlined with linked subsections. This may have enabled the Trust investigation team to have addressed more fully the specific aspects of Mr SU's care and treatment in their report.

The Chronology
The chronology was not presented in the most logical way, appearing under the following headings:

- Incident Investigation;
- Psychiatric History; and
- Relevant Chronology of Events Leading up to the Incident.

However, although the 'relevant chronology' was presented in summary format, it did provide a reasonable overview of Mr SU's contacts with mental health services in the 13 months preceding the incident (the main antecedent period) and also an insight into historical contacts.

Problems/Issues Identified
This appears to have been the main findings section of the Trust's report. It addresses each of the stated terms of reference, with one or two short paragraphs associated with each term of reference.

It does not state clearly or consistently
- What was acceptable in relation to Mr SU's care and treatment.
- What aspects of Mr SU's care and treatment fell below expected standards and where these lapses were considered to be significant.
- The opinion of the Trust's investigation team.
- The reasons why there was a lapse in standards where such lapses were identified.

The information presented is generally presented in a superficial way that does not evidence the depth of analysis expected in an investigation of this gravity.

Below are a number of examples to illustrate the above.

Under the heading *"The care Mr SU received at the time of the incident and the suitability of that to the assessed health and social needs"*, the Trust's report says that there was *"clearly a lack of co-ordinated approach"* to the care of Mr SU. However, it does not say how it lacked co-ordination or why it lacked co-ordination.

It also highlighted that there *"could be criticism"* because *"after perusal of the notes post incident"* there was a delay in the community mental health team accepting Mr SU as a patient; but the Trust's report does not say whether it considered there to have been a delay, and whether or not a delay was reasonable.

Further on in the Trust's report, under the heading *"The extent to which concerns raised by relatives and close friends of Mr SU were taken into account in the management of his care and treatment"*, the Trust report says *"She was unhappy about him being on medication, which somehow affected the care that was provided".* This was an unqualified and loaded statement. The Trust's report does not say why Mr SU's mother was unhappy about her son being on medication, and it does not evidence how her feelings affected the care and treatment of her son.

Neither does the Trust's report set out how the community mental health team, or psychological services, attempted to engage with Mr SU's mother and whether or not their efforts were acceptable.

Under the heading *"The clinical effectiveness of treatments and interventions"*, the Trust's report says that *"it would appear that Mr SU benefited from the psychotherapy provided to him as there was evidence of deterioration when this was stopped".* It would have been helpful if the Trust's report had set out how Mr SU had benefited and how he deteriorated when he was no longer in receipt of it.

With regards to the issue of clinical leadership, also addressed in the Trust's report, it appears that there were issues between the then consultant psychiatrist to the community mental health team, and the then team leader. These tensions were also apparent to the Independent Investigation Team when they interviewed the team leader in 2011. However, the Trust, whilst drawing attention to this issue, did not link these tensions to the care and treatment of Mr SU.

The Trust's investigation did identify an issue relating to the lack of senior presence at the community mental health team clinical meetings, which resulted *"in some decisions being made outside of meetings without the full knowledge or awareness of relevant professionals involved in the care and treatment of the patient".* Again, whether or not this was a factor in relation to identified weaknesses in the care and treatment of Mr SU is not stated. It is the contention of the Independent Investigation Team that in Mr SU's day-to-day management it was not a significant factor, but that the overall *modus operandi* of community mental health teams at the time, on the balance of probabilities, did disadvantage Mr SU. However, that situation no longer exists and the way community teams now work is vastly different to 2006 and 2007.

Finally, the Trust's report says: *"We were told in evidence that, although there was nothing specific indicating a request for a specialist opinion, however in view of the aetiological factors and his presentation, it might have been helpful to obtain a specialist opinion about the management of risk".* The Independent Investigation Team found nothing in the content of the Trust's report to support this assertion.

The next main section of the Trust's report was entitled "Contributory Factors (Root Cause Analysis)".
The Trust's report sets out a range of factors linking each to a particular component of the National Patient Safety Agency's human factors framework. However, the Trust's report does not make clear what specific, or specifically, identified problems the contributory factors analysis relates to.

This whole section of the report suggests to the Independent Investigation Team that the authors of the Trust's report had:

- an insufficient understanding of how to analyse investigation information (evidence) against identified care management concerns;
- an insufficient understanding of the purpose of the contributory factors analysis; and
- insufficient training in this aspect of the investigation process.

Contributory factor information that is not linked to a specifically identified care management concern (normally a significant lapse in the care and treatment of a service user) has little meaning, or use, as it does not facilitate the identification of the 'root causes' (most significant influencing factors) to the identified care management concerns.

It is the identification of the ‘root causes’ to specifically identified problems that can enable the identification of appropriate recommendations.

In the Trust’s investigation report the Independent Investigation Team were completely unclear as to what the ‘root causes’ were to the lapses in care standard identified in its report.

Conclusions of the Trust’s Investigation
The Trust’s report concluded that the incident involving Mr SU was neither predictable nor preventable. The Independent Investigation Team agrees with this.

It does not, however, present its other conclusions as they related to the terms of reference. It does say that it remained unclear about the decisions made regarding the delay in accepting Mr SU on to the community mental health team caseload, focusing solely on the role of the then consultant psychiatrist.

Recommendations Made
The first recommendation said: *“We recommend that some thought should be given to how care and treatment can be provided for this group of patients with head injury, whose complex needs cannot be adequately met by a CMHT.”*
The Independent Investigation Team agreed with this recommendation. It could have been strengthened had it made clear that within the CPA process there was already a route for the effective engagement with other agencies to enable a holistic care plan to be delivered for service users with acquired brain injury who required the input of other agencies and that an audit mechanism needed to be developed so that the Trust could be assured that its staff were working effectively with other agencies for the benefit of its service users where required.

The second recommendation said: *“We recommend that there should be greater clarity of the roles and responsibilities of the Consultant Psychiatrist and the Team Manager to avoid issues of confusion of roles.”*
The Independent Investigation Team considers this to have been a pragmatic recommendation; however, it was unclear on what basis this recommendation was made. However, East London Foundation Trust has now completely re-engineered its community mental health teams and the principles of this recommendation have been addressed as part of that process.

The third recommendation said: *“We recommend that when indicated clinical teams should be provided with some support in exploring issues and difficulties within the team. In some cases this may mean using external facilitators.”*
The Independent Investigation Team could not see a clear link between this recommendation and the content of the Trust’s investigation report.

The fourth recommendation said: *“We recommend that all activities of professionals are recorded in one integrated database to allow shared responsibilities for difficult to engage patients.”*

As with the above, the Independent Investigation Team could not determine a link between the Trust's investigation and this recommendation. However, it is aware that at the time there was no such system and that information was disparately recorded. Therefore, in terms of patient safety, the recommendation was appropriate.

The fifth recommendation was: *"We recommend that processes are in place to ensure that supervision of junior medical staff, particularly non-training grade, takes place and can be evidenced."*
The Independent Investigation Team considers that this was a sensible recommendation and the Trust's investigation team made a clear link to information gathered during their investigation.

The sixth recommendation was: *"We recommend that in cases of multi-professional and multi-agency involvement in the care of service users, all significant individuals in the provision of the care from the various services should be involved in the CPA, when appropriate."*
This recommendation has a very clear link to a significant lapse identified in the care and treatment of Mr SU. It also relates to the first recommendation made. However, this recommendation, as it was written, is weak in terms of failsafe. It does not require the Trust to provide evidence that its staff are appropriately involving other teams and agencies to deliver effective care. Consequently, although the principle of the recommendation is correct, it was unlikely to be successful in promoting a sustainable improvement in practice.

The seventh recommendation was: *"We consider in complex and difficult cases such as this, where there are inherently issues of risk by virtue of the aetiological factors and presentation, an opinion from a specialist service including assessment and management of risk would be helpful."*
The Independent Investigation Team considers that this recommendation is too sweeping to be helpful. It recommends what should be an 'every-day' consideration for all clinical teams managing challenging and complex patients.

4.0 CONTACT WITH THE SERVICE USER, THE FAMILY OF MR SU AND THE FAMILY OF THE DECEASED

The Independent Investigation Team made an initial attempt at contact with the Service User on 30 September 2010; successful contact was achieved on 20 October 2010. An appointment was made to meet with the Service User's mother on 13 December 2010. A meeting was convened between members of the Independent Investigation Team and the Service User on the same day.

Subsequent to these initial contacts, the Independent Investigation Team has periodically contacted the Service User's mother by e-mail to update her about the progress of the investigation.

The Service User expressed remorse about the incident and told the Independent Investigation Team that he did not intend to harm his then girlfriend. He did not have any questions about his care and treatment. He said that now he was being treated with a mood stabiliser he felt much better and did not experience the mood swings he did pre-incident.[4] The Service User's mother, however, felt a general sense of frustration about the lack of services for persons with acquired brain injury. She said she had been advocating for her son for many years and was understandably very upset by the events and her son's subsequent loss of liberty.

The Service User's mother wanted to know:

- What aspects of her son's mental health care and treatment met reasonable standards;
- Whether there were any aspects of his mental health care and treatment that could and should have been better; and
- Whether any identified areas of potential improvement would have made a difference to the incident in which he was involved.

The Independent Investigation Team advised the Service User's mother that exploration of the wider issue of services for persons suffering from an acquired brain injury were not within the remit of this investigation.

With regards to the family of the victim, the Independent Investigation Team sought the assistance of the Metropolitan Police in tracing her family. At the time of writing, the police had not been able to provide the Independent Investigation Team with any current contact details for the victim's family. An internet search conducted by the Independent Investigation Team revealed no viable leads enabling positive contact to occur with the family of the victim.

[4] The MHSU was encouraged to accept a mood stabiliser by the consultant psychiatrist in psychological therapies on more than one occasion pre-incident.

5.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the Independent Investigation Team's findings in relation to the following questions:

5.1 Was the care and treatment provided by psychological therapies services reasonable?

5.2 Was it reasonable not to seek a specialist neuropsychiatric opinion for the Service User?

5.3 Was it reasonable to delay acceptance of the Service User on to the community mental health team caseload until 29 September 2006?

5.4 Once accepted on the caseload, did the community mental health team:

- Appoint a care co-ordinator appropriate to the Service User's needs?
- Conduct an appropriate assessment of the Service User?
- Devise and implement a care plan appropriate to the Service User's needs?

5.5 Did the community mental health team communicate appropriately with other agencies and professionals to enable:

- A sufficient understanding of the Service User's brain injury and diagnosis?
- An informed awareness of the ancillary support other agencies could offer and/or were offering the Service User, and any limitations?
- Care co-ordination responsibilities to be fulfilled?

5.6 Was there appropriate communication with the Service User's mother?

5.7 Was the incident predictable on the basis of information known, or that should reasonably have been known, by the mental health services at the time?

5.8 Was the incident preventable by different actions/care/treatment by the mental health services on the basis of what was known, or should reasonably have been known, by them at the time?

In setting out its findings, the Independent Investigation Team is very mindful of the tragic outcome of the incident which occurred on or about 19 April 2007.

Furthermore, in assessing the adequacy of the care and treatment provided to Mr SU, it was the responsibility of the Independent Investigation Team to avoid hindsight bias[5] and to analyse the appropriateness of decisions made

[5] Hindsight bias: this is the inclination to see events that have occurred as more predictable than they in fact were before they took place. Hindsight bias has been demonstrated experimentally in a variety of settings, including politics, games and medicine. In psychological experiments of hindsight bias, subjects also tend to remember their predictions of future events as having been stronger than they

on the basis of the information available to clinicians at the time the care and treatment was provided, with consideration of the circumstances in which they acted. It was also the responsibility of the Independent Investigation Team to determine whether a broader range of independent clinical opinion was required than that contained within the Independent Investigation Team to enable a proper consideration of what a reasonable group of similarly qualified clinicians would have done in similar circumstances. This is what the National Patient Safety Agency (NPSA) refers to as the "substitution test" in its incident decision tree.[6] In this case, the Independent Investigation Team decided that additional independent clinical input was not required.

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actually were, in those cases where those predictions turn out correct. This inaccurate assessment of reality after it has occurred is also referred to as "creeping determinism".

[6] http://www.msnpsa.nhs.uk/idt2/(jg0xno55baejor55uh1fvi25)/index.aspx

5.1 WAS THE CARE AND TREATMENT PROVIDED BY PSYCHOLOGICAL THERAPIES SERVICES REASONABLE?

The Independent Investigation Team concluded that the management and treatment of Mr SU by the psychological therapies service over the period 22 November 2004 to 13 October 2006 was of a good standard. It also concluded that Mr SU was provided with a more holistic service than might ordinarily be provided by a specialist psychological therapies service. This was achieved as a result of the dual qualification in psychotherapy and psychiatry held by the consultant psychiatrist (in psychological therapies) who delivered Mr SU's care and treatment.

The Independent Investigation Team considers that the following events are evidence for this opinion:

- Prompt acceptance of Mr SU for assessment on 9 July 2004, following initial referral from the consultant psychiatrist in the outpatients department on 11 June 2004;
- Repeated written offers of an initial appointment after Mr SU's delay in responding;
- A comprehensive report by the consultant psychiatrist in psychological therapies services dated 24 December 2004 based on a review of earlier reports relevant to Mr SU's frontal lobe injury and a thorough assessment over three appointments, and which included the following:
  - Diagnoses of 1. Organic personality disorder (frontal lobe syndrome) – F07.0, severity score 3 of 4; and 2. Organic bipolar disorder (current episode moderate depression) F06.31, severity score 3 of 4. These diagnoses were not subsequently challenged;
  - A coherent care plan that included pharmacotherapy (antidepressants and mood stabilisers) and specific psychotherapy (cognitive behavioural therapy);
  - A detailed risk assessment concluding low risk to self and no elevated risk to others; and
  - Recognition of Mr SU's mother as his primary support and the importance of involving her in his care.
- Cognitive behavioural therapy from 15 August to 27 October 2005, when it became clear to both the consultant psychiatrist in psychological therapies and Mr SU that specific counselling sessions were no longer of value;
- Repeated offers of rescheduled appointments when Mr SU did not attend;
- Continued liaison about progress by correspondence with the GP, community mental health team, Mr SU and his mother, with a request for community mental health team cover during a period of therapist leave;

- Availability and increased frequency of appointments in response to Mr SU's needs;
- When Mr SU agreed in February 2006, prescription of antidepressants in accordance with NICE clinical guideline 23;[7]
- Recommendation of/referral to multiple agencies to assist with Mr SU's multiple life problems, including the Shaw Trust, Headway, Rehab UK, Citizens Advice Bureau, employment support and Day Opportunities;
- Referral to the community mental health team on 3 March 2006. This occurred when it became evident that Mr SU's multiple life problems made it difficult for him to use psychotherapy and that he would prefer a more general supportive psychotherapeutic approach; and
- Continuing support in the context of further community mental health team referrals on 25 August 2006 and 29 September 2006, until the final appointment with Mr SU on 13 October 2006, after he had been accepted by the community mental health team.

The above points are recorded clearly and comprehensively in the psychological therapies services records and evidence:

- a thorough initial evaluation of Mr SU's difficulties;
- considerable efforts to engage Mr SU;
- the involvement of Mr SU's mother over the relevant period;
- the provision of specific psychological therapy to its limit of usefulness; and
- flexibility in seeing Mr SU at points of crisis.

The Independent Investigation Team is aware that Mr SU's management by psychological therapy services extended well beyond the delivery of specific psychotherapy. Due to the consultant psychiatrist's dual qualification in psychiatry and psychotherapy, the psychological therapy management included the prescribing of medication. There were also attempts to engage and co-ordinate support for Mr SU from multiple third party agencies.

The Independent Investigation Team identified no deficiencies in the psychological therapies services care. Indeed, the Independent Investigation Team is of the view that the consultant psychiatrist's efforts in relation to Mr SU are to be commended.

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[7] National Institute for Health and Clinical Excellence (NICE) clinical guideline 23 (CG 23) was issued in December 2004 and was the relevant guideline at the time covering the management of depression in primary and secondary care. Clinical guideline 90 (CG 90) replaced CG 23 in October 2009.

5.2 WAS IT REASONABLE NOT TO SEEK A SPECIALIST NEUROPSYCHIATRIC OPINION FOR THE SERVICE USER?

On analysis of Mr SU's clinical records and information gathered during the course of the investigation, including detailed information provided by the consultant psychiatrist in psychological therapies services, the Independent Investigation Team were of the view that there was no clinical indication to refer Mr SU for a specialist neuropsychiatric opinion. The dual qualifications and neuropsychiatric experience of the consultant psychiatrist in psychological therapies services, reflected in the quality of his initial assessment report and later assessments, made such a referral unnecessary.

The evidence for this conclusion is:
On 15 June 2001 Mr SU's general practitioner (GP) referred him to psychiatric outpatients with a diagnosis of post-traumatic stress disorder and depression following a traumatic head (frontal lobe) injury in a road traffic accident in 1998. On 28 June Mr SU was referred to the Psychology and Counselling Service and saw a counsellor for 6 sessions over 2 months in 2002, following which he went to 'Community House'[8] weekly for 2 months. He was well for 8 months following this. However, on 20 May 2004 his GP referred him to the local community mental health team with the same diagnoses.

When assessed by the community mental health team consultant psychiatrist on 11 June, Mr SU's recorded signs and symptoms were:

- depression;
- anxiety with panic attacks;
- staying alone at home;
- wanting to kill himself; and
- hearing voices telling him to do things. These were thought likely to be pseudo-hallucinations rather than command hallucinations.

Mr SU also reported poor memory and being quick tempered and aggressive at times.

At the assessment the consultant psychiatrist found Mr SU to be *"quite jolly and appropriate"* and not depressed or suicidal or showing other signs of mental illness. On 15 June 2004 Mr SU was referred to psychological therapies services for cognitive behavioural therapy with a plan for outpatients follow-up in three months' time.

On 9 July the consultant psychiatrist in psychological therapies responded to the referral, agreeing to assess Mr SU, advise on the preparation of his care plan and, if appropriate, provide the necessary psychotherapy. He specifically declined, however, to take over Mr SU's care because, in the light of his experience in providing neuropsychiatry-psychotherapy and the complex

[8] This is assumed to be a supportive project that operated in the community at the time.

nature of Mr SU's difficulties, he considered that *"the comprehensive approach of a multi-disciplinary team including the services of the local community mental health team"* would be needed.

At the same time the consultant psychiatrist in psychological therapies wrote to the local general hospital requesting copies of neuropsychology assessments, neuroradiology findings and treatment details in relation to Mr SU's hospitalisation and rehabilitation for his severe head injury in 1998. On 30 July 2004, after receipt of a neuropsychological report dated 15 September 1998, the first letter inviting Mr SU to telephone the psychological therapy department and arrange an assessment appointment was sent.

The report received by the consultant psychiatrist in psychological therapies documented that at the relevant time Mr SU had a relative weakness of non-verbal skills consistent with right hemisphere brain damage, with memory difficulties and executive performance reflecting evidence of disinhibition, impulsivity, poor planning and deficits in monitoring.

Mr SU did not respond to the invitation letters and further letters were sent on 17 and 31 August, indicating possible times and flexibility in relation to alternative arrangements if required. The letters also included a specific invitation to notify any problems or fears that might make attending an appointment difficult.

On 3 September Mr SU telephoned and agreed a one-and-a-half hour appointment for 20 September. However, he did not attend this appointment. He finally attended for assessment on 22 November. This was the first of three appointments that culminated in a detailed Psychotherapy Assessment Report, finalised on 24 December 2004.

The assessment report diagnosed Mr SU as suffering from the consequences of a significant brain injury, specifically:

- Organic personality disorder (frontal lobe syndrome), severity score 3 (of 4);
- Organic bipolar disorder (current episode moderate depression), severity score 3 (of 4).

Mr SU's symptoms and signs were recorded as:

- episodes of hypomania (elevated mood) and depression;
- significant psychosocial difficulties as a consequence of the mania, notably debt and loss of his compensation money;
- interpersonal isolation;
- difficulties with role transition;
- issues of loss associated with the head injury; and
- negative subjective reaction to symptoms arising from depression and mania.

Further, from a cognitive perspective Mr SU had negative beliefs relating to himself, his future and others' perceptions of him, which contributed to his depression.

Mr SU was judged as some risk to self with suicidal ideation but no intent or plans, and as presenting no elevated risk to others at the time.

The assessment report findings are additional to but consistent with those documented in the neuropsychological report completed by the clinical neuropsychologist on 15 September 1998.

The management proposed on the basis of the psychological therapies assessment was:

- The consultant psychiatrist in psychological therapies to continue to see Mr SU specifically in relation to pharmacotherapy. This would encompass the education of Mr SU and his family regarding the potential benefits of medication in head injury-related mood disorders and, if accepted, the prescribing of medication for Mr SU's mood disorder and depression;
- Cognitive behavioural therapy by a trained therapist (entry on to waiting list in first instance); and
- Consideration of group therapy following cognitive behavioural therapy if Mr SU's psychosocial network could not provide the support he required.

In a letter dated 24 December the consultant psychiatrist in psychological therapies communicated a summary of the information in his assessment report to the referring psychiatrist, the community mental health team and Mr SU's GP. On 13 January 2005 he met with Mr SU and his mother and wrote to the GP with copy correspondence to the community mental health team, advising that he had not arranged to see Mr SU again and made recommendations for pharmacotherapy for both hypomania and depression, should Mr SU agree to this at some future time.

On 15 August 2005 Mr SU attended the first of 10 planned cognitive behavioural therapy sessions with a trained cognitive therapist, supervised by the consultant psychiatrist in psychological therapies. After five sessions the consultant psychiatrist in psychological therapies services assumed the conduct of the sessions because the therapist was absent due to illness. Mr SU was offered three appointments and attended again after a five-week interval on 26 October. At this session the consultant psychiatrist concluded, with Mr SU that he (Mr SU) was not looking for more than general supportive counselling, for which specialist psychological therapies were not required. He planned to review Mr SU in December 2005 with a view to discharging him into his GP's care should the situation be unchanged. It is clear from the records that the consultant psychiatrist in psychological therapies remained prepared to review Mr SU in the event of a further episode of hypomania or depression.

Following three letters of invitation to book an appointment, Mr SU next attended the department of psychological therapy on 24 February 2006. The consultant psychiatrist in psychological therapies diagnosed a further

depressive episode characterised by persistent low mood, disturbed sleep, negative thoughts, guilt, poor concentration and impaired memory. He prescribed antidepressant medication (Citalopram) and made arrangements to engage a number of third party agencies to assist Mr SU with his cognitive and financial difficulties (see section 5.1 for details). He reviewed Mr SU on 3 March 2006 and prescribed alternative antidepressant medication (Reboxetine) since Mr SU had discontinued Citalopram because of headache and nausea.

At this time the consultant psychiatrist in psychological therapies made the first formal referral of Mr SU back to the community mental health team for on-going care and management. This was entirely in keeping with:

- The initial letter of referral to psychological therapies on 15 June 2004 which indicated a plan for continued follow-up by outpatients. While there is no evidence that the outpatients' appointment proposed after 3 months took place, Mr SU continued to be offered and did attend occasional outpatient appointments, being seen during the course of cognitive behavioural therapy by a locum consultant psychiatrist on 23 September 2005 with a plan for further review in 3 months, which also did not take place. Mr SU did not attend an appointment scheduled with a third psychiatrist on 2 May 2006, a re-booked appointment for 25 July 2006 or a final one scheduled for 23 January 2007, by which time he had, however, been accepted for care co-ordination for almost 4 months.
- The letter of response from the consultant psychiatrist in psychological therapies on 9 July 2004 which accepted Mr SU for assessment, management advice and provision of cognitive behavioural therapy by a trained psychological therapist, but specifically declined to assume his overall care.
- The assessment report of 24 December 2004 which planned further contact for Mr SU with the consultant psychiatrist in psychological therapies only in relation to the prescription of pharmacotherapy for hypomania or depression. When Mr SU declined such pharmacotherapy, he was placed on the cognitive behavioural therapy waiting list and no further appointments with the consultant psychiatrist in psychological therapies were scheduled.
- Although the consultant psychiatrist in psychological therapies saw Mr SU again from 26 October 2005, this was specifically to continue cognitive behavioural therapy during the trained therapist's absence due to illness. When the limits of the usefulness of cognitive behavioural therapy and the need for third party agency involvement to assist with Mr SU's multiple life problems became evident, the consultant psychiatrist referred Mr SU for the *"comprehensive approach of a multidisciplinary team including the services of the local community mental health team"* that he had earlier stipulated Mr SU would require in his letter of response at the time of initial referral.

The Independent Investigation Team considers that the information detailed above establishes that there would have been no added value by referral to a neuropsychiatrist. Mr SU had a clear diagnosis based on a comprehensive assessment with a detailed management plan that included the prescribing of appropriate medication and specific psychological counselling in the form of cognitive behavioural therapy.

5.2.1 The perspective of the then community mental health team manager

Several interviewees among community mental health team staff considered that it would have been helpful for Mr SU to have been referred for a specialist assessment of some sort and/or absorption of part of his care by other services such as the Adult and Physical Disability (Social Services) team. The Trust's investigation team also considered the value of this.

Exploration of this perspective revealed an underlying perception by community mental health team staff that perhaps they lacked the necessary experience or skill-set to properly manage service users with psychiatric problems arising in the setting of an acquired brain injury.

The community mental health team manager at the relevant time said:

"It [*i.e. a specialist referral*] *should have been initiated",* referring to the Trust's memory clinic, which offered an assessment service for the identification of organic brain problems or, if that was not appropriate, to another Trust.

"A specialist referral would have been helpful in establishing the best way forward and most appropriate management. … [*The consultant psychiatrist in psychological therapies*] *was the best person to care for [Mr SU] because he had experience in neuropsychiatry and psychotherapy."*

"An up to date neurology assessment would have been helpful. A current assessment of the impact of [*Mr SU's*] *cognitive impairment, memory problems, might have clarified what was due to … brain injury and what was due to psychopathology and/or personality issues. … A current assessment might have provided more direction about* [*Mr SU's*] *care, given different scope, more knowledge of how to manage him."*

"My view is that any mental health issues could probably have been monitored through outpatients every 3 months but that other needs, such as cognitive, social and behavioural problems arising from the injury, should be met by other services."

"… the view was that [*Mr SU*] *did not have a severe and enduring mental health problem, he has an organic brain disorder, he's not as high risk as other clients."*

Mr SU's care co-ordinator told the independent investigation team that she was confident in her skills to provide effective care co-ordination for him.

Although she was aware that he had an acquired brain injury, she did not assess his needs as being more than those she could competently deliver. At the time she was Mr SU's care co-ordinator she did not consider that further specialist input was required.

The Independent Investigation Team acknowledges and has fully considered the above opinions, and the content of the Trust's own internal investigation report, including the interview records made at the time of that investigation. However, it has concluded that referral of Mr SU to a neuropsychiatrist or other suggested specialist, whether within the Trust or a neighbouring Trust, would not have made any material difference to diagnosis or management for the following reasons:

- community mental health team staff had a copy of the psychological therapies assessment report, which contained as much information with respect to diagnosis and management direction, including with respect to mood stabilising medication, as would likely have been obtained from a neuropsychiatric referral;
- since the organic nature of Mr SU's problems was clearly established, no useful purpose would have been served by referring Mr SU to the Trust's own memory clinic assessment service;
- it is most unlikely that an out-of-Trust specialist referral would have involved any form of follow-up, so that the need for on-going management would always have remained with the community mental health team;
- it was always open to community mental health team staff to contact the consultant psychiatrist in psychological therapies who had seen Mr SU over a period of almost two years, to discuss any concerns or clarify any uncertainties they may have had about best management; and
- although by virtue of his brain injury Mr SU differed from most community mental health team users, the long-term support and management required for his various life problems was not in reality very different from any other service user. The community mental health team were well placed to co-ordinate and supervise the provision of the appropriate psychosocial support package.

5.3 WAS IT REASONABLE TO NOT ACCEPT THE SERVICE USER ON TO THE COMMUNITY MENTAL HEALTH TEAM CASELOAD UNTIL 29 SEPTEMBER 2006?

The answer to this question is largely dependent on the "threshold" of morbidity above which it is possible, within available resources, for a community mental health team to take on new cases. The Independent Investigation Team concluded that at the time of first assessment on 19 March 2006 Mr SU did not fulfil the eligibility criteria for community mental health team allocation. At the time of second assessment on 1 September 2006 the eligibility criteria had been revised. The Independent Investigation Team considered that it was arguable that Mr SU did then meet them and therefore could have been accepted on the basis of the second referral on 25 August 2006. However, the Independent Investigation Team noted that Mr SU was subsequently accepted on 29 September 2006 and considered that this four-week delay would not have impacted on the management of Mr SU in any material way.

The following sections set out the process of referral and assessment within adult services in the then East London and the City Mental Health Trust.

5.3.1 The process of referral and assessment

Paragraph 8 of the *Operational Policy for Community Mental Health Teams: Draft V* (18/08/97) provides for a wide range of referrals, including self-referrals, to the community mental health team, handled by a duty rota of social workers and community psychiatric nurses. As soon as the referral is received, a letter of acknowledgement of receipt and immediate action is sent to the referrer (8.3) and, if appropriate, a screening assessment is arranged (8.5). The decision to undertake an assessment, including a medical assessment if appropriate, and the decision about who will do so is made at the allocation meeting (9.1) and communicated to the service user within 5 working days of the meeting with an offer of appointment within a further 10 working days, with a copy to the referrer (9.2). The results of the assessment are to be ready for the next allocation meeting (10.1). This was the relevant policy at the time of the Service User's first referral in March 2006.

At the time of the second referral in August 2006 the relevant policy was the *Mental NHS Trust Operational Policy for Community Mental Health Teams* (Draft, September 2005, revised and amended April 2006 and June 2006). In addition to an initial letter of acknowledgement, all referrals were to receive a response within 7 working days (7.4). Referrals were handled by the Access and Assessment Team (AAT) duty service (10.3) with a letter to all professional referrers advising the outcome of the panel decision (10.4). All referrals thought to require a community mental health team assessment were discussed at the weekly allocation meeting (11.1) with joint assessments allocated to a lead worker and a colleague (11.2). Contact with the Service User was within 7 working days of the allocation meeting with an offer of an appointment within a further 7 working days (11.5). All decisions about assessment were to be reviewed if additional information that informed the

risk assessment came to light (11.6). There was a complaints procedure and information on using it was to be given to people who disagreed with the outcome of their screening or assessment (11.7). The outcome of an assessment was to be presented to the subsequent allocation meeting (12.1).

The Independent Investigation Team noted that the policy in use in March 2006 seemed to have remained in draft form for a prolonged period (three months), which was not good practice. Furthermore, the Independent Investigation Team noted that no date of finalisation or implementation was listed on either policy.

5.3.2 The first referral

The first letter of referral dated 3 March 2006 enclosed the psychological therapies assessment report and the Service User's treatment history and stated that:
"… [Mr SU] has been reluctant to take medication and has had difficulty engaging in therapy … he remains depressed … and is at the moment having suicidal ideation. My hope is that once he engages with Headway this would reduce the risk and I have also begun treatment with Reboxetine. … He is in somewhat of a mix up about his finances and his ability to return to work. I would be grateful if he could be given specific advice in this area, together with additional support targeted at the identified risk."

It was received and in accordance with policy guidelines acknowledged by the community mental health team on 9 March. On the same day a letter was sent to Mr SU advising that the referral was being processed and providing contact numbers for support if required. On this day Mr SU was again reviewed by the referring consultant psychiatrist in psychological therapies. He followed up his letter of referral with another directed to the community mental health team psychiatrist, noting that Mr SU remained depressed on half the prescribed daily dose of antidepressant medication and expressing the view that he would benefit from the full adult dose and also from mood stabilising medication, noting Mr SU's reluctance to take medication because of side effects. He also advised that he would be away on leave for the next month, requesting additional community mental health team support for Mr SU during *"a particularly risky"* period.

At the allocation meeting on 13 March 2006 a social worker and student social worker were allocated to assess Mr SU. The assessment took place on 20 March and was recorded as a Full Needs Assessment dated 21 March 2005 [*sic*] with a section 7: Summary as follows:
"… [Mr SU] was involved in a road traffic accident in 1998 and since this time has suffered from severe depression. This is characterised by persistent low mood, disturbed sleep, negative thoughts about himself, the world and the future, feelings of guilt, poor concentration and impaired memory … he has been advised to take [Reboxetine 0.5 mg] twice daily, however he appears to be very sensitive to side effects and is reluctant to take medication. Mr SU stated … that he will prefer someone to visit him at least three days a week to talk to him during his periods of low mood."

There is no entry under section 8: Initial Action Plan and there is no documentation of a formal risk assessment.

The community mental health team progress notes for 22 March document receipt of the further letter from the consultant psychiatrist in psychological therapies, advising of his absence on leave, with a plan by the social worker to discuss the matter with the community mental health team psychiatrist. The intention to defer a decision pending further discussion was communicated by telephone to Mr SU's mother on 31 March. Although it appears from the progress notes that a decision not to accept Mr SU was made in the allocation meeting on 3 April, he was not advised until 9 May with a letter dated 19 May sent to the referring consultant psychiatrist in psychological therapies. The reason for the eight-week interval between assessment and notification of the outcome was not clear from the records and, due to the passage of time, could not be determined from additional information gathered in the course of the investigation by the Independent Investigation Team. It is noted, however, that the assessing social worker did have a period of annual leave at this time and reported to the Trust's investigation team that she did discuss Mr SU with the then consultant psychiatrist.

The consultant psychiatrist in psychological therapies responded by letter on 31 May, noting that the assessment had not included an examination of Mr SU's risk, consideration of previous correspondence or the diagnosis of organic bipolar disorder, noting that Mr SU was not able to engage with cognitive behavioural therapy. He requested that the issue be raised with the line manager for further discussion. There is no evidence in the records that this was followed up and no letter in response. As with the issue of the delayed response to the consultant psychiatrist in psychological therapies, community mental health team staff interviewed by the Independent Investigation Team were not able to recall what if any consideration occurred at the community mental health team weekly clinical team meeting as a consequence of this correspondence.

To make its own determination, the Independent Investigation Team referred to the *Department of Health's Community Mental Health Team Policy Implementation Guidance* (2002) (*DoH 2002 Guidance*), the *Operational Policy for Community Mental Health Teams: Draft V* (18/08/97) and *East London's Draft Operational Policy for Community Mental Health Teams* (2005, and revised in April and June 2006).

The *DoH 2002 Guidance* says:
"The community mental health team (CMHT) performs functions for two groups of people:
1. Most patients treated by the CMHT will have time limited disorders and be referred back to their GPs after a period of weeks or months (an average of 5–6 contacts (Burns et al 1993)) when their condition has improved.

2. A substantial minority, however, will remain with the team for ongoing treatment, care and monitoring for periods of several years. They will include people needing ongoing specialist care for:

i. Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder.
ii. Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up.
iii. Any disorder where there is significant risk of self harm or harm to others (e.g. acute depression) or where the level of support required exceeds that which a primary care team could offer (e.g. chronic anorexia nervosa).
iv. Disorders requiring skilled or intensive treatments (e.g. cognitive behavioural therapy, vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care.
v. Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act (1983), except where these have been accepted by an assertive outreach team.
vi. Severe disorders of personality where these can be shown to benefit by continued contact and support except where these have been accepted by an assertive outreach team or a specialised personality disorder team where there is one."

Of these criteria it is arguable that Mr SU met criterion iv.

However, in March 2006, East London and the City Mental Health Trust appeared to have been using eligibility criteria that pre-dated the *DoH 2002 Guidance*. There is no clearly defined local interpretation of the *DoH 2002 Guidance* contained within the draft 2005 (ratified June 2006) East London Community Mental Health Team (CMHT) Operational Policy document, or in its 2006 CPA policy document.

The 1997 operational policy says:
"Subject to a full needs assessment, an individual will be eligible to receive help from the CMHT if he/she meets the following criteria:

- *Age: between 18–65 years ...* **(Yes met criteria)**
- *Diagnosis: people with a mental disorder, or people presenting for the first time with psychotic symptoms* **(Yes met criteria)**
- *Health functioning: users have to meet at least one of the following criteria:*
    - *Persons requiring a multi-disciplinary assessment due to high risk of hospitalisation. (**Did not meet criteria)***
    - *Three or more admissions to hospital in the past two years, or has been hospitalised for a continuous six months or longer, within the past three years. (**Did not meet criteria)***
    - *History of violent and/or seriously assaultative behaviour which, in the opinion of the mental health professional, is due to mental health problems. (**Did not meet criteria)***
    - *Current at high risk of deliberate self injury and/or suicide. (**Did not meet criteria)***
    - *Currently at risk of serious self neglect, leading to high risk of hospitalisation and self harm. (**Did not meet criteria)***
    - *Suffering from mental disorder and requiring professional intervention to reduce danger to life. (**Did not meet criteria)***

- *Has had compulsory admissions, been placed on the Supervision Register and/or Guardianship orders within the last five years. (**Did not meet criteria)***
- *Users requiring statutory intervention under the 1983 Mental Health Act, including assessment s117 and s25. (**Did not meet criteria)***
- *Persons requiring social supervision under the Mental Health Act. (**Did not meet criteria)***

*7.4 **Social Functioning:** as well as meeting the above 'History' criteria, users must also be experiencing serious disruption in at least one of the following areas of social functioning:*

- *Symptoms of mental disorder and substantially interfering with living skills. **(Yes met criteria)***
- *Severe social isolation and impaired ability to interact socially due to mental health support needs. **(Partially met criteria)***
- *At high risk of offending behaviour, due to mental disorder. (**Did not meet criteria)***
- *Significant accommodation problems due to mental disorder, resulting in actual or high risk of homelessness. (**Did not meet criteria)***
- *Unable to manage finances, leading to high risk of neglect and exploitation, especially including inability to necessary welfare benefits, due to mental health problems. **(Yes met criteria)***
- *Severe disruption within the family, due to mental health support needs. **(Partially met criteria)***

7.5 ... 7.6 Individuals with the following problems will be the primary responsibility of other services ...

- *People who suffer from mental distress, such as anxiety, phobias, depressive as intensive help.*"

These eligibility criteria, though pre-dating the *DoH 2002 Guidance*, were reflective of the principles espoused in 2002. On the supposition that East London community mental health team staff were applying these criteria and from the content of the clinical records, Mr SU did not satisfy the essential 'Historical' criteria for allocation. Therefore the decision not to accept him on to the community mental health team caseload at the time of first assessment in March 2006 can be justified. However, it could be argued that Mr SU did meet some of the specified social criteria and may also have met criterion iv: *"Disorders requiring skilled or intensive treatments (e.g. cognitive behavioural therapy, vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care" (DoH 2002 Guidance, page 4).*

Recognition of this by the consultant psychiatrist in psychological therapies may have been one reason why he found the community mental health team's decision frustrating.

5.3.3 The second referral

The second letter of referral was dated 25 August 2006. At this time East London and the City Mental Health Trust had revised the 1997 community mental health team operational policy, finalising it in June 2006.

The consultant psychiatrist in psychological therapies stated in his letter of referral:

"[*Mr SU*] *contacted me today in a state of crisis. He reports feeling dysphoric and angry. …* [*He*] *tells me that he was also distressed as a consequence of his financial difficulties and that he currently has no money. I think it would be helpful if he could receive some additional input and in particular, an assessment to form an opinion, whether or not he suffers from an Organic Bipolar disorder."*

The referral letter was also a request for a home treatment team assessment of Mr SU's mental state. These events occurred on the Friday before a bank holiday weekend.

The home treatment team accepted Mr SU for management over the long weekend and assessed him at home on Saturday 26 August. Recorded under the heading *"Brief Summary and Management Plan"* of the Risk Checklist form of that date are "Possible suicidal ideation", with a management plan for daily risk/suicide assessment by the home treatment team, oral Lorazepam as required, crisis house placement if needed, and referral back to the community mental health team after the holiday weekend on 29 August. On this date a letter was sent to Mr SU notifying him of his community mental health team referral.

An assessment was arranged by phone and expeditiously undertaken on 1 September 2006 by a community psychiatric nurse and social worker assigned in the allocation meeting on 29 August. On the same date the community psychiatric nurse wrote a letter to the consultant psychiatrist in psychological therapies, advising that:

"[*Mr SU*] *was down because of his financial problems … appeared to have good insight into his mood … denied any suicidal ideation …"*, concluding in the progress notes that Mr SU *"was coping and dealing with his problems and really there was no role for community mental health team".*

On review of the clinical records it was not initially clear that this decision was taken to the next allocation meeting in accordance with expected multi-disciplinary team practice. However, Mr SU's name was listed for the allocation meeting on 4 September and the note made at this meeting said: "Case closed 5 September 2006". The Independent Investigation Team therefore accept that the required procedure for multidisciplinary discussion of referrals took place.

The revised East London and the City Mental NHS Trust *Operational Policy for Community Mental Health Teams* (ratified June 2006) said:

"Point 2.1: People requiring treatment, care and monitoring may include the following:

- ❐ *Severe and persistent mental disorders often associated with significant disability and poor quality of life, predominantly psychotic disorders.* ***(Did not meet criteria)***
- ❐ *Longer-term conditions of lesser severity but which are characterized by poor treatment adherence or requiring proactive follow up. (****Yes met criteria)***
- ❐ *Any disorders where there is significant risk of self harm or harm to others or where the level of support required exceeds that which a primary care services are able to provide. (****Yes met criteria)***
- ❐ *Disorders requiring skilled or intensive treatments not available in primary care. (****Yes met criteria)***
- ❐ *Complex problems of management of engagement such as presented by service users requiring interventions under the Mental Health Act. (****Did not meet criteria****)*
- ❐ *Severe personality disorders where there has been shown to benefit by continual contact and support. (****Did not meet criteria****)*

These criteria were considerably broader than those in the earlier policy document cited above and more reflective of the inclusive principles in the *DoH 2002 Guidance*. The Independent Investigation Team considers that, at the time of this second referral, Mr SU arguably met one or more of the eligibility criteria for allocation, as indicated above. The case for allocation at this time was stronger than at the time of first assessment in March 2006.

Once notified of the community mental health team's decision to again not accept Mr SU, the consultant psychiatrist in psychological therapies responded by letter dated 8 September that he thought *"it almost inevitable that* [*Mr SU*] *is likely to represent to services repeatedly over the next few years"* so that he wondered *"if managing him in the duty system is the best way of approaching his care?".* There is no evidence of a response to his letter or the concern he raised.

Why was the Service User not accepted by the Community Mental Health Team?

The principal reason Mr SU was not accepted at the time of second referral was that CMHT staff considered, from his history of acquired brain injury and his personal presentation, that he did not suffer from a severe and enduring mental health illness warranting the input of a community mental health team.

The following quotation from the then locality manager encapsulates what was consistently reported to the Independent Investigation Team at interview and appears in written information both collected by the Trust in its internal investigation and that obtained by the Independent Investigation Team.

"It appears [*Mr SU*] *would have a crisis that would pass fairly quickly … in crisis in one day, but the next day when seen by another service present as calmer and in less need of intensive intervention."*

This was not the perspective of the consultant psychiatrist in psychological therapies, who said:

"Enduring … without any doubt whatsoever. [*For*] *severity, the fluctuating level of disability is an issue. …* [*Mr SU*] *can come across as quite high functioning, the kind of person a community mental health team should be moving on. But at other times* [*he was*] *clearly not."*

He was of the view that Mr SU's excessive spending, including of all his compensation money, was one indicator of severity that others perhaps did not take seriously.

The Independent Investigation Team suggests that the lack of any senior clinical assessment of Mr SU within the community mental health team, most notably the lack of senior medical input, may have contributed to a lack of appreciation of Mr SU's complexity.

Although the Independent Investigation Team does not consider workload issues to have been a gross influencing factor, the high demand on the finite capacity of community mental health team services would impact on the threshold of the team and its perception of the needs of referred service users.

The Independent Investigation Team formed the impression from both management and medical professional interviewees that the community mental health team was quite hard pressed at the time with staff recruitment and retention problems, since resolved. The operational policy stipulates a maximum community mental health team caseload of 250 service users (4.1). The Independent Investigation Team had no independent information on these factors. However, it recognised that they may have been operative in deciding who should benefit from community mental health team allocation, and that resource constraints are an endemic problem within NHS mental health services.

The Independent Investigation Team asked whether Mr SU would be accepted on to the community mental health team caseload today in 2011. The then team manager responded to this question by saying:

"Yes, if he presented in the way he did in April 2007."

This was a reference to Mr SU's presentation to the community mental health team on 12 and 13 April. He had self-presented with a friend to A&E after midnight on 12 April following an overdose of painkillers and his antidepressant medication. When seen on the following morning at the community mental health team by the care co-ordinator and staff-grade doctor he was depressed, distraught and confused, raising sufficient concern to warrant a request for assessment and support from the home treatment team.

The Independent Investigation Team concluded that Mr SU would still not necessarily be accepted on to the community mental health team caseload

today if, for example, he had presented as he did in September 2006, i.e. that a principal operative criterion for community mental health team appeared to be, and appears to be, presentation in distress.

Overall perspective of Independent Investigation Team

The Independent Investigation Team is mindful that hindsight allows a degree of clarity about events not possible at the time. Nevertheless, it is the Independent Investigation Team's perspective that community mental health team staff applied the eligibility criteria for community mental health team allocation in a narrow way. This did not allow for or convey an understanding of the long-term and fluctuant nature of Mr SU's condition, in particular, the manifestations and risks of elevated mood swings as well as the more persistent symptoms of depression.

The presentation and needs of Mr SU were more complex than primary care could accommodate. The Independent Investigation Team believes that the community mental health team should have considered more carefully not merely Mr SU's presentation but also his history, before deciding that it should not offer him a service. As events transpired, Mr SU was accepted on to the community mental health team caseload some four weeks after the letter declining to accept him was written, an interval which the Independent Investigation Team considered did not make a material difference to Mr SU's care and treatment.

In summary

The role of a community mental health team is to provide specialist care for patients with severe and/or enduring mental health needs which cannot be met by a primary care service. Such care may be necessary to activate and co-ordinate a range of multi-agency support required to establish and maintain stability. Mr SU had an enduring mental health disorder arising from his acquired brain injury and which created a range of complex needs. Although community mental health team staff may not have felt entirely confident in their understanding of acquired brain injury, the kind of practical supports Mr SU needed fell within those commonly provided by a community mental health team service. Indeed, the community mental health team were best placed to co-ordinate the appropriate package of care and support for him.

5.4 ONCE ACCEPTED ON THE CASELOAD, DID THE COMMUNITY MENTAL HEALTH TEAM

5.4.1 Appoint a care co-ordinator appropriate to the Service User's needs?

5.4.2 Conduct an appropriate assessment of the Service User in relation to medical review, needs assessment and risk?

5.4.3 Devise and implement a care plan appropriate to the Service User's needs?

The Independent Investigation Team's analysis of the community mental health team clinical progress notes suggests that the care co-ordinator and other community mental health team staff involved in his care were sensitive to and spent considerable time and effort in seeking to address Mr SU's needs. Despite this, however, the care plans recorded are lacking in detail, focus and coherence. Medical assessments did occur, but only at times of crisis, with no planned and detailed assessment of Mr SU's needs when relatively stable.

5.4.1 Appointment of 'an appropriate' Care Co-ordinator

In September 2006 Mr SU was assigned a community psychiatric nurse care co-ordinator to perform his initial assessment, which initially resulted in his non-acceptance on to the community mental health team caseload. Shortly after, in October 2006, Mr SU was subsequently accepted on to the community mental health team caseload and the same community psychiatric nurse as had assessed him in the September was allocated as his care co-ordinator. This individual was working together with a student social worker supervised by the senior practitioner/team leader. The professional qualification of the care co-ordinator meant that she was an appropriate person to take this role.

When the Independent Investigation Team commenced the investigation, Mr SU's then care co-ordinator was no longer working with East London Foundation Trust, having left the Trust in 2007. Because she was no longer living in London, and had a range of personal matters she had to attend to, initial attempts to contact her were not successful; however, in May 2011 contact was achieved and she agreed to meet with a member of the Independent Investigation Team to review the draft report and findings and to provide her recollections on the basis of a review of her own records at the relevant time.

The Independent Investigation Team concluded (above under 5.3.3) that the needs of Mr SU were not remarkable for a community mental health team to address and considered that a community psychiatric nurse was an appropriate person to appoint as care co-ordinator. The team manager told the Independent Investigation Team that Mr SU's care co-ordinator was *"a very caring and empathetic nurse … service users warmed to her, she had good engagement qualities and a good relationship with them … I had no concerns and received no complaints about* [*her*] *clinical work."*

However, there were some issues that may have impacted on the overall care co-ordination of Mr SU, and/or other service users on this care co-ordinator's caseload. The team manager told the Independent Investigation Team that the care co-ordinator was an agency member of staff. She had been offered a permanent contract, but she wished to return to her home some considerable distance from London. The personnel records for the care co-ordinator showed frequent absences on sick or other leave that created difficulties with respect to both regularity of supervision/case review and service coverage by colleagues. On 12 February the senior practitioner/team leader e-mailed the team manager as follows:
"I am continuing to be concerned about [*the care co-ordinator's*] *non attendance at work. … I am concerned that this means that colleagues have to regularly pick up her duties."*

The team manager e-mailed in reply:
"… I am really not happy with her attendance. … We also need to go through case notes … supervision!"

The supervision notes with the lead clinical nurse for 20 February 2007 record:
"[*The care co-ordinator*] *has had a lot of time off sick and days off work. Discussed impact this has on her work/caseload and on team."*

Specifically with respect to Mr SU, his care co-ordinator was absent:
- for the first scheduled CPA meeting on 5 December 2006;
- when he self-presented in a state of distress on 13 February 2007 and required supportive intervention over several days to 18 February 2007; and
- on 20 March 2007 when he telephoned and later presented at the community mental health team in distress.

It is not possible to say whether the care co-ordinator's absences had a negative impact on Mr SU's care delivery or the completeness of his care plans. However, the Independent Investigation Team did ask the team manager why, in view of the concerns expressed at the time, she continued to utilise the care co-ordinator within the community mental health team.

The team manager and staff-grade doctor told the Independent Investigation Team of general difficulties with staff recruitment and retention in East London and the City Mental Health Trust at the time. There was a pay freeze due to financial constraints and the team manager was working with many bank and agency staff. Although the team manager considered this was not ideal, the skills and empathy the care co-ordinator showed service users made her a valued member of the team in spite of her sickness record, so that she was keen to retain the care co-ordinator's services.

The Independent Investigation Team also considered the reasonableness of allocating a student social worker to work with Mr SU, given the complexity of his needs. The professional supervision records showed that the student social worker had a small caseload and was closely and carefully supervised

by the senior practitioner/team leader. Furthermore, the clinical progress notes evidence a good standard of record keeping and a supportive interaction with Mr SU, particularly with respect to practical strategies for dealing with his debt problems in February 2007. These included letters to various debt collection agencies explaining Mr SU's mental problems and financial situation and proposing strategies for repayment, and an application to the local council for Mr SU to be disregarded for council tax. The Independent Investigation Team have no criticism of the care afforded Mr SU by the student social worker.

5.4.2 The appropriateness of Mr SU's assessments (medical, needs and risk)

5.4.2.1 Medical Assessment

A review of the Trust's CPA policy for 2006 and 2007 revealed no documented standard for the frequency with which service users on CPA should be assessed by a member of the psychiatric team. However, the staff-grade psychiatrist to the team recalled during her interview, conducted by the Trust's own investigation team on 19 August 2007, that the *"agreement was that* [*the consultant psychiatrist for the community mental health team*] *needed to see clients twice a year."* The Independent Investigation Team can confirm that it was at the time considered best practice for service users on enhanced CPA to have two medical assessments per year; however, where service users were considered to be stable, annual assessment was also considered acceptable.

The Independent Investigation Team noted that the Trust's community mental health team operational policy required that a database be maintained of service users and the date of their last medical review. However, this policy document did not set out the expected time intervals for medical review or the standard expectation for medical review when a service user had been assessed as suitable for community mental health team care and treatment.

The Independent Investigation Team considered that this lack of statement about the expected frequency of medical review for service users on CPA was a gap in the policy documents at the time.

The Trust's own interviews with the community mental health team consultant psychiatrist (2005-2007) revealed that, with the benefit of hindsight, he felt under-informed about Mr SU when he was referred by the consultant psychiatrist in psychological treatments. He felt that the initial (March 2006) referral letter was not as robust as it could have been (the Independent Investigation Team has some empathy with this), and he reported not receiving the September correspondences. The community mental health team consultant psychiatrist also reported not always being in attendance at the community mental health team weekly clinical team meeting. However, team meeting records show that he was present on 4 September 2006 when the decision not to accept Mr SU on to the community mental health team caseload was confirmed.

In the interview conducted by the Trust during its internal investigation the community mental health team consultant psychiatrist also confirmed that the system, at the time, was for clinicians (not necessarily doctors) to perform initial assessments and bring their findings to the team meeting for discussion. He told the Trust's investigators that he had raised concerns about the variable quality of information presented at the community mental health team weekly clinical team meeting and that, as a consequence, it was an issue addressed at a team development day towards the end of April or in the early part of May 2007.

The sense the Independent Investigation Team had on reviewing the community mental health team's consultant psychiatrist interview records was that, with the benefit of hindsight, he considered that medical assessment of the Service User soon after his acceptance on to the community mental health team caseload may have been prudent.

Face-to-face medical reviews after October 2006

An analysis of Mr SU's clinical records revealed that on:

- 26 October 2006 there was a plan by Mr SU's care co-ordinator to book a medical review for him;
- 7 November the supervision record made by the team leader noted that a medical appointment had been made, but not the date;
- 5 December the planned CPA review did not happen – it was rebooked for April 2007;
- 23 January 2007 Mr SU did not attend an already scheduled outpatient appointment. The status of this outpatient appointment remains unclear. It was routine that when a service user was accepted on to the community mental health team caseload, follow-up at outpatients ceased. It seems that in this case either the appointment was already in the system, or that it went out to Mr SU during the cross-over period. Either way, to have been offered an appointment was not at all disadvantageous to the service user;
- 14 February 2007 Mr SU was assessed following presentation 'in crisis' by the community mental health team's staff-grade doctor;
- 12 April Mr SU was again assessed by the community mental health team staff-grade psychiatrist at the planned CPA review. He was in a state of distress and confusion following his A&E attendance for an overdose the previous night; and
- 19 April Mr SU had a planned appointment with the community mental health team staff-grade psychiatrist. This was subsequently changed to 26 April, although the reason for this is not known. Mr SU would not have attended either date as a consequence of the incident in which he was involved.

Comment by Independent Investigation Team

It is unclear what happened to the medical review reportedly booked for Mr SU by 7 November 2006. Mr SU's then care co-ordinator told the Independent Investigation Team that the normal process for booking a medical review was

by going to the administrator who held the CPA diary. Medical reviews and CPA reviews were booked in the same diary. When a CPA review was conducted, this would usually be denoted in the diary with a tick. The Independent Investigation Team did have sight of the CPA diary for 5 December 2006. The CPA review for Mr SU was clearly listed, and it is clearly marked with a tick.

Mr SU's care co-ordinator told the Independent Investigation Team that she would not be confident that the then consultant psychiatrist for Mr SU would have made a record of any assessment he conducted that day. Furthermore, she also told the Independent Investigation Team that it would be very unusual for a CPA review to be cancelled because the 'care co-ordinator' was off sick. Normal practice was to arrange cover for CPA. Her recollection of that time period is that she would, when notifying her manager of sickness, highlight any CPA reviews booked for that day so that cover could be arranged.

With regards to the pre-scheduled outpatient appointment of 23 January 2007, there were at the time two separate sets of notes, one for the outpatients department and the other for the community mental health team 'multi-disciplinary' record. Furthermore, when a service user was accepted on to the community mental health team caseload, outpatient appointments did not continue. If a medical review was required for an allocated patient, the routine procedure was for the relevant care co-ordinator to book an available slot in the CPA/MR (medical review) diary. If an urgent review was required, it could usually be arranged within 24-48 hours.

The Independent Investigation Team considers that, on the balance of probabilities, an appointment for a medical review was booked for Mr SU using the procedure outlined above, but that Mr SU did not attend. The care co-ordinator's record of her contacts with Mr SU, and the frequency with which she re-booked appointments he did not attend, are robust and evidence that Mr SU regularly missed scheduled appointments.

The Medical Assessments That Did Occur

The only medical assessments the Independent Investigation Team has been able to establish for the period after Mr SU's community mental health team allocation were on 13 February and 12 April 2007. These assessments are set out in detail below.

13 February 2007
The student social worker referred Mr SU for assessment by the community mental health team's staff-grade doctor after he self-presented in distress.

The staff-grade recalled that Mr SU was *"dysphoric*[9] *in his mood, anxious, tense, reporting poor appetite, and difficulties to fall and maintain sleep".* She recalled that he *"reported suicidal thoughts but denied acute suicidal plans",* and having *"re-started his Reboxetine 4mgs"* twice instead of once a day. Overall, she considered that he might benefit from more intensive support and advised referral to the home treatment team. This was done on 14 February.

The primary record of the encounter on 13 February was made by the team manager. She noted that she spent approximately one-and-a-half hours with Mr SU, which was a longer period of time than that required for the medical assessment to be completed.

Her records noted in detail the issues causing distress to Mr SU, including:

- His *"feeling very stressed by a summons he got from Council Tax offices to appear in court for non-payment"*;
- Mr SU *"also spoke about having thoughts of punching others, however he managed to contain his anger and distract himself by going to the gym etc"*;
- That he *"continued to drive but had not paid HP payments on the car".*

The record noted that the community psychiatric nurse and student social worker would complete the assessment of Mr SU the following day and he agreed to come to the community mental health team for this. The record also noted that Mr SU *"left the office feeling better within himself. Said although he had thoughts of self harm he will not carry them out as he does not want his family to go through what they went through ... following his accident."*

The plan agreed with the staff-grade doctor was:

- re-refer to cognitive behavioural therapy;
- contact the consultant psychiatrist in psychological therapies;
- offer a follow-up community mental health team appointment; and
- arrange a joint assessment with the home treatment team.

The staff-grade doctor also recalled considering that Mr SU might benefit from Olanzapine 7.5mg at night to alleviate his anxiety and sleeping difficulties.

On 14 February Mr SU attended the community mental health team and, his care co-ordinator being absent on sick leave, was seen by the student social worker, a social worker, the senior community mental health team practitioner and again by the staff-grade doctor. Olanzapine was prescribed for 7 days. A referral to the home treatment team was also made on 14 February at

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[9] Dysphoria is a condition of mood. It means that one is experiencing mood deterioration, such as sadness.

15.20hrs. The plan as a consequence of the referral, was for home treatment team to *“monitor mental state/compliance through crisis period”.* It was also agreed that a joint assessment between the community mental health team and home treatment team would take place at Mr SU’s address at 09.30 on 15 February. On 15 February the social worker and the student social worker made the home visit. Home treatment team were not in attendance. Mr SU was noted as much calmer and reported *“that he did not feel he needed the home treatment team any longer as his mood had improved and he was taking his medication, including the Olanzapine.”* This decision was communicated to the home treatment team. In the continuing absence of the care co-ordinator, Mr SU’s care and follow-up was resumed by the student social worker and community mental health team senior practitioner.

The CPA Review on 12 April 2007
On 12 April 2007 Mr SU attended his local A&E at approximately 01.05hrs following an overdose of Diclofenac and Ibuprofen (anti-inflammatory medications) and Reboxetine (his antidepressant medication). He was discharged home in the early hours of the morning and attended the community mental health team for a scheduled CPA review later in the day.

He was seen by his care co-ordinator and the staff-grade doctor. The care co-ordinator’s record of this review noted:
“[*Mr SU*] *attended for his CPA – he informed* [*the staff-grade doctor*] *and myself that he had o.d. the night before, and had been seen in A&E.* [*Mr SU*] *was very confused and low in mood.”*

The interview with the staff-grade conducted by the Trust on 19 August 2007 reported her recollection of this day:
“I suggested to him that he consider commencing a mood stabiliser to try and stabilise his affect and reduce impulsivity; he denied my offer; I suggested Day Hospital as an attempt to contain risk but he didn’t agree to that either. He agreed to be referred to the home treatment team. I was sufficiently concerned to offer him a follow up appointment the following week. He agreed to see me on 19 April 2007. At that point I felt there were no grounds to compulsorily admit him to a Psychiatric Unit.”

This was the last contact by mental health services with Mr SU. The incident occurred on or after the planned medical review on 19 April.

Overall Comment by the Independent Investigation Team
For the reasons already addressed above, Mr SU had his first medical review the day after he self-presented *“in crisis”* on 13 February 2007, some four months after being accepted on to the community mental health team’s caseload. Although a second medical review took place in the setting of a scheduled CPA meeting on 12 April, the focus at this time was diverted to the management of Mr SU’s distressed and confused state following his A&E attendance for an overdose the night before.

On the basis of the information analysed by the Independent Investigation Team, it has concluded that the lack of an earlier medical review would not

have made a significant difference to the overall care and treatment of Mr SU. His needs were predominantly for practical strategies to help with his social problems, particularly financial problems, and general counselling to support him emotionally. These the Independent Investigation Team believes could adequately be provided by non-medical community mental health team staff and indeed were provided, within the constraints imposed by Mr SU's repeated non-attendance when he felt well.

The desirability of adding a mood stabiliser to Mr SU's anti-depressant medication regime had been proposed prior to Mr SU being accepted on to the community mental health team caseload, by the consultant psychiatrist in psychological treatments, and the Independent Investigation Team does not consider that the Service User's continual refusal of this would have changed had the community mental health team medical staff achieved earlier assessment of him.

Following the medical review in February 2007, there were no particular indications for further medical follow-up and, if it was later needed, the care co-ordinator knew how to arrange one and this the Independent Investigation Team considers was acceptable.

At the medical review in April 2007 the staff-grade doctor concluded Mr SU was not coping and made arrangements for immediate Home Treatment Team assessment and support, with a follow-up medical appointment in seven days' time (19 April). This was an appropriate course of action within a reasonable time frame.

What was not reasonable was the lack of medical notes made by the staff-grade doctor, including of the findings on mental state examination on 12 April and medication prescribed. In circumstances of concern about a mental health service user, some written information about the Mental State Examination would be expected as routine. The Independent Investigation Team was informed that it was, and indeed remains, routine practice for the care co-ordinator to make a single comprehensive record of all care plan decisions. However, the Independent Investigation Team are of the view that it is not the role of a care co-ordinator to record the findings of a Mental State Examination or any medication prescribed. This is always the responsibility of the doctor.

The Independent Investigation Team formed the impression that the staff-grade doctor intended to conduct a thorough assessment at the time of follow-up on 19 April, and that the priority on 12 April was the immediate management of Mr SU's distressed state. It is unfortunate that the date of 19 April was subsequently changed to 26 April without any rationale for the change being recorded in Mr SU's clinical records. Although the change in date would not have made any difference given the sequence of events that occurred, given the staff grade's documented concerns, there should have been a clear rationale for the delayed medical assessment.

Nevertheless, on the basis of the Independent Investigation Team's interview with the staff-grade doctor, its analysis of Mr SU's clinical records, and information gathered by the Trust's own investigation team, the Independent Investigation Team was satisfied that, on the balance of probabilities, the criteria for conducting an assessment of the MSHU under the Mental Health Act were not met when Mr SU was seen on 12 April.

5.4.2.2 The CPA Needs Assessment

Mr SU was accepted on to the community mental health team caseload on 29 September 2006 and allocated a care co-ordinator on 2 October. On 18 October the care co-ordinator wrote to Mr SU offering him an appointment for 26 October. The progress notes for this date document the plan for a medical review and CPA, to be discussed with the staff-grade doctor, with a further appointment on 8 November.

The records contain one CPA *Referral Needs and Assessment Form* dated 5 March 2007. The care co-ordinator completed the form on the basis of an evaluation of Mr SU's presentation over the period 10 October 2006 to 4 March 2007. In light of Mr SU's erratic attendance, particularly in December 2006 and January 2007, this time period for evaluation was not unreasonable.

The form evidences a comprehensive assessment of Mr SU and addresses the following:

- presentation;
- psychiatric history and medical history;
- current mental health state;
- current social situation;
- own views of his strengths and resources,

and includes a statement of Mr SU's needs and an action plan.

On review of the assessment, the Independent Investigation Team considered that it provided a reasonable overview of Mr SU's issues and needs. However, there were some areas of the assessment form that could and should have included a more detailed description of Mr SU's circumstances.

The areas the Independent Investigation Team considered that could and should have been more fully documented were:

- Information relating to why Mr SU had been referred to the community mental health team. The care co-ordinator had noted the broad reasons for this, but did not record the impact the acquired brain injury had had on Mr SU's life functioning. This was the main reason for the referral from psychological therapies to the community mental health team.
- The history of the presenting problem: The care co-ordinator noted that the acquired brain injury affected the way in which Mr SU dealt with anger. However, the form did not explore this or describe how Mr SU dealt with anger.
- Thought content: The care co-ordinator noted that Mr SU could have some paranoia from time to time. However, there was no evidence of

exploration of how the paranoia manifested or how Mr SU managed such episodes.

- Appetite and diet: The assessment form simply noted *"no problems".* This is markedly different from the assessment document completed at the time of first referral in March 2006. This noted that, when stressed, Mr SU did not eat and his mother supported him to make sure he did. The risk assessment in December 2006 also identified problems for Mr SU in maintaining good dietary habits. Mr SU had not achieved a recovery in his presenting features between March and October. Therefore, the Independent Investigation Team would have expected the care co-ordinator to note these discrepancies and to explore them with Mr SU and try to reconcile or explain them.
- Finance and Income: The assessment form noted that Mr SU had *"accumulated a lot of debts, but* [*was*] *getting help from the community mental health team".* There is no indication of the size of debt or of what practical help he was receiving.

With regards to 'Specific Carer Views', the form noted *"*[*Mr SU*] *does not think that there was a need for a carer's assessment".* However, it is also noted that Mr SU had a close and supportive family, and the March 2006 form details the range of support Mr SU's mother provided. The Independent Investigation Team did not consider it acceptable that the care co-ordinator accepted Mr SU's opinion about the lack of need of a carer's assessment for his mother. This issue should have been directly explored with her.

5.4.2.3 The Risk Assessments Conducted

Mr SU's care co-ordinator conducted two risk assessments dated:

- 29 December 2006; and
- 5 March 2007.

Risk assessment dated 29 December 2006

This assessment noted:

- a history of verbal aggression but no physical aggression;
- an arrest at the age of 15 years for smashing a milk float while playing 'bumper cars' with it with friends;
- previous suicide attempts;
- previous but no current experimentation with illicit substances;
- non-compliance with medication;
- financial risk issues caused by poor budgeting; and
- risk associated with the way Mr SU could come across to others – 'slightly aggressive'.

The management plan was reflective of the care plans written for Mr SU in January and April 2007. The only feature not replicated in his care plans was Mr SU's intention to start an Anger Management course.

There was a specific assessment of Mr SU's dangerousness/risk to others, which noted that *"there appears to be no situation or behaviour dangerous to others or that puts others at risk. Never thought of harming anyone."*

This form reiterated that the issues for Mr SU were:

- not eating properly;
- self-neglect;
- lack of motivation;
- not sleeping well;
- isolation from others.

All of these issues were in keeping with the findings of the assessments undertaken by the consultant psychiatrist in psychological therapies prior to acceptance of Mr SU on to the community mental health team caseload.

A risk control for Mr SU was noted to be his mother. Other risk controls were noted as being *"in a safe environment".*

Risk Assessment dated 5 March 2007

This risk assessment contained much the same information as that recorded on 29 December 2006. However, it noted a number of differences based on further information available subsequent to December 2006.
It noted that:

- Mr SU *"was involved in some aggression when he was younger"*;
- *"when he was younger he did become involved in the use of knives and guns, but not presently"*; and
- he *"admits to having threatened people in the past"*, although *"no longer has this urge"*.
- under the heading 'Provocative behaviour', the form stated: *"*[*Mr SU*] *states that yes he can wind other people up".*

Under the heading 'Brief summary and management plan', it was recorded: *"*[*Mr SU*] *admits he can be volatile, and in the past got mixed up with the wrong sort of people. He has worked on anger issues with* [*the consultant psychiatrist in psychological therapies*] *and is more aware now and has tools to deal with it.* [*Mr SU*] *does have thoughts of suicide at times and this is usually linked to non-compliance of medication and increased debts.* [*Mr SU*] *admits to becoming stressed at times but is a lot more equipped to deal with these periods and will ask for help.* [*Mr SU*] *appears very positive and keen to conquer his problems."*

At the end of this assessment the care co-ordinator did not consider that a more detailed risk assessment was required. The completed form was countersigned by the team manager.

No new risk management care plan was documented on the basis of this second assessment. The then care co-ordinator considered that the pre-existing plan was sufficient. She told the Independent Investigation Team that Mr SU was quite straightforward in his consideration of his past involvement with gangs. He told the care co-ordinator that he had never hurt anyone and that 'they' did not do anything like that. The care co-ordinator expressed clearly to the Independent Investigation Team that she took the risk assessment process very seriously and considered it a core component of her job. Her contacts with Mr SU did not give her cause for concern regarding his

risks to others. He did not display features that in her experience would trigger such concerns. He was generally a charming young man, a significant issue for whom was his own body image following his road traffic accident.

Comment by Independent Investigation Team

The Independent Investigation Team considered that the risk assessment documents were unremarkable. The Independent Investigation Team also note that for a care co-ordinator to update a risk assessment after an interval of three months based on a longer period of evaluation and a better understanding of the person for whom they were care co-ordinator was and remains good practice.

However, noting the above, it would have been optimal practice if the care co-ordinator's exploration of risk with Mr SU had been more fully documented. The Independent Investigation Team accept that these behaviours pre-dated Mr SU as an adult and that as an adult there was no evidence of any behaviour to suggest that Mr SU posed a risk to anyone other than himself.

The Independent Investigation Team also noted that the risk assessment documented in March 2007 did not draw on any of the information elicited as a consequence of Mr SU's 'crisis' in mid-February, where it had been noted in the community mental health team progress notes and the Home Treatment Team referral form that:

- he had presented with suicidal thoughts and had held a knife to his throat; and
- he was mixing with the wrong types of people, involved in criminal activities.

The care co-ordinator at the time agreed that these issues should have been documented and that it was and remains expected risk assessment practice to draw on recent contemporary behaviours and significant past behaviours in order to formulate a realistic risk perspective and risk plan.

The above being said, with regards to the decision made by clinicians not to conduct a further detailed risk assessment in March 2007, the Independent Investigation Team considered that, based upon what was known about Mr SU at the time, this was not required. The risk indicators elicited were historical, pertaining to Mr SU's adolescence, and he did not have any history of violence or aggression. There was no prior forensic history of any note.

5.4.3 As a consequence of the referral information and the community mental health team's own needs and risk assessments of Mr SU, did the community mental health team devise and implement a care plan appropriate to his needs?

The care plan arising from assessment of Mr SU's needs

Mr SU had two care plans. The first, the Independent Investigation Team deduced, was prepared for a CPA meeting scheduled for 5 December 2006 and was finally dated 1 January 2007. The second was dated 12 April 2007.

The first care plan dated 1 January 2007

As previously noted, there remains uncertainty regarding the conduct of the CPA review of 5 December 2006.

With regards to the care plan subsequently created for Mr SU, it appears that the care co-ordinator completed the care plan on her return to work early in the New Year, possibly on 3 January 2007. The form itself, however, was dated New Year's Day. The care co-ordinator was able to confirm to the Independent Investigation Team that the date recorded on the care plan document was a typographical error. The 3 January was the date of creating the care plan and the date it was sent to Mr SU.

This first care plan set out a reasonable and succinct summary of Mr SU's issues, but detailed only one 'care need' for him. This was:

"[*Mr SU*] *was involved in a RTA, as a result he suffered front lobe damage which culminated in depression."*

The interventions/actions recorded were:

- *"*[*Mr SU*] *needs to continue to be compliant with his anti-depressant medication, Reboxetine 2mg bd;*
- [*Mr SU*] *to attend at the* [*community mental health team base*] *on a regular basis to monitor and assess his mental health;*
- [*Mr SU*] *to remain on standard CPA;*
- [*Mr SU*] *to attend all meetings with consultant;*
- [*Mr SU's*] *care to be transferred."*

Review was scheduled for 4-6 weeks.

A possible explanation for the brevity of this first care plan was that at the time it was completed Mr SU had not attended an appointment on 20 December 2006. When last seen on 29 November 2006, he had said he was taking his antidepressant medication and feeling fine. When contacted by phone on 21 December Mr SU said he had forgotten his appointment the day before and was offered another for 5 January. There was no indication from the records of any concerns about Mr SU's state at this time. It appeared that the intention was therefore to transfer his further management either to outpatients or psychological therapies. Indeed, consideration of this was part of the documented plan.

As events transpired, Mr SU then did not attend rescheduled appointments offered for 5, 11 and 17 January, finally keeping an appointment on 19

January. At this time he told his care co-ordinator that he did not want to be discharged from community mental health team care.

The second care plan dated 12 April 2007
This document was written on the day of the CPA review and provided a detailed account of Mr SU's contemporary situation, including:

- His attendance at A&E in the early hours of that day;
- His involvement in another car accident two weeks previously;
- His confusion about the type of help he needed; and
- His reluctance to take medication.

It also set out the immediate plan to manage Mr SU's distress (see above under 1 January 2007).

The care plan itself identified two issues:

- Support required for Mr SU in continuing to come to terms with the impact of his acquired brain injury on his life; and
- Debt management.

The documented strategy to address these issues, detailed under the heading 'Interventions/actions', was similar to that documented in the first care plan.

Overall, the strategy to be adopted by the care co-ordinator and student social worker, to support Mr SU, was not outlined in any detail. However, the brief descriptors were sufficient to enable the Independent Investigation Team to determine that the care co-ordinator had a reasonable appreciation of Mr SU's needs and the range of support he required. Her appreciation of this was further validated at a face-to-face meeting with her on 5 August 2011.

There were three disappointing aspects to this second care plan, which are as follows:

- There was no evidence that exploration of the need for 'time to talk' and the utilisation of talking therapies, within the context of what the community mental health team could provide, was considered. Mr SU had repeatedly highlighted that what he found helpful was 'time to talk'. However, the Independent Investigation Team noted that the progress records showed clearly that, whenever Mr SU attended the community mental health team base needing to talk, he was given time by his care co-ordinator, the student social worker and the team manager.
- There was no evidence that the care co-ordinator was aware of the earlier Headway referral and therefore there was no reflection of the need for joint working in the care plan.
- The lack of any reference in the care plan to Mr SU's mother. His mother provided regular support to him and some plan for building an effective joint working relationship with her to best support Mr SU would have been good practice.

The Independent Investigation Team discussed the above observations with Mr SU's care co-ordinator. She recalled the following:

- That she was aware of the referral to Headway, and she did discuss it with Mr SU. However, her recollection was that he was very ambivalent about it and that he did not believe that further engagement with them would be helpful, as he did not consider that they were able to help him all that much previously.
- That Mr SU did not want his mother involved in his care and treatment. The care co-ordinator recalled that the Service User felt very strongly about this. He felt that he had already caused her enough stress and distress. The care co-ordinator did acknowledge that, with the benefit of hindsight, she should have ensured that Mr SU's mother was offered a Carer's Assessment, and that it was not for Mr SU to say whether or not this was required, but the individual herself. The care co-ordinator also highlighted to the Independent Investigation Team that communication with a service user's family/carer in circumstances where a service has said they do not want them involved can be difficult, as it can pose a threat to the trust necessary between a care co-ordinator and service user in achieving an effective therapeutic relationship. Nevertheless, the care co-ordinator accepted that she should have ensured that another member of the team undertook to communicate with Mr SU's mother if she considered there to be conflict of interests.

The Crisis Plan

The care plan noted clearly the early warning signs of relapse for Mr SU. However, the contingency and crisis plan was weak. It was noted that Mr SU would ask for help, but there were no other meaningful features of a crisis plan.

The actual contact achieved with Mr SU and the care provided to him

With regard to the actual contact and support provided to Mr SU, the clinical records show that his care co-ordinator or other community mental health team staff met with him, or offered appointments to meet with him, on the following dates:

- 8 November 2006: Mr SU did not attend a planned appointment with his care co-ordinator.
- 15 November 2006: Mr SU attended at the community mental health team base, to meet with his care co-ordinator, as planned.
- 29 November 2006: Mr SU attended at the community mental health team base, to meet with his care co-ordinator, as planned.
- 5 December 2006 CPA meeting: As already highlighted, there is uncertainty about this meeting. However, it is known that Mr SU did not attend.
- 20 December 2006: Mr SU did not attend his planned appointment with his care co-ordinator.
- 5 January 2007: Mr SU did not attend his planned appointment with his care co-ordinator.

- 11 January 2007: Mr SU did not attend.
- 17 January 2007: Mr SU did not attend.
- 19 January 2007: Mr SU did attend and apologised for missing earlier appointments, explaining that he had not attended because his mood had been good at this time. However, he told his care co-ordinator that he did not want to be discharged from the service.
- 13 February 2007: Mr SU self-presented in distress because of council tax arrears. His care co-ordinator was absent on sick leave and he was seen by the team manager and the staff-grade psychiatrist.
- 14 February 2007: Mr SU was seen and assessed by the senior community mental health team practitioner and the student social worker. He was also seen by the staff-grade psychiatrist and the community mental health team social worker.
- 15 February 2007: The student social worker and a qualified social worker made a home visit to meet with Mr SU. The home treatment team were not in attendance.
- 20 February 2007: Mr SU attended at the community mental health team base to meet with his care co-ordinator and the student social worker. He was noted to be feeling better but had stopped his Olanzapine as it “knocked him out”. The records noted that Mr SU reported that his stress was reduced by talking. Assistance was provided to Mr SU regarding his debt management. Specifically, the care co-ordinator undertook to write to the debt collection agencies and the council regarding Mr SU’s council tax.
- 2 March 2007: Mr SU attended at the community mental health team base and was assessed by his care co-ordinator and the student social worker. He was noted to be looking well at this assessment. It was also noted that he requested further assistance with his debt management and letter writing. A full needs assessment was conducted at this time.
- 20 March 2007: Mr SU made contact with his community mental health team by telephone and was invited to attend for an assessment, which he did. Mr SU self-presented with a range of concerns, including ongoing debt and relationship issues.
- 21 March 2007: Mr SU attended as planned to meet with his care co-ordinator. It was noted that he remained stressed at this visit.
- 22 March – 11 April 2007: There is a gap in contact with Mr SU. There is nothing in the clinical records to explain this and the MHSU’s care co-ordinator was unable to recall why he was not seen over this 21-day period.
- 12 April 2007: Mr SU attended at the community mental health team base for a planned CPA review meeting.
- 13 April 2007: This was a planned community mental health team and home treatment team assessment of Mr SU at the community mental health team base.

The 13 April 2007 was the last face-to-face contact Mr SU's care co-ordinator had with him.

The relevant operational policy for community mental health teams in the then East London and the City Mental Health Trust required a minimum of between weekly to monthly contacts with a mental health service user depending on their assessed need.
The Independent Investigation Team considers it fair to say that the care co-ordinator, together with the student social worker and other community mental health team staff in her absence, did their reasonable best to achieve this for Mr SU. The Independent Investigation Team understands that Mr SU preferred to be seen at the community mental health team base and did not wish for home visits. Over the seven-month period Mr SU was a patient of East London and the City Mental Health Trust, he had a total of 11 face-to-face contacts with either his care co-ordinator, the student social worker or other community mental health team staff when Mr SU's care co-ordinator was absent. The Independent Investigation Team considers that this level of contact was acceptable. Although more contact may have provided greater opportunity for Mr SU to talk about his life stressors, including his impulsivity, his inability to manage his finances, and the complexity of his personal relationships, he did not present as high risk or with signs of such severity that more frequent visits were warranted as a matter of course.

Furthermore, it is notable that, although Mr SU's care co-ordinator was considering discharging him because of his continued lack of attendance in December 2006 and January 2007, this plan was changed when he asked to be maintained on her caseload.

The Quality of Contacts
The clinical records evidenced that when Mr SU met with his care co-ordinator or other community mental health team staff, a reasonable length of time was spent with him. The records also evidence that staff appeared to treat the issues that were bothering him seriously; for example, offering assistance with debt management, as detailed above. Good quality records were made following contact between the community mental health team and Mr SU on the following dates:

- 15 November 2006;
- 13 February 2007;
- 14 February 2007;
- 15 February 2007;
- 16 February 2007;
- 20 February 2007;
- 2 March 2007; and
- 20 March 2007.

These records showed that Mr SU was given time to talk about his concerns. Mr SU's care co-ordinator and the then team manager confirmed that this was indeed the case. Mr SU also confirmed to the Independent Investigation Team that when he met with his care co-ordinator he did have time to talk about how

he felt. It was, however, also his recollection that sometimes he would attend at the community mental health team base to find what he believed to have been a planned appointment cancelled. The Independent Investigation Team were unable to validate the recollection of Mr SU. However, knowing that the care co-ordinator was off sick from time to time, there is no reason to consider that his recollections were not accurate.

Mr SU's care co-ordinator told the Independent Investigation Team that Mr SU was from time to time inconsistent in his presentation, being happy and satisfied with life one day and then next day not so. Her overriding sense was that he did not want to take responsibility for the quality and direction of his life, or for the relationships he engaged in. Mr SU's mother confirmed to the Independent Investigation Team that her son was variable in his mood. However, it was and remains her perspective that because of his acquired brain injury her son was not as able to take responsibility for his life as the mental health professionals consider he should have been.

Looking at the evidence for March 2007, the month prior to the incident, the Independent Investigation Team noted the following:
For 20 March there were three separate entries in the community mental health team progress notes made by the senior practitioner and the student social worker.

- The first, at 12.10pm, following a telephone call from Mr SU, who was noted to be tearful and reporting feeling very depressed.
- The second, following a telephone call to Mr SU from the student social worker and senior practitioner/team leader, at 12.40pm (possibly a continuation of the earlier call). The content of the record suggests the continuing of a phone call rather than 'a fresh call'. In this record it is noted that the senior practitioner persuaded Mr SU to have some food and to come into the office later in the day to see him and the student social worker.
- The third, at 14.40pm, when Mr SU attended at the community mental health team base, where he was seen by the student social worker and the social worker who had originally assessed him in March 2006.

It was clearly documented that Mr SU presented with depression, thoughts of self-harm related to guilt he felt over his relationship with a married woman (and her husband's possible discovery of this), *"hassle"* he was experiencing from an ex-girlfriend, the recent death of one grandmother, and his other grandmother suffering from cancer. The records make clear that he was able to talk about his problems and counselled to give careful consideration to his current relationship difficulties and to try and determine what it is he wants. The record also noted that *"we said that we could support* [*Mr SU*] *in finding daytime activities which might help to distract him from his depression and help to relieve stress".* Also, *"we explored the possibility of* [*Mr SU*] *being seen by a psychiatrist in the team and explained that they might suggest some medication as last month (referring to 14 February when Olanzapine was prescribed by the staff grade doctor)."* It is noted that the MHSU said that *"this had a negative effect on him and* [*he*] *did not feel he needed more*

medication." An arrangement was also made for him to return on the following day when he met with his care co-ordinator at 4pm. At this meeting he was encouraged to try *"compiling a timetable to organise his day".* He was noted to remain very talkative and stressed.

There was then a gap in appointments for Mr SU of three weeks. This, to the mind of the Independent Investigation Team, was too long a gap, given the levels of anxiety and stress for Mr SU at this time. His care co-ordinator told the Independent Investigation Team that she could not explain why there was no contact for three weeks and that she was surprised by this. She told the Independent Investigation Team that she was confident that he would have been offered telephone support, but that after the passage of time she could not be more specific.

Mr SU's next contact with the community mental health team was for his scheduled CPA review on 12 April 2007. As has already been set out in this report, this meeting followed his attendance at A&E for an overdose earlier that day.

Although it was subsequently decided that Mr SU was not in crisis and there was not sufficient cause for the home treatment team to take over his management, his ongoing care plan was restated and included:

- continuing antidepressant therapy;
- ongoing support from his care co-ordinator;
- consideration of further psychotherapy;
- ongoing practical help with debt management;
- continuation on enhanced level CPA; and
- review by the community mental health team staff-grade doctor in one week (19 April).

Although the Independent Investigation Team found the formal care plan documents lacking in comprehensiveness, the community mental health team progress notes did not support that impression. They were generally well recorded and evidenced that the care co-ordinator and her colleagues, particularly the student social worker, had been appropriately attentive to Mr SU and had implemented practical strategies to address his concerns. Examples are the letters written to debt collection agencies, an intervention to assist with council tax arrears, supporting Mr SU's application for gym membership, and consideration of day hospital referral (which was not something Mr SU took up).

Furthermore, the notes evidenced that the care co-ordinator and her colleagues were attentive to medication issues and the need, firstly, to monitor Mr SU's continuing compliance with his antidepressant therapy and, secondly, to encourage him where possible to take the advice of the medical staff about the potential usefulness of a mood stabiliser. Discussion around medication, and Mr SU's persistent reluctance to comply with the prescribed dose of antidepressant medication and refusal of other medication, was clearly documented on the following occasions:

- 20-21 March 2006;

- 1 January 2007;
- 14 February 2007;
- 20 February 2007;
- 20 March 2007; and
- 12 April 2007.

Overall conclusion of the Independent Investigation Team in relation to care plans and community mental health team care

As stated above, the care plan and risk assessment documentation was not as robust as it could or should have been. The completed documents did not evidence a robust exploration of identified issues for Mr SU, or detail a clear and coherent management strategy for him. They did, however, show that the mental health professionals planned to respond to issues and stressors as they arose.

However, the progress notes provided a different and more detailed picture of the actual care provided to Mr SU. On the basis of these, the Independent Investigation Team considered that, overall, the care provided to Mr SU was of a reasonable standard, with evidence that Mr SU was given time to talk freely during periods of distress, provided with general counselling, and more detailed assessments were undertaken and support provided from the home treatment team when required.

The Independent Investigation Team felt that the main disappointment in the care provided to Mr SU was the lack of engagement with the specialist head injury services offered by Headway. Although Mr SU did not himself pursue the placement opportunity Headway offered to him in September 2006, the Independent Investigation Team considered that the non-communication with Headway was a significant lapse in effective care co-ordination. It also considers that this lapse may have detracted from a more effective, dynamic and proactive care plan for Mr SU.

The Independent Investigation Team however recognise the difficulties of, and limitations in, the coherent and proactive delivery of care for Mr SU consequent to factors such as:

- his erratic engagement;
- his medication non-compliance; and
- his refusal of other offered treatment or supportive options, such as his non-response to the opportunity to engage with Headway when it finally arose in the last quarter of 2006 (see section 5.5 below).

5.5 DID THE COMMUNITY MENTAL HEALTH TEAM COMMUNICATE APPROPRIATELY WITH OTHER AGENCIES AND PROFESSIONALS TO ENABLE:

- A sufficient understanding of Mr SU's brain injury and diagnosis?
- An informed awareness of the ancillary support other agencies could offer and/or were offering Mr SU, and any limitations to this?
- Care co-ordination responsibilities to be fulfilled?

Effective communication with the range of professionals and agencies actively engaged in providing support to a service user is a core component of effective care co-ordination. Mr SU had received extensive input from the consultant psychiatrist in psychological therapies, who had referred him to Headway[10] on 3 March 2006. On 16 March Headway acknowledged receipt of the referral and advised that Mr SU had been placed on the waiting list for assessment and a potential placement at the East London Centre. There was no subsequent communication between Headway and the specialist mental health services. The onus for establishing and maintaining this communication was on the community mental health team as part of its role in delivering effective care coordination.
The lack of communication between the community mental health team staff with the consultant psychiatrist in psychological therapies and Headway was a missed opportunity in Mr SU's management. However the Independent Investigation Team does not believe that even proper exploration of these avenues of communication would have averted the incident that subsequently occurred.

5.5.1 Did the community mental health team staff have a sufficient understanding of Mr SU's brain injury and diagnosis, and could this have been improved by communication with other agencies?

The assessment report by the consultant psychiatrist in psychological therapies dated 24 December 2004 was clear and detailed. It should have provided other East London and the City Mental Health Trust staff with a good understanding of the MHSU's injury and diagnosis, namely that Mr SU suffered from an Organic Bipolar disorder and an Organic Personality disorder secondary to an acquired brain injury. In addition the consultant in psychological therapies' correspondence to Mr SU's care coordinator of 8 September 2006, and his email to the community mental health team leader of 29 September underlined his concerns and Mr SU needs.

[10] Headway – the brain injury association – is a company and Registered Charity whose stated mission is to promote understanding of all aspects of brain injury and to provide information, support and services to people with a brain injury, their families and carers: www.headway.org.uk.

This email stated:
"You will be familiar with Mr SU's care, he has an organic bipolar disorder secondary to a head injury that caused extensive frontal lobe damage. He still has irritability and impulsiveness. He occasionally overspends and then becomes dsyphoric as a consequence of this. He is reluctant to take medication. He has episodes of dysphoria and between times minimises his difficulties. In his last contact with his employment coach he communicated a high degree of despair and intense suicide ideation."

The consultant in psychological therapies went on to say:
"I don't think this man's difficulties are going to go away, and given the intermittent risk, the complexity of his needs (head injury rehab, employment rehab, mental illness, financial difficulties, organic personality difficulties) I really think it would be safer all round if he were allocated to a case manager who could coordinate this and integrate his care with a more comprehensive risk management plan."

The information provided was quite specific and straight forward. It is the contention of the Independent Investigation Team that the community mental health team could not but understand the range of needs for Mr SU.

On 13 February 2007 Mr SU self-presented to the community mental health team in distress (see above under 5.4.2.1). He was seen by the team manager as his care co-ordinator was not at work. In addition to sending e-mails to deal with Mr SU's immediate problems with non-payment of council tax, the team manager is noted in the clinical record to have phoned the consultant psychiatrist in psychological therapies. It was also noted that he was not available to speak to her. There was no record of any further attempt of the community mental health team trying to communicate with the department of psychological therapies. However, part of the plan formulated for Mr SU at this assessment included re-referral for cognitive behavioural therapy once the crisis situation had been successfully managed. The consultant in psychological therapies told the Independent Investigation Team that he was never, at any time, aware of any attempt by Mr SU's community mental health team to make contact with him.

Except for the above, there is no evidence that Mr SU's care co-ordinator, or any other of the community mental health team staff occasionally involved in his care, communicated or tried to communicate directly with the consultant psychiatrist in psychological therapies at any time. The Independent Investigation Team finds this disappointing, especially in view of the team manager's comment that *"*[*the consultant psychiatrist*] *was the best person to care for* [*Mr SU*] *because he had experience in neuropsychiatry and psychotherapy. He could have given us more advice."* The team manager also suggested that the consultant psychiatrist in psychological therapies could have continued to provide a component of care with the community mental health team acting as care co-ordinator, and provided more support *"by not closing* [*Mr SU*] *from his care on acceptance from community mental health team."*

The Independent Investigation Team is of the view that, if the community mental health team staff felt insufficiently informed or believed the consultant psychiatrist in psychological therapies could have usefully contributed to Mr SU's continuing care and management, it was open to (and indeed incumbent on) them to contact him to discuss the matter with a view to agreeing a mutually workable care delivery plan. The consultant psychiatrist in psychological therapies indicated to the Independent Investigation Team that *"had the community mental health team said to him that they did not feel they had the skills necessary to manage* [*Mr SU*] *he would have been willing to continue to see him in conjunction with continuing community mental health team care."*

The Independent Investigation Team is also of the opinion that Mr SU's care co-ordinator, student social worker, or community mental health team manager could have undertaken a simple internet search to better inform themselves about the impact frontal lobe damage has on an individual's behaviour. To have conducted such research may have resulted in a better appreciation of the impact Mr SU's injury had on his ability to make informed and rational choices about his life.

Wikipedia[11] says that:
"The executive functions of the frontal lobes involve the ability to recognize future consequences resulting from current actions, to choose between good and bad actions (or better and best), override and suppress unacceptable social responses, and determine similarities and differences between things or events. Therefore, it is involved in higher mental functions.

The frontal lobes also play an important part in retaining longer term memories which are not task-based. These are often memories associated with emotions derived from input from the brain's limbic system. The frontal lobe modifies those emotions to generally fit socially acceptable norms."

This snippet of information alone would have alerted the mental health professionals against making judgements regarding Mr SU's apparent choices and lifestyle behaviours.

However, the above being said, the Independent Investigation Team considers that even had the community mental health team staff made contact with the consultant psychiatrist in psychological therapies, and undertaken some additional research into the role of the frontal lobe, and the range of impact following damage to it, the substance of Mr SU's care and treatment would not have changed in a material way. The factor that may have changed was the efforts made by the community mental health team to engage with Mr SU's mother as a knowledgeable person about her son's behaviour. This, however, would have required the consent of Mr SU, which was expressly withheld.

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[11] http://en.wikipedia.org/wiki/Frontal_lobe

5.5.2 Did the community mental health team have an informed awareness of the ancillary support offered by other agencies?

As mentioned in the previous section, there is no evidence of any follow through by Mr SU's care co-ordinator, or other community mental health team staff, regarding the referrals made to other agencies by the consultant psychiatrist in psychological therapies, in particular the referral to Headway.[12] There was also no evidence of attempts to contact Rehab UK[13] or the other agencies Mr SU had been encouraged to contact on his own behalf at various times during the course of his management by psychological therapies.

The Independent Investigation Team asked Mr SU's care co-ordinator why no contact was made with other agencies. She told the Independent Investigation Team that she was aware of the referral made to Headway, and that her impression from speaking with Mr SU was that he was ambivalent about what the service could offer him, as it was his belief that it had not helped before. Because Mr SU indicated that he would not be taking up a service from Headway, she did not make contact with them. This professional now recognises that to have contacted Headway would have been prudent, even if the only benefit would have been to provide an avenue for her to be more informed about acquired brain injury.

The team manager and service manager for the community mental health team told the Independent Investigation Team that they believed that agencies such as Headway and the then Rehab UK were better placed than the community mental health team to provide appropriate care and support for patients with acquired brain injury and its associated problems. However, the team manager did not promote proactive communication with these agencies when Mr SU was in receipt of care and treatment. She would do so now.

To the Independent Investigation Team it seems logical that priority should have been given to contacting such agencies to:

- determine what input they could have offered;
- establish if they were already providing a service to Mr SU, and if not why; and
- seek specific advice about acquired brain injury and particular issues to be aware of in managing Mr SU.

It is confident that those professionals involved in the care and treatment of Mr SU would do so today.

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[12] Headway – the brain injury association -- is a company and Registered Charity whose stated mission is to promote understanding of all aspects of brain injury and to provide information, support and services to people with a brain injury, their families and carers: www.headway.org.uk.

[13] The Independent Investigation Team was unable to locate any contemporary information about Rehab UK. It can only surmise that it was a head injury organisation that previously existed but that this is no longer the case.

On request, Headway East London (Headway) provided the Independent Investigation Team with a copy file for Mr SU which evidenced the following chronology:

3 March 2006: Referral of Mr SU to Headway.

16 March 2006: Mr SU was placed on the waiting list for assessment and potential placement at the East London Headway Centre. Headway wrote to the referring consultant psychiatrist in psychological therapies, Mr SU and his mother, enclosing for his mother information about the local Carer's Network and advising that she had been added to the Headway carers' support group mailing list.

25 September 2006: Mr SU was assessed by Headway, the outcome of which was approval for an initial six-month placement.

18 December 2006: Headway closed Mr SU's case because of his non-engagement. The Headway *"Final Outcome of Referrals"* form documented that Headway had made a number of unsuccessful attempts to contact Mr SU over a period of weeks. The form also records that messages had been left with Mr SU's mother, who had told Headway that she had passed their number on to Mr SU. Although the decision was made to close the file, it was still open to Mr SU to contact Headway in the future should he be in need of help.

The Independent Investigation Team also wrote to Rehab UK at its last known address. However, the (signed for) letter was returned to the office of Consequence UK Ltd, with a note that the organisation had 'gone away'. The Independent Investigation Team was unable therefore to pursue this line of enquiry.

Summary Opinion

The Independent Investigation Team considered that Mr SU's care co-ordinator should have made contact with the other agencies believed to be, or even actually, engaged with Mr SU. To have done so was an integral part of an effective care co-ordinator's role as outlined in the then East London and the City Mental Health Trust policy (see below). Given the widely expressed concern about the lack of experience in supporting service users with acquired brain injury-related problems, it is also something the Independent Investigation Team would have expected to have received attention in the care co-ordinator's management supervision sessions. It recognises, however, that Mr SU's care co-ordinator did not feel that she lacked any of the necessary skills to effectively care co-ordinate for him.

5.5.4 The impact of the non-communication on the fulfilment of care co-ordination responsibilities

The Independent Investigation Team viewed the community mental health team's non-engagement with Headway as a significant missed opportunity for Mr SU. It is of the view that it was the responsibility of the care co-ordinator to follow up the psychological therapies referral and establish what additional care and support might have been available to him. This task was and remains fundamental to the care co-ordinator role. Indeed, the then East London and the City Mental Health Trust's *"The Key Essentials of the Care Co-ordinator Role*, *Appendix 1 to Mental NHS Trust Operational Policy for Community Mental Health Teams"* (Draft September 2005, revised and amended April 2006 and June 2006) says that the care co-ordinator is to: "*Formulate, Update and Monitor the implementation of the CPA Care Plan and liaise with other agencies as appropriate to ensure that user's needs are met…"* (point 10, p 15). Along the same lines, the then East London and the City Mental Health Trust's *"Revised Care Programme Approach Policy (January 2006)"* lists as a key essential of the care co-ordinator's role (under 12.7, p 19):
"Providing a link with services for the service user and carers and providing support in the community."

Had the care co-ordinator followed up with Headway, she may have become aware, firstly, that Mr SU had not responded to Headway's six-month placement offer, and, secondly, that the opportunity to contact them for support remained open. It was beyond the care co-ordinator's power to insist that Mr SU engage with Headway. However, she was well positioned to encourage him and explain that Headway was an organisation specifically set up to assist with the very issues with which he needed support and assistance, namely:

- debt management;
- relationship management; and
- someone to talk to about his problems.

In addition, it is expected practice, subject to permission from Mr SU, to invite other agencies involved in the user's care and treatment to any scheduled CPA meetings, in this case on 5 December 2006 and 12 April 2007.

The Independent Investigation Team acknowledge the proposition of the consultant psychiatrist in psychological therapies that Mr SU also had an obligation to pursue some of the resources he was being offered. However, this does not detract from lapse in practice in respect of the lack of contact initiated by the care co-ordinator with Headway. In March 2006 Mr SU had authorised the community mental health team to communicate with and share information on an "as needs" basis. Although good practice required reaffirmation of this consent in October 2006, there is nothing in Mr SU's records to suggest that he had withdrawn his earlier consent.

5.6 WAS THERE APPROPRIATE COMMUNICATION WITH MR SU's MOTHER?

The Independent Investigation Team concluded that, although aware that Mr SU's mother was his principal support, the community mental health team did not make the required efforts either to engage her as a potential collaborator in her son's management or to address her needs as his main carer.

Communication with Mr SU's mother was early accorded a high priority by the consultant psychiatrist in psychological therapies and seems to have been unproblematic while Mr SU was under the care of psychological therapies.

However, there is no documentation before the Independent Investigation Team to indicate that Mr SU's mother was invited to be involved in the CPA process after he was allocated for community mental health team care. Specifically, Mr SU's mother was not listed as a potential invitee in documents prepared for CPA meetings scheduled for 5 December 2006 and 12 April 2007. It became clear to the Independent Investigation Team, after its meeting with Mr SU's care co-ordinator, that he did not want his mother involved in his care package out of consideration and concern for her. A better understanding of the role of Mr SU's mother in his life may have resulted in the community mental health team having more detailed discussions with Mr SU about this and the potential benefits of including her in key clinical events such as the CPA review.

The Carer's Assessment

The East London and the City Mental Health Trust operational policy for community mental health teams in place at the time Mr SU was receiving care says (page 9):

"With the service user's permission, family and carers will also be given information. If permission is not given, and the information relates to safety of other individuals, a case discussion will be held and the Consultant / community mental health team manager will take the decision re. information sharing on a need to know basis.

12.3. A carer's assessment will be offered to carers of service users on enhanced CPA and where the input from a carer is significant; this will be added onto the database."

With respect to a carer's assessment for Mr SU's mother, the *Full Needs and Assessment* form dated 21 March 2006 (i.e. at the time of Mr SU's first referral to the community mental health team) noted that a comprehensive carer's assessment was required and then noted that Mr SU's mother, who attended this appointment, did not agree to one.

On 4 March 2007 the *Referral and Needs Assessment* form completed noted that Mr SU *"*[*did*] *not think there* [*was*] *a need for a carer's assessment"* and concluded (in the absence of and apparently without other communication with Mr SU's mother) that a detailed assessment was not required. This was and remains unacceptable.

In addition to the operational policy cited above, the policy in *"The Key Essentials of the Care Co-ordinator Role"* (Appendix 1 to the "*Operational Policy for Community Mental Health Teams"* (Draft September 2005, revised and amended April 2006 and June 2006), pp 14 -16, in particular points 12, 13, 17, 24) stipulates the importance of working towards carer engagement and support as follows:
"12. Identify carers who provide regular and substantive care for a person on CPA and offer to undertake a carer's assessment and record in the care record;
13. When a significant carer or family member is going away … the crisis and contact form should reflect this and all agencies be informed;
17. Share information about the care plan and the contingency and crisis plan with the service user and carer and other services; and
24. Provide a link with services for the service user and carers. …"

This was endorsed without contradiction by interviewees and also in the written information provided by a community psychiatric nurse with no connection to the care and management of Mr SU, or the team responsible for his care and treatment.

The community mental health team leader in her interview emphasised that Mr SU's mother was recognised as *"very, very supportive"* for him, and that her opinion, including about medication, was influential for him. The team leader also said that carer support was recognised as important and carer assessments were encouraged and monitored. However, she was not able to explain the minimal involvement of Mr SU's mother in his community mental health team management.

When the Independent Investigation Team met with Mr SU's mother, it was clear that she felt marginalised by the community mental health team, especially at the time of first referral in March 2006. She felt that there was no place for her voice, her information to be heard. She believed then, and still believes now, that she was very well placed to ensure that the community mental health team had the most comprehensive understanding of her son.

When the Independent Investigation Team met with Mr SU, he confirmed that his mother was central to his support network. However, he also confirmed that he did not want her overly involved in his care because of all the stress he perceived he had caused in previous years. Nevertheless, his mother was a central support person to him.

When the Independent Investigation Team asked Mr SU's care co-ordinator about the lapse with regards to offering a carer's assessment to his mother, she told the Independent Investigation Team that at the time she considered it appropriate not to do so because of Mr SU's wishes. However, with the benefit of hindsight, she now appreciated that Mr SU's mother had a right to an assessment, regardless of her son's perspective. This being said, she did highlight the potential conflict this could cause to the therapeutic relationship with a service user. Although it may not have been the case with Mr SU,

where a service user asks a care co-ordinator not to be in contact with family members, then to do so can breach the trust-based relationship with a service user and lead to disengagement. How the needs of close family members/carers are met therefore in such circumstances does require careful consideration. The Independent Investigation Team agrees with this.

Conclusion to section 5.6

To conclude, the Independent Investigation Team are of the view that Mr SU's care co-ordinator should have made efforts to contact and work with his mother, or to have arranged for a colleague to do so. Engagement of Mr SU's mother might have provided an opportunity for education and discussion around the recommended medication for her son, and how this might benefit him. Mr SU's mother may also have been an effective ally in her son's care had the team been able to address her concerns about mental health medication. In addition to the potential benefit for the community mental health team from the relationship, the care co-ordinator had a responsibility to ensure that Mr SU's mother received all support potentially available to her if she met the local authority's carer's criteria. It is good practice for a locally delivered carer's assessment to be offered on an annual basis.

5.7 WAS THE INCIDENT PREDICTABLE ON THE BASIS OF INFORMATION KNOWN, OR THAT SHOULD REASONABLY HAVE BEEN KNOWN, BY THE MENTAL HEALTH SERVICES AT THE TIME?

The Independent Investigation Team concluded that there was no information available to the mental health services that indicated that Mr SU presented an above-normal risk to other persons.

Although Mr SU clearly displayed some degree of impulsivity and disinhibition (most probably head injury related) and had a possible diagnosis of organic bipolar disorder, which might have exacerbated those traits from time to time, he had no history of significant aggression or violence towards others.

As detailed earlier in this report, the risk assessments undertaken identified that, in his teenage years, Mr SU was apt to get into trouble from time to time, demonstrated by an incident with a milk float that resulted in property damage and his admission of mixing with the wrong crowd and having an association with guns and knives. However, there was nothing to suggest that these behaviours were a feature of his adult life or that in his teenage years he had ever threatened harm to others.

Mr SU's risk-related behaviours in adulthood and for several years following his acquired brain injury manifested themselves in driving fast, spending more money than he had at his disposal, and engaging in complicated relationships with women. He also expressed thoughts of suicide from time to time, took at least one overdose in 2007, but made no serious attempt on his life and said that he would not do so.

The staff he came in contact with all found Mr SU to be charming and polite, and there was no information available to mental health services to suggest that Mr SU had the capacity or capability for his act of violence in April 2007. The consultant psychiatrist in psychological therapies was noted to have formed the impression that Mr SU viewed the various relationships he had with women as a positive feature in his life. Furthermore, he noted that Mr SU *"appeared to show an appropriate empathic and caring attitude to others".*

It is therefore the strongly held opinion of the Independent Investigation Team that the information available to mental health services prior to the incident evidenced that the major risk to Mr SU was one of self-harm. There were no indicators at any stage of his management that he presented an above-normal risk to other persons.

5.8 WAS THE INCIDENT PREVENTABLE BY DIFFERENT ACTIONS/ CARE/TREATMENT BY MENTAL HEALTH SERVICES, ON THE BASIS OF WHAT WAS KNOWN OR SHOULD REASONABLY HAVE BEEN KNOWN BY THEM AT THE TIME?

The care provided to Mr SU could have been better in a number of respects. However, on the available evidence the Independent Investigation Team concluded that, even if it had been optimal, the incident was of such an unexpected nature that, on the balance of probabilities, it was not preventable by any act that could reasonably have been undertaken by mental health services.

The Independent Investigation Team considers that the only missed opportunity that might have impacted on the events of 19 April 2007 was the acceptance of a mood stabiliser by Mr SU. However, this consideration is speculative and cannot be made with any degree of certainty at all.

Mood stabilisation drug therapy was first recommended to Mr SU by the consultant psychiatrist in psychological therapies and subsequently by the community mental health team staff-grade doctor on two occasions in 2007.

Mr SU initially refused all medication recommended to him by the consultant psychiatrist in psychological therapies. However, from February 2006 he took the antidepressant medication Reboxetine, albeit often at half the recommended dose. He consistently refused treatment with mood stabilising medication, as was his right.

Mr SU's mother asked if her son should have been detained in hospital following his overdose on 11/12 April 2007. There is no evidence before the Independent Investigation Team to contradict the conclusion of the community mental health team staff-grade doctor that on 12 April 2007 Mr SU was not sufficiently unwell or thought disordered to meet the criteria for a Mental Health Act Assessment. The staff-grade doctor was sufficiently experienced to make this clinical judgement. That Mr SU remained distressed after 12 April would not in itself have been sufficient cause to have conducted a Mental Health Act Assessment.

With regards to aspects of care that could have been better for Mr SU, these were:

- initiation of contact and potential engagement with Headway;
- relationship building with his mother, including in relation to medication issues;
- more frequent contact with him between 21 March and 12 April 2007; and
- more detailed documentation of the exploration of the circumstances of his past risky behaviours when young.

The Independent Investigation Team does not believe that improvement in these aspects would in themselves have altered the course of events.

6.0 ACTIONS TAKEN BY EAST LONDON NHS FOUNDATION TRUST FOLLOWING ITS OWN RECOMMENDATIONS IN MARCH 2008

Following the incident involving the Service User, East London NHS Foundation Trust undertook its own internal investigation to identify what lessons it could learn and make recommendations for improving its internal systems and processes. The following recommendations were made as a consequence of the internal investigation:

1. "That thought be given to how care and treatment can be provided for this group of patients with head injury whose complex needs cannot be met by a community mental health team."
2. "That there should be greater clarity of the roles and responsibilities of the Consultant Psychiatrist and Team Manager to avoid issues of confusion of roles."
3. "That clinical teams be provided with some support in exploring issues and difficulties within the team. In some cases this may mean using external facilitators."
4. "That all activities of professionals are recorded in one integrated database to allow shared responsibilities for difficult to engage patients."
5. "That processes are in place to ensure and provide evidence of the supervision of junior medical staff, particularly those of non-training grade."
6. "That in cases of multi-professional and multi-agency involvement in the care of service users, all significant individuals in the provision of care from the various services be involved in the CPA, when appropriate."
7. "That in complex and difficult cases such as this, where there are inherent issues of risk by virtue of aetiological factors and presentation, an opinion from the forensic service on risk management would be helpful."

The Trust was able to provide the Independent Investigation Team with a document that showed that all of the above recommendations had, in some way, been addressed. However, it was not able to provide information that evidenced that the Trust had tested the benefit achieved for practice, quality or safety, as a consequence of addressing the recommendations.

In addition to the above recommendations, there have been since 2008 considerable changes in the now East London Foundation NHS Trust and in particular the operation of community mental health teams following a Community Service Review, commissioned by the current Chief Executive.

The team leader for Mr SU's community mental health team told the Independent Investigation Team that:

"We currently have permanent consultants who offer continuity of care and clinical leadership in the community mental health teams. Each consultant has their own sub-team with service users aligned to the GPs. Within the sub-team you have a senior practitioner/lead nurse, two social workers, two

community psychiatric nurses. Other disciplines work across the two sub-teams.

The consultants now have three sessions in the team, one of which is used for a weekly sub-team meeting to discuss all service users under their care, including complex caseloads. A traffic light system has been introduced to grade the risks for service users identified as having complex needs, in crisis or who at any time require further support.

We liaise with other agencies, inviting them to professional meetings, to explore/discuss how to manage each case effectively. We have disbanded the whole team approach of allocation meetings and, in place, we have the Access and Assessment Team (AAT), with only seniors carrying out or taking the lead on assessments.

Assessments are presented, fully documented and clinical details are minuted. All assessments are completed within 28 days and, if appropriate, either care co-ordinated or referred on to the service who would be more appropriate to offer a service.

The Psychological Therapies Services are now integrated into the community mental health teams to offer a seamless transfer of care and to offer specialist treatment; group work, psychotherapy."

This information was independently validated by the Locality Manager and the consultant psychiatrist in psychological therapies.

It was very clear to the Independent Investigation Team that the changes that have occurred are welcomed in the Trust, as is the decision to appoint a consultant psychiatrist as the clinical lead in the community mental health teams.

With regards to the development of its internal policies and procedures, during this investigation the Independent Investigation Team worked with a number of policy documents that were noted as remaining 'in draft'. This did not represent best practice in document management or healthcare governance. The Trust now has a "Policy for the Development of Procedures" which addresses the requirements for good practice in policy and procedure development. The Trust's approach has been successfully assessed against the National Health Service's Litigation Authorities Level 2 standards. The East London Foundation Trust informed the Independent Investigation Team that to date the Trust's guidance document has been restricted to Trust-wide policies, but that it is now being revised to include directorate operational policies. This will include having a central store/archive of operational policies and monitoring the need for reviews. The monitoring of compliance with this will take place via the Trust's Policy Committee.
From the Independent Investigation Team's perspective the changes that have already been implemented have in many ways addressed recommendations it would otherwise have made.

7.0 CONCLUSIONS

The incident in which Mr SU was involved was tragic and its impact has been enormous for all concerned. The Independent Investigation Team's conclusions are based on an objective and detailed analysis of Mr SU's care and treatment in the then East London and the City Mental Health Trust in the 28 months preceding the incident, with consideration of the previous medical history in relation to his traumatic brain injury with frontal lobe damage in 1998 and his subsequent period of rehabilitation.

With regard to the question "Was it predictable that Mr SU would show physical violence towards another person, including his girlfriend?", the Independent Investigation Team has concluded that it was not predictable. There was no previous history of aggression or violence towards others. All the evidence supported the clinical assessments that Mr SU was at risk of harming himself rather than others.

With regard to the question "Was the death of the victim preventable by virtue of different mental health care and treatment?", the Independent Investigation Team has concluded that the incident was, on the balance of probabilities, not preventable. The only caveat to this conclusion is whether mood stabilising medication might have altered the course of events, had Mr SU agreed to take it as repeatedly recommended. Even with the benefit of hindsight, however, it is not possible to know whether that would or would not have made any difference to the outcome.

The Independent Investigation Team did identify aspects of Mr SU's care and treatment that could have been better. However, there are no grounds to suggest that, even had they been optimal, the incident would not have happened.

With regard to the specific terms of reference, these have been addressed in section 3 of this report and throughout the findings section of this report (section 5). To summarise:

- The Trust's own investigation report did not evidence a quality of investigation sufficient to meet the standard required for this seriousness of incident.
- For the most part there was an acceptable level of compliance with core policies and procedures (for example, the CPA policy and risk assessment policy) in terms of frequency of contact, treatment recommendations and performance of risk assessments.
- There was insufficient compliance with local and national policy expectations in relation to the involvement of carers and the offer of a carer's assessment for the period after January 2007.
- There was insufficient attention given to the requirement to work effectively with other agencies, which may usefully have been, or were actually involved in, Mr SU's care.

The Independent Investigation Team noted that, in the aftermath of the incident, some community mental health team staff considered themselves insufficiently skilled in the area of acquired brain injury to have been able to provide adequate care and treatment to Mr SU. The Independent Investigation Team disagrees with this. The Independent Investigation Team considers that the community mental health team was ideally placed to provide the effective care co-ordination service Mr SU required.

The Independent Investigation team considers that the community mental health team did provide a caring and compassionate service to Mr SU. However, the quality of this service would have been enhanced by appropriate initiatives to access specialist expertise and advice in relation to persons with acquired brain injury, which were readily available within the Trust's own psychological therapies service and from specialist brain injury rehabilitation organisations in the local community.

8.0 RECOMMENDATIONS

The recommendations that the Independent Investigation Team would have made following its analysis of the care and treatment provided to Mr SU have been largely implemented as a consequence of the Trust's own community services review. This resulted in the complete reorganisation of community mental health teams, their operation and clinical leadership. The present picture is not at all as it was between 2005 and 2007.

Consequently, the Independent Investigation Team only has six largely practical recommendations:

Recommendation 1: Audit of CPA documents
Effective care co-ordination depends on effective communication with all agencies engaged with a mental health service user. This did not happen in this case. The limitations of the independent investigation mean that the Independent Investigation Team does not know if the lapse that occurred in this case was an isolated occurrence or if there is a culture of non-communication with other teams, services and agencies. It is incumbent on East London Foundation Trust to determine whether or not its staff reliably communicates with involved third parties in the delivery of effective care and treatment to its service users.

Consequently, the Independent Investigation Team recommends that, within the context of existing activities, namely:

- management supervision;
- CPA audit; and
- record-keeping audit,

East London Foundation Trust determines:

- Whether it is possible from the existing design of its documentation tools to identify those service users engaged with other services and agencies; and
- Whether the records evidence:
  - Consent reliably being sought from service users to engage with third party services/agencies;
  - Direct communication from the community mental health team to identified third party services/agencies;
  - Invitation of third parties/agencies to CPA reviews.
  - Appropriate exception reporting, i.e. if no communication where third party service/agencies are involved, why this decision has been made.

If it is possible with the current design of documentation to assess the above, then East London Foundation Trust must ensure that evidence of appropriate communication with relevant third parties involved in a service user's care and treatment is included in contemporary activities such as:

- CPA audit;
- Record-keeping audit;
- Peer review; and
- Management supervision.

Evidence of such audit will need to be provided to the relevant commissioners of its services.

If it is not possible to assess the above activities on the basis of the current design of documentation tool(s), the Independent Investigation Team recommends that the Trust considers amending the documentation tools at the time of next review to enable the assessment of the above, or alternatively devising another method of conducting the audit.

Target audience: The Medical and Nursing Directors, the Director of Governance and Locality Managers.

Timescale: The Independent Investigation Team suggests that East London Foundation Trust make provision for addressing the above in line with its existing audit timetable.
All community mental health team leaders should be directed to raise the issue on a periodic basis during clinical team meetings and to address the same issue during management supervision as a form of local self-assessment. The provision (by the Trust) of a common, but simple, audit tool for managers may assist this process.

Recommendation 2
The minutes of the community mental health team weekly clinical team meetings were uninformative, consisting only of a list of service users discussed/for discussion. Consequently, the Independent Investigation Team recommends that it would be prudent to develop a minute template that enables accurate and appropriately detailed minutes to be taken of the weekly clinical team meeting. The advantages of doing so are that:

- All services providing the 'same service' are working to a common set of standards;
- It is easier for these important documents to be audited when required;
- When staff move from team to team, the core systems and processes that are not 'service dependent' are uniform.

Suggested headings for a 'minutes template' are:

- Persons present and designations;
- Business matters;
- Case discussions:
  - Patient ID and traffic light rating;
  - Assigned care co-ordinator;
  - Key features presented;
  - Key decisions made and/or advice given;
  - Date for review.

Target audience: The Director of Governance and the Director of Operations at East London Foundation Trust.

Timescale: This is a simple, practical recommendation that should be readily addressed and implemented not later than three months after the publication of this report. If East London Foundation Trust decides not to implement this recommendation, it must provide a reasoned rationale for this to its commissioners.

Recommendation 3

In this case the quality of medical record-keeping by community mental health team medical staff was not of an acceptable standard. There was an over-reliance on the care co-ordinator to make accurate records of assessments conducted by medical staff.

In this case the staff-grade doctor did not consider that the service user's presentation in April 2007 was such that an assessment under the Mental Health Act (1983) was required. However, there was no evidence in the clinical records of the medical assessment on the basis of which this decision was made. This was not acceptable.

The Independent Investigation Team recognises that the approach to, and philosophy of, care and treatment within the community mental health teams within East London Foundation Trust has altered significantly since 2007. However, it recommends that the Trust provides assurance to its commissioners about the current record-keeping standards required of medical staff and provides evidence of how those standards are currently audited in relation to:

- The making of records by doctors following contacts with and assessments of service users;
- The quality of the records; for example, consistent methodology for recording a mental state examination and to a sufficient level of detail.

Note: The Independent Investigation Team is aware that East London Foundation Trust has a detailed records audit tool of a quantitative nature. However, this tool does not necessarily assess the quality of record-keeping, or differentiate between the standards required of medical staff and non-medical staff.

Target audience: The Medical Director and Clinical Leads.

Timescale: It should be possible to incorporate this recommendation into the standardised approach the Trust takes to records audit and peer review, including for medical staff. On this basis, East London Foundation Trust should be able to incorporate this recommendation into its next timetabled notes audit. The Trust's supervision framework for medical staff should also provide opportunity for the ongoing assessment of the quality of medical record-keeping.

The time period for the audit of medical record keeping quality should be notified to the Trust's commissioners at the action planning meeting prior to publication of this report.

Recommendation 4
It was clear to the Independent Investigation Team that the care co-ordinator to Mr SU, whose care and treatment was the subject of this investigation, does appreciate the importance of offering carers a Carer's Assessment. The commitment to the provision of a Carer's Assessment was endorsed by the then, and current, community mental health team leader. However, in this case the mother of Mr SU was not offered such an assessment because of a perceived conflict of interest for the care co-ordinator.

The Independent Investigation Team considers that East London Foundation Trust must assure the commissioner of their services that:

- Carers' Assessments are offered to all carers and family members who are providing support to a Service User, regardless of whether the service user wants their care co-ordinator to be in communication with the care/family member or not.
- That the Trust has a system in place to enable a Carer's Assessment to be offered in circumstances where there is a conflict of interests that would prevent a Service User's care co-ordinator from doing so; for example, a threat to the therapeutic relationship between care co-ordinator and service user.
- That where a Carer's Assessment is identified as being required and is subsequently not provided then the reason(s) for the non-provision are clearly documented, aiming for a 100% documentation rate.

Target audience: The Director of Nursing and Service/Operational Managers.

Timescale: The audit component of this recommendation can be absorbed into the Trust's existing audit framework and timetable.

The issue of how the conduct of a 'local' Carer's Assessment is progressed, where it is not appropriate for the care co-ordinator to do so, needs to be determined within the Trust. The process agreed will need to be reflected in relevant Trust policy and also in Community Mental health Teams operational policies. Because the Independent Investigation Team recognises that this is a complex issue it recommends that the Trust agrees the timeframe and process within which this issue is to be addressed at the action planning meeting with its commissioners prior to the publication of this report.

Note: The Independent Investigation Team is referring to the assessment of a carer's needs as it can be delivered within mental health services, and not the more far-reaching assessment which is the responsibility of the local authority.

Recommendation 5
Although it was clear to the Independent Investigation Team that East London Foundation Trust has taken action on the recommendations it made following its own internal investigation into the care and treatment of Mr SU, whose care and treatment is subject to this independent investigation, the Trust was not able to provide any information showing that it had subsequently tested out the impact (or benefit) of the actions taken with regards to practice, quality or safety improvement.

It is therefore a recommendation of the Independent Investigation Team that East London Foundation NHS Trust devises a process by which it can reliably test the impact of all recommendations made following its internal investigation of its categorised serious untoward incidents, and the impact of implementing the recommendations made following independent investigations such as this one.

The Independent Investigation Team suggests that for all such action plans devised the Trust's serious incident committee does not sign these off unless the action plan identifies:

- How the impact of implementation is to be measured;
- The timetable for 'post implementation' audit in the short, medium and, where appropriate, the long term.

It is essential that the Trust is aware of actions taken that do not result in the desired level of improvements in practice, quality and safety and that it does not assume that this has been achieved.

Target audience: The Medical Director, Director of Nursing and Director of Operations.

Timescale: The principles of this recommendation need to be implemented with immediate effect.

Recommendation 6
The analysis of the Trust's own investigation did not reveal information consistent with an effective investigation process, or one that evidenced knowledge and competency in information analysis or root cause analysis.

Consequently, it is important that East London Foundation Trust:

- Identify lead investigators for its serious untoward incident investigations who:
  - Understand what constitutes an effective investigation.
  - Have the skills to take comprehensive interview records, or are supported by administration staff competent to do so.
  - Know how to formulate 'care management concerns' and/or critical questions.

- Know how to conduct a repeatable information analysis using the evidence gathered during the investigation process. Content analysis with affinity mapping would be one such approach.
- Understand how to differentiate between the contributory factors to a specified problem and the most significant factors, otherwise referred to as root causes.
- Understand that, for complex investigations following incidents such as homicide and suicides where the service user remained under the direct care of the Trust, applying a contributory factors framework 'to the incident' rather than to the specifically identified problems in the case management is not the correct application of process.
- Have an understanding of the fail-safe attributes of improvement measures and know how to write S.M.A.R.T. (specific, measurable, achievable, realistic and timely) recommendations.

In addition to the above, it is recommended that the committee quality assuring the Trust's serious untoward incident investigations also have a good understanding of the above.

Target Audience: The Director of Nursing and Quality Assurance and the Associate Director of Governance.

Timescales: All Trust's should have a register of individuals who are competent in the above. However, it is recognised that achieving this has proved challenging for Trusts. The Independent Investigation Team considers that, within 18 months of the publication of this report, East London Foundation Trust must be able to evidence to its commissioners that it can consistently deliver serious untoward investigation reports that evidence the above.

APPENDIX 1: INVESTIGATION METHODOLOGY

The investigation methodology was structured and embraced the key phases detailed in the National Patient Safety Agency's root cause analysis e-learning toolkit. Key activities were:

- Critical appraisal of Mr SU's clinical records and the identification of areas that the Independent Investigation Team needed to understand better.
- Document analysis – pre-existing interview data, relevant policies and procedures, supervision records.
- Face-to-face and telephone interviews and discussions with staff working in East London NHS Foundation Trust.
- Obtaining written information relating to independent support agencies in the community.
- Obtaining written information from the relevant A&E department.

The investigation tools utilised were:

- Structured timelining.
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping.
- Qualitative content analysis.

APPENDIX 2: SOURCES OF INFORMATION USED TO INFORM THE INVESTIGATION FINDINGS

The sources of information (copy documents, unless otherwise stated) used to inform the investigation findings were:

- Mr SU's mental health records;
- The original Internal Review Report dated 11 March 2008, commissioned by East London NHS Foundation Trust;
- The transcripts of interviews and written statements obtained for the purpose of the Internal Review Report;
- The Trust's relevant policies and procedures in operation at the time, notably:
  - Clinical Risk Assessment and Management Policy (April 2002, February 2006);
  - Current definitions for the CPA;
  - the Operational Policy for Community Mental Health Teams: (draft V - 18/08/97);
  - the Operational Policy for Community Mental Health Teams (draft – September 2005, revised and amended April and June 2006);
  - Key Essentials of the Care Co-ordinator Role, interpreting the document *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* (October 1999);
  - The Key Essentials of the Care Co-ordinator Role (reviewed 2008, but core document about care co-ordinator role in place in 2007);
  - The Directorate Management Team Structure; Management Supervision Guidelines (18/10/04);
  - East London and the City Mental Health NHS Trust Audit Tool for Record Keeping (version 5.2, undated);
  - Minutes of CPA Implementation Group meeting 11/10/06;
- Supervision records for Mr SU's care co-ordinator for 07/11/06 and 20/02/07. (Records for 25/07/06 and 17/01/07 were requested but not available);
- Supervision records for student social worker allocated to Mr SU;
- Record of the care co-ordinator's leave over period 10/06 to 04/07 and related e-mail correspondence;
- Records of community mental health team allocation meetings 13/03/06, 20/03/06, 27/03/06,03/04/06,10/04/06, 24/04/06,02/05/06, 08/05/06, 15/05/06, 29/08/06 and 04/09/06;
- Exchange of correspondence, agenda and minutes relating to Neuro interface meetings 23/10/06 and 24/01/07;

- Records from Headway East London;
- Correspondence from a local Citizens Advice Bureau.

The Independent Investigation Team conducted meetings with:

- Mr SU on 13 December 2010;
- Mr SU's mother on 13 December 2010 and 22 August 2011; and
- The management and clinical staff of East London NHS Foundation Trust on 27 October 2010.

The Independent Investigation Team conducted one-to-one interviews with and received detailed written responses from:

- The Community Mental Health Team Operational Team Manager (now and in 2007), on 4 March 2011;
- The Head of Operations, Specialist Community Teams; Team Locality Manager (2007), on 4 March 2011;
- The Associate Clinical Director, Assertive Outreach; previously a Consultant Psychiatrist, in Mr SU's community mental health team on 14 March 2011;
- The Consultant Psychiatrist in Psychotherapy, Specialist Psychotherapy Resource Unit (formerly Psychotherapy Services), on 14 March 2011;
- The Associate Specialist Psychiatrist and Senior Medical Officer, community mental health team - North East on 14 March 2011.

The Independent Investigation Team requested written information from the following:

- Mr SU's care co-ordinator;
- Headway East London;
- The Citizens Advice Bureau;
- Rehab UK;
- The Shaw Trust;[14]
- Day Opportunities Service, Continuing Care and Engagement Services; and
- A local Psychological Treatment Centre.

Because of the initial challenges associated with locating and engaging with Mr SU's care co-ordinator, the Independent Investigation Team also obtained detailed written information from a community psychiatric nurse currently engaged in community mental health team work within the Trust, who was working as a community psychiatric nurse at the time of the incident, but was not involved in the care and treatment of Mr SU. The purpose of seeking such information was to ensure that the Independent Investigation Team had a grounded understanding of the work of a community psychiatric nurse and

[14] The Shaw Trust is a national charity which supports disabled and disadvantaged people to prepare for work, find jobs and live more independently.

that its perspective about what was and was not reasonable in practice was evidence-based.

The Independent Investigation Team did succeed in meeting with Mr SU's care co-ordinator on 5 August 2011.

APPENDIX 3: GLOSSARY

Acquired Brain Injury (from Wikipedia, the free encyclopedia)
An acquired brain injury (ABI) is brain damage caused by events after birth, rather than as part of a genetic or congenital disorder such as fetal alcohol syndrome, perinatal illness or perinatal hypoxia. ABI can result in cognitive, physical, emotional, or behavioural impairments that lead to permanent or temporary changes in functioning. These impairments result from either traumatic brain injury (e.g. physical trauma due to accidents, assaults, neurosurgery, head injury etc.) or non-traumatic injury derived from either an internal or external source (e.g. stroke, brain tumours, infection, poisoning, hypoxia, ischemia, encephalopathy or substance abuse). ABI does not include damage to the brain resulting from neurodegenerative disorders.

While research has demonstrated that thinking and behaviour may be altered in virtually all forms of ABI, brain injury is itself a very complex phenomenon having dramatically varied effects. No two persons can expect the same outcome or resulting difficulties. The brain controls every part of human life: physical, intellectual, behavioural, social and emotional. When the brain is damaged, some part of a person's life will be adversely affected.

Consequences of ABI often require a major life adjustment around the person's new circumstances, and making that adjustment is a critical factor in recovery and rehabilitation. While the outcome of a given injury depends largely upon the nature and severity of the injury itself, appropriate treatment plays a vital role in determining the level of recovery.

The Care Programme Approach (CPA)[15]
CPA is the framework for good practice in the delivery of mental health services. In early 2008 the *"Refocusing the Care Programme Approach: policy and positive practice"* document was published.[16] This made changes to the existing Care Programme Approach.
One of the key changes is that CPA no longer applies to everyone who is referred to and accepted by specialist mental health and social care services. However, the principles and values do. CPA still aims to ensure that services will work closely together to meet your identified needs and support you in your recovery. If you have a number of needs, and input or support from a range of people or agencies is necessary, then the formal CPA framework will apply. When your needs have been identified and agreed, a plan for how to meet them will be drawn up and a care co-ordinator will be appointed. You and your views will be central throughout the care and recovery process.
There are four elements to the Care Programme Approach:

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[15] http://www.mentalhealthleeds.info/infobank/mental-health-guide/care-programme-approach.php

[16] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

- Assessment – this is how your health and social care needs are identified.
- Care co-ordinator – someone is appointed to oversee the production and delivery of your care plan, keep in contact with you, and ensure good communication between all those involved in your care.
- Care plan – a plan will be drawn up which clearly identifies the needs and expected outcomes, what to do should a crisis arise and who will be responsible for each aspect of your care and support.
- Evaluation and review – your care plan will be regularly reviewed with you to ensure that the intended outcomes are being achieved and, if not, that any necessary changes are made.

The (new) CPA will function at one level and what is provided is not significantly different to what has been known previously as “enhanced CPA”.

Risk Assessment

Risk assessment and risk management should be part of the routine care provided to a mental health service user. At present there is great local variability in the practice of risk assessment and in the documentation tools used. However, the general principles of risk assessment and risk management rely on undertaking an assessment and identifying aspects of an individual’s behaviour and lifestyle that might pose a risk to self, or to others, and to the qualification of that risk where possible. Once risks are identified, it is the role of the assessing professional to judge the magnitude of the risk and to devise a plan aimed at reducing or removing the risk.

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