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

March 2013

A report for NHS London
Undertaken by
L Winchcombe and Associates

NHS London

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Acknowledgements

The members of the independent investigation panel in this case were asked to examine the care and treatment provided to an individual prior to the tragic death of a fellow resident, and prior to his own subsequent death. Both men had been in receipt of mental health services provided by South West London and St George's Mental Health Trust.

The independent investigation panel necessarily revisits the circumstances and events in great detail causing all of those involved to re-examine often difficult and sometimes disturbing experiences. The independent investigation panel acknowledges this, as well as the discomfort caused by the process itself. The investigation underlines the importance of ensuring that such processes are properly conducted in order to learn from them, improve the services to individuals and so continue to operate those services without inappropriate risk. The priority for the independent investigation panel and the commissioning body is to ensure that there is a comprehensive effort to support the delivery of this objective.

Those who attended to give evidence were asked to account for their roles, and provide information to the independent investigation panel. All have done so in accordance with expectations and candour for which they must be commended. We are grateful to all of those who have given evidence, who have supported those giving evidence, and who granted access to facilities and individuals throughout this process. This has allowed the independent investigation panel to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

Grateful thanks are also extended to the independent investigation panel of experts who so diligently examined the documentation, participated in the interviews, considered the evidence and contributed to the report.

Condolences to the Family and Friends

The independent investigation panel at the outset of this report publicly offer their condolences to the families and friends of the individuals who died. We were unable to meet the family of the victim. However we met the mother of Mr D who helped us understand the issues relating to her son and gave consent for the investigation to access her son's case notes and other records relating to his care and treatment.

Executive Summary

On 4th May 2010 Mr D assaulted a fellow resident at the supported accommodation where he was a resident. Later that same evening he attacked a second resident who died of his injuries. He was arrested, charged with murder and assault and remanded in custody at HMP Highdown.

Following a court appearance he was transferred to HMP Belmarsh where on 13th June 2010 at 13.00 hours Mr D was found in his cell with a thick ligature made from a prison sweatshirt around his neck. Attempts to revive him failed and he was pronounced dead at 14.36 hours.

Mr D had been in receipt of community mental health services provided by South West London and St George's Mental Health NHS Trust, (the Trust). The Trust commissioned an internal review of the incident.

The Prison and Probation Ombudsman commissioned an investigation into the incident which was led by NHS Greenwich.

NHS London commissioned this further Independent Mental Health Investigation from L. Winchcombe Associates on 9th January 2012 under the auspices of Health Service Guidance (94) 27. *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.

Mr D

Mr D, born in 1982, received care from a variety of children's mental health services. This included family work, educational psychology, behavioural strategies, dietary advice, psychiatric and physical health assessments.

On 13th September 1999 Mr D, 17 years old, was admitted to the Paediatric Ward at St Helier Hospital via the Accident and Emergency department following an attempt to hang himself with a belt at home after drinking three litres of cider.

Mr D was spending approximately £200 per week on cocaine, crack, cannabis, and more intermittently, amphetamines, ecstasy, solvents and considerable quantities of alcohol. He also inhaled deodorant. The funding of his habit had led to him committing criminal acts which resulted in him being charged with theft and actual bodily harm.

On 16th September 1999, Mr D was transferred to the Woodside Adolescent Unit (Surrey Oaklands NHS Trust), where he revealed that he owed about £1,000 to drug dealers.

There is little further recorded in regard to Mr D until 25th July 2003 when he was assessed in the Accident and Emergency department by a liaison psychiatrist. He described mental health symptoms and was diagnosed with a psychotic episode. It was thought that this was due to his considerable cannabis intake.

Mr D was referred to Dr A, an adult consultant psychiatrist who diagnosed Mr D as having schizophrenia. Mr D was subsequently referred by Dr A to the Early Intervention Service, (EIS).

Three years later, on 16th August 2006 Mr D was taken to the Accident and Emergency department at St Helier Hospital by the police as he was threatening to commit suicide by jumping from a height. He had taken amphetamines and consumed alcohol. He was admitted to hospital but discharged himself against advice the following day.

In March 2008 Mr D presented at Sutton Hospital asking for help. He had broken up with his girlfriend that morning and cut his wrists. He stated that he was not suicidal but was generally depressed.

In November 2008 Mr D attached his car exhaust to the inside of his car and left the engine running for two to three hours. He had left a note for his ex-girlfriend but it was found by a neighbour who assisted Mr D and called an ambulance. He reported feeling low and depressed for the past two months suffering from a broken heart since breaking up with his girlfriend. He was not admitted on this occasion but was seen by the Home Treatment Team (HTT).

Over the weekend of 1st May 2010, a bank holiday, it was reported by Mr D's family that he was agitated and had run out of medication which they tried unsuccessfully to obtain for him.

On Tuesday 4th May 2010, at his supported accommodation during the night, Mr D assaulted a fellow resident and later attacked another resident who died from his injuries. He was arrested at the scene and later charged with murder and assault while detained at Sutton Police Station. His care coordinator acted as the appropriate adult during the police interviews.

At 13:00 hours an officer saw Mr D in his cell with a thick ligature made with a prison sweatshirt round his neck and tied to the window bars. Attempts to revive Mr D failed and he was pronounced dead at 14:36 hours.

Mr F

The victim of the homicide, Mr F, was born in 1960 and had minimal contact with psychiatric services. He had reported that he had been admitted to Springfield

University Hospital approximately 20 years previously for one week. He had not been able to explain why the admission had taken place or what had been his diagnosis.

He came in contact with the Trust's mental health services via the Accident and Emergency department of the local hospital when he presented there on 25th January 2010 at 14.26 hours having suffered an epileptic fit three days previously, when he sustained an injury to his wrist.

On assessment he was found to be dishevelled in appearance, very anxious but denying active suicidal ideation or intent. He was not thought disordered although distressed and agitated.

The following morning Mr F was much calmer, he reported that he was no longer experiencing the bizarre sensations of the previous day. It was decided that Mr F could go home and his key worker from his supported accommodation was informed of the situation. A letter was also sent to Mr F's GP. No further contact was made with psychiatric services.

Findings and Recommendations

The following section sets out the independent investigation panel's findings and recommendations. These have been identified from a detailed analysis of the evidence, both oral and written, that has been presented to the independent investigation panel. The recommendations have been completed for the purpose of learning lessons and for the Trust to put into progress any actions required to prevent a similar occurrence. It also sets out areas where the independent investigation panel have identified notable practice.

Whilst writing this report the independent investigation panel are mindful of the changes, both in Chief Executives and service provision during the period under consideration and whilst the independent investigation was taking place.

Service change can be a challenge and the Trust has had this challenge compounded by the senior executive management difficulties. It is acknowledged by the independent investigation panel that changes in large organisations do not happen overnight. The Trust has significantly more to do to achieve their vision for the future.

The independent investigation panel heard from one of the Trust's commissioners that the Trust has been committed recently to implement the service developments required to make their services safer for the individuals under their care.

Notable Practice

It is normal process in investigations into tragic circumstances such as the death of a patient to set out areas of notable practice. In this case there were several areas that the independent investigation panel found they specifically wished to single out as examples of good practice. These have been set out as follows: -

Paediatric Services

Mr D's long history of contact with both general Paediatric and Child and Adolescent Mental Health Services was extensive. He received specialist and holistic care from these services which was committed and consistent with the aim of him to remain mostly with his family and in mainstream schooling.

During Mr D's late teenage years there were areas that could have been improved and these are dealt with later in this section.

Early Intervention Service

The referral by Dr A of Mr D to the Early Intervention Service in 2003 was the most appropriate given Mr D's presentation at that time. The independent investigation panel noted the communication between Dr A to Mr D when he failed to attend the appointments with the Early Intervention Service. This demonstrated good practice in persisting in attempting to engage with Mr D.

Psychology Service

The independent investigation panel commend the flexible response made by the psychology service to re-open Mr D's case when he presented in crisis in January 2009. This was done despite a period of non-engagement and non-attendance for psychology appointments.

Recommendations

The independent investigation panel's experience of undertaking this investigation was made more difficult by the lack of senior Trust commitment to ensure that the independent investigation process received an appropriately high profile.

This impacted on the process and participation of staff at all levels of the Trust and has been discussed with the Trust's new Chief Executive.

The independent investigation panel's opinion was that the degree of responsibility taken and leadership within the Trust for both the internal and external investigation

process was not proportional to the gravity of the incident. Trust leadership did not impact positively on the organisation in regard to taking responsibility and accountability for the investigation process or an appropriate level of responsibility and subsequent accountability for Mr D and his care.

These recommendations are in relation to specific findings working on the basis that the Trust has properly constituted appropriate governance lines to assist the Trust in furthering and improving the quality of their services. The recommendations have not been set out in priority order.

Residential Detoxification

Mr D, aged 17 years, attempted to self harm with a belt around his neck. Although the services did attempt to provide adequate age appropriate care to Mr D in regard to the predominance of substance misuse and the availability of residential and other drug services, there were no adolescent services specifically for this purpose.

A long term plan to reduce Mr D's dependence on illicit drugs was not available.

Recommendation One

It is recommended that the Trust considers how future services and clinical care pathways are established for adolescent substance misusers to address their needs, and that a report outlining appropriate plans to address this issue is presented to the executive committee.

Family Communication

The independent investigation panel found that up until their involvement Mr D's family had not been contacted by the Trust or the internal review team.

The family informed the independent investigation panel that the trauma of realising their son may have caused the death of another and then dying whilst in prison, had a profound impact. They reported that they had no support or information except having access to the Prison and Probation Ombudsman Report which was completed in January 2011.

They did not have access to the Trust's internal review report until requested to do so by the independent investigation panel. It is understood that the Trust have now met with Mr D's mother and offered her counselling. Senior managers have also discussed the internal review report with his family.

Recommendation Two

It is recommended that following a serious incident such as a homicide by an individual receiving mental health services that the Trust's responsibilities are aligned to the expectations set out within the Department of Health guidance HSG (94) 27 and their duty of care. This would ensure that families of the victim and perpetrator are notified of the actions being taken and that support is provided within a timely manner. It is further recommended that the implementation of this recommendation be monitored by regular audit reporting to the Trust's Clinical Governance Committee.

Recommendation Three

It is recommended that following a serious incident such as a homicide a senior manager from the Trust is designated to provide support and information to the family. It is further recommended that the implementation of this recommendation be monitored by regular audit reporting to the Trust's Clinical Governance Committee.

Recommendation Four

It is recommended that for all serious incidents, such as a death of a patient, that results in the Trust setting up an internal review the family of that individual are given an opportunity to participate in the review process. The family should also have access to the final review report. It is further recommended that the implementation of this recommendation be monitored by regular audit reporting to the Trust's Clinical Governance Committee.

The independent investigation panel heard that the police investigating Mr F's death did not appoint a family liaison officer to support Mr D's family and keep them informed of the ongoing investigation. It was acknowledged by a senior police officer that although not a routine process in murder investigations, this should have been considered in Mr D's case taking into consideration his mental state and the close involvement of his mother as an informal carer.

Recommendation Five

It is recommended that in cases where individuals with mental illness commit a serious crime causing the death of another that the police consider appointing a family liaison officer to support that person's immediate family.

<u>Engagement with Services and Clinical Care</u>

The mental health services found Mr D difficult to engage with, frequently not attending appointments and mental health reviews. He was referred to services appropriate to his

care needs such as the Early Intervention Service and Home Treatment Team but discharged from their caseloads after not attending appointments as per the protocol and without a team review of Mr D's care and treatment. When allocated a care coordinator in 2010, Mr D received practical support but there is limited documentation regarding his mental state, risk and substance misuse.

Recommendation Six

It is recommended that in complex cases such as Mr D's that a care plan to establish and maintain contact and engagement is agreed between the individual and service. This should include liaison with close family and the support that they can give and consideration of a carer's assessment. It is further recommended that the implementation of this recommendation be monitored by regular audit of the Care Programme Approach as functioning in the Trust and is reported to the Trust's Clinical Governance Committee.

Housing Applications

The independent investigation panel were informed that details regarding Mr D's risk to himself and others, his self harm, paranoia and illicit substance misuse were not disclosed on the housing application made to support his housing requirements. The Housing Organisation was therefore unaware as to the potential risk that he posed to other more vulnerable residents.

Recommendation Seven

It is recommended that the Trust reviews its systems and training for clinical staff to ensure adequate focus on mental state, risk assessment and carer's needs. This should be included in regular audit and governance processes.

Recommendation Eight

It is recommended that when professionals write to support an individual's housing application that information regarding potential risk areas is disclosed. Regular audit of this should be undertaken in conjunction with the case record audits. Additionally a review of the application form should take place between the two organisations to ensure it meets the relevant objectives.

Local Action taken following the Incident

The independent investigation panel heard that Mr D's care coordinator acted as his appropriate adult following his arrest and also visited him in prison on her own. Although this member of staff was not available to interview evidence was provided that this process had a profound impact on that person emotionally.

Recommendation Nine

It is recommended that when staff, particularly junior staff, are required to act as appropriate adults and also maintain support to a patient under tragic circumstances this should be documented in the patient's case notes.

In addition it is further recommended that the member of staff should receive support from their senior managers and this recorded in multi disciplinary team notes and supervision records.

Communication and In-reach Prison Services

The independent investigation panel heard that there is not a formalised requirement to share clinical information with healthcare professionals once a patient is on remand. However Mr D was a patient of the CMHT and as a patient on enhanced CPA there was a clinical obligation to ensure adequate transfer of relevant information especially in the circumstances when risk has increased.

Recommendation Ten

It is recommended that following a high profile catastrophic event that results in a patient under their care being arrested and on remand, that the Trust, as part of its initial response, will actively consider and follow through the transfer of clinical information, and audited as part of the Trust's monitoring of its response to serious incidents.

Organisation Response

It was found that the organisational responsibility taken by the Trust after such a high profile and tragic incident was inadequate and a missed opportunity to support both learning and professional obligations to their patients and families.

Recommendation Eleven

It is recommended that the Trust review and establish robust procedures following such catastrophic events to ensure senior leadership oversees their response. This must include support and understanding for the local team, ensure professional medical leadership, organisational learning and awareness of the impact on patients, families, carers and the organisation, and that this response is audited as part of the Trust's monitoring of its response to serious incidents.

The independent investigation panel have no further comment to make about Mr F's contact with psychiatric services. It is considered that the appropriate care was provided and the decision not to refer Mr F for further psychiatric services and his GP informed of this was adequate and in line with good practice.

In Conclusion

The independent investigation panel considered whether the death of Mr F could have been predicted and or prevented.

Both Mr D and his family sought help over the weekend of the incident. However the independent investigation panel are unable to say that a service response would have changed the subsequent event.

In considering the death of Mr D, if a thorough assessment by a senior psychiatrist or suitable qualified mental health professional had taken place, the level of risk that he posed might have been understood differently and his care needs informed accordingly. Again the independent investigation panel cannot conclude whether this would have altered events, nor to identify causative factors that would have contributed to the events that took place.

1. General Introduction

1.1 On 4th May 2010 Mr D assaulted a fellow resident at the supported accommodation where he was a resident. Later that same evening he attacked a second resident who died of his injuries. He was arrested, charged with murder and assault and remanded in custody at HMP Highdown.

1.2 Following a court appearance he was transferred to HMP Belmarsh where on 13th June 2010 at 13.00 hours Mr D was found in his cell with a thick ligature made from a prison sweatshirt around his neck. Attempts to revive him failed and he was pronounced dead at 14.36 hours.

1.3 Mr D had been in receipt of community mental health services provided by South West London and St George's Mental Health NHS Trust, (the Trust). The Trust commissioned an internal review of the incident. The review was chaired by a non-executive director of the Trust but facilitated by an independent management consultant. The Trust investigation report is not dated.

1.4 The Prison and Probation Ombudsman commissioned an investigation into the incident which was led by NHS Greenwich. Their investigation report was completed in January 2011.

1.5 NHS London commissioned this further Independent Mental Health Investigation from L. Winchcombe Associates on 9th January 2012 under the auspices of Health Service Guidance (94) 27. *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.

1.6 The Independent Mental Health Investigation Panel is referred to as the independent investigation panel throughout this report and the Trust's internal review as the internal review.

2. Purpose of the Investigation

2.1 The purpose of this independent investigation is to review the patient's care and treatment, until the victim's death, and subsequently up to Mr D's death in order to establish the lessons to be learnt.

2.2 The role of this independent investigation is to understand what was known, or should have been known at the time, regarding the patient by the relevant clinical professionals. Part of this process is to examine the robustness of the internal review and to establish whether the Trust has subsequently implemented changes resulting from the internal review's findings and recommendations. The purpose is also to raise outstanding issues for general discussion based on the findings identified by the independent investigation team.

2.3 The independent investigation team is required to make recommendations for outstanding service improvements and have been alert to the possibility of misusing the benefits of hindsight and have sought to avoid this in formulating this report.

2.4 We have remained conscious that lessons may be learned from examining the care of the individual associated with the incident but also more generally from the detailed consideration of any complex clinical case. The independent investigation panel has endeavoured to retain the benefits of such a detailed examination but this does not assume that the incident itself could have been foreseen or prevented.

2.5 The independent investigation is intended to be a positive process that examines systems and procedures in place in the Trust at the time of the incident, and works with the Trust to enhance the care they provide. The wider aim is that we all learn from incidents to ensure that the services provided to people with a mental illness are safer, and as safe and comprehensive as possible; that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and delivering services.

3. Terms of Reference

Commissioner

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

Terms of Reference

3.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr D to include: -

- A review of the Trust's internal investigation to assess the adequacy of its findings, recommendations and action plans:
- Reviewing the progress made by the Trust in implementing the action plan from the internal investigation:
- Involving the families of both Mr D and the victim as fully as is considered appropriate:
- A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident:
- The relationship between Mr D and the victim:
- An examination of the mental health services provided to Mr D and a review of the relevant documents:
- The care provided by the prison in-reach health team whilst Mr D was a remand prisoner in the days leading up to his death.
- The extent to which Mr D's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies:
- The appropriateness and quality of assessments, care planning and care delivery:
- Consider the risk that was posed to others and management of that risk:
- Consider other such matters as the public interest may require:
- Complete an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

Approach

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

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

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

3.6 Lessons learnt from this investigation will be shared with the lead commissioner so that these can be factored into future commissioning arrangements.

4. Panel Membership

4.1 The independent investigation has been undertaken by a panel of professionals independent of the services provided by South West London and St George's Mental Health NHS Trust and its preceding bodies.

4.2 The panel comprises of:

Panel Chair:	Lynda Winchcombe, a management consultant who specialises in investigations within the NHS and Social Care Services, Director of L. Winchcombe Associates.
Panel Membership:	Dr Nicky Goater, Consultant Psychiatrist, Crisis Resolution Home Treatment Team, West London Mental Health NHS Trust.
	Natalie Hammond, Consultant Nurse, Promotion of Safe and Therapeutic Services, South London and Maudsley NHS Foundation Trust
Administration Transcription Services	L. Chenery, LC Transcription Services

5. Method

5.1 NHS London commissioned the independent investigation under the Terms of Reference set out in Section 3.

5.2 The independent investigation panel held an initial meeting on 18th January 2012 to agree the process that would be undertaken to complete the investigation. Diary dates for future meetings and interviews were identified. The independent investigation panel also identified the written documentation that it required. Additional documentation relevant to the investigation was requested as the investigation progressed. A full list of the documents examined can be found at Appendix One.

5.3 As each document was received it was indexed and paginated. A chronology of the critical events for the case was compiled together with that of the victim who had had some contact with the Trust's psychiatric services. An outline of these can be found at Sections 7 and 8.

5.4 A presentation was provided to the independent investigation panel on 20th April 2012 by the Trust's Interim Chief Executive, Medical Director and the Borough of Sutton's Service Director. The purpose of this was for the independent investigation panel: -

- To gain an understanding of the services provided by the Trust and their partners at the time of the incident.
- Learn about the plans for the future of the services.
- Understand the action taken following the incident.
- To provide an opportunity to meet the Trust's senior managers and discuss the process that the investigation would follow.

5.5 An informal staff meeting was offered to those staff members who had been directly involved with Mr D. However most relevant staff had already left the Trust and the remaining two staff were not available on the dates identified. This would have provided the staff with an opportunity to ask questions about the investigation and to have discussed the process that was to be undertaken. A further aim would have been to reassure those that were to be called to interview that the process was one of learning lessons via systems and processes and not one of blame.

5.6 Evidence was received from fifteen individual witnesses during April, May, June and July 2012. Some of the interviewees provided statements prior to their interview. Representatives from related agencies such as housing, police,

commissioners and the internal review chair were also seen. Difficulty was experienced with meeting all relevant staff for a variety of reasons:-

- Organisational difficulties
- Personal circumstances
- Unknown whereabouts

5.7 A letter detailing the areas of questions to be discussed was sent to each individual prior to the interview together with copies of the Terms of Reference and the Investigation Procedure (Salmon requirements).

5.8 Each interview was recorded. Transcripts were sent to the individuals to check for accuracy and to amend as necessary. The amended version is the one that the independent investigation panel have used to evidence their report.

5.9 Analysis of the evidence was undertaken using Root Cause Analysis methodology. The report is divided into three sections: -

- Outline of Events for Mr D and the victim, Mr F
- Analysis of the Evidence
- Findings and Recommendations

5.10 The independent investigation panel met the mother of Mr D to establish whether she had any concerns or issues that needed to be considered. Consent to access her son's records had been previously obtained.

5.11 The independent investigation panel were unable to meet the family of the victim as advised by the police.

6. South West London and St George's Mental Health NHS Trust Service Profile

6.1 The Trust was formed in 1994 from several local mental health services from South West London. It provides mental health services to the communities of Kingston, Merton, Richmond, Sutton and Wandsworth.

Services Provided

6.2 A wide range of community and inpatient services to children, young people, adults of working age, older adults and forensic services together with national specialist services are provided by the Trust.

Mental Health Inpatient Services

6.3 The Trust has inpatient services on a number of hospital sites with the main site at Springfield University Hospital. The additional sites are: -

- Barnes Hospital
- Kingston Hospital
- Queen Mary's Hospital
- Richmond Royal Hospital
- St George's Hospital
- St Helier Hospital
- Sutton Hospital
- Tolworth Hospital

Community Mental Health Services

6.4 Community Mental Health teams are based in the five boroughs served by the Trust of Kingston, Merton, Richmond, Sutton and Wandsworth.

Forensic Services

6.5 Male Forensic services are provided in a medium secure unit at the Shaftesbury Clinic, Springfield University Hospital. A low secure unit, Phoenix Unit, provides services for both male and female patients. A prison in-reach team works with the local HMP Wandsworth as well as other prisons that take patients from the Trust's services.

National and Specialist Services

6.6 A Deaf, (severely impaired hearing) inpatient service is located in two units on the Springfield University Hospital site. The Trust also provides outreach centres in Cambridge and Kent for deaf people with a mental health illness.

6.7 National obsessive-compulsive disorders and body dysmorphic disorder units are also based on the Springfield University Hospital site.

6.8 A national inpatient Eating Disorder Service is provided at Springfield University Hospital together with a local community services. The Trust also provides a Specialist National Addiction Inpatient Service on their Springfield University Hospital site.

Child and Adolescent Mental Health Services (CAMHS)

6.9 There are both inpatient and community CAMH services provided by the Trust. In addition they provide a National Eating Disorder Service for eleven to eighteen years old. Education is provided to the inpatient CAMHS which is regularly monitored by the regulatory body, Ofsted.

New Service Provision

6.10 The Trust is committed to the principles of a Recovery Service and have developed the South West London Recovery College which promotes self-confidence, respect and self worth to help people with a mental illness to move on in their lives. It centres on recovery-focused practice through courses and workshops.

Governance Process

6.11 Prior to 2011, Governance was part of the Trust's Nursing Directorate. The Trust recognised that they needed to focus more on Clinical Governance and clinical risk. It is now managed in a Clinical Governance and Compliance structure within the Medical Directorate.

Trust Foundation Status

6.13 The Trust has not yet achieved Foundation status and their plans to gain approval are on hold. This is partly due to having had three Chief Executives (one interim) in the past four years. A new Chief Executive has been appointed and took up post during this independent investigation process.

7. Outline of Events – Mr D

7.1 The following chronology of events has been compiled from case notes, oral, written and documentary evidence available to the independent investigation panel in regard to Mr D and his care and treatment.

Background

7.2 Mr D was born in Wallington, South West London, in October 1982 and had two younger sisters. During his early years he had some difficult behaviour recorded from age two, which became worse after his father died. He could become very aggressive and abusive, particularly but not exclusively to his mother. He made continued demands on her and she found him difficult to manage. As a child he developed faecal soiling, was often overactive and easily bored.

7.3 His mother described Mr D as having been a wonderful but boisterous child until the age of three and a half when his father died. Aged 27 years, his father committed suicide by carbon monoxide poisoning in a car after being missing for four days. Mr D's mother stated at the time that she had had no warning of the suicide as her husband was not obviously depressed and had lots of friends. He left a note stating he heard voices. Mr D appeared to have never come to terms with his father's death and it troubled him throughout his life. He continued to have significant behavioural problems as a child and had contact with paediatric services as detailed below.

7.4 Aged 15 years, Mr D was expelled from school with no qualifications and was allegedly "thrown" out of his home by his mother because of his bad behaviour. At 16 years he attended and completed a bricklaying course. He reported taking illicit drugs from the age of 12 years that included cannabis, amphetamines, ecstasy and in later years, cocaine. His use of these drugs varied from intermittent to more chronic. He mostly used cannabis.

7.5 It is reported that his first sexual relationship was aged 11 years. He had several relationships as an adult. Mr D has two sons from his relationship with his stepfather's daughter.

7.6 After leaving college he worked as a bricklayer and then became a builder for six years but left after altercations with his manager. He then worked as a telephone salesman but left as he was dissatisfied with his wages. Mr D had a variety of short term jobs after this.

Forensic History

7.7 Mr D was known to have had a criminal record which has not been consistently recorded. He had admitted several charges of criminal damage. Mr D's history included theft, drug misuse, actual bodily harm, and in 2000 he was found in possession of a sharply pointed blade in a public place. He was found to have a knuckleduster on his person in 2004. Other offences recorded, included being in charge of a motor vehicle whilst under the influence of alcohol, taking a vehicle without permission and possession of cannabis. He had been fined by the Courts and had a probation order. None of these offences resulted in a custodial sentence and all are reported to have been before the age of 20 years.

Referral to Paediatric Services and Developmental Years

7.8 Mr D received care from a variety of children's mental health services. This included family work, educational psychology, behavioural strategies, dietary advice, psychiatric and physical health assessments. Physical investigations undertaken found no abnormality. The services liaised between schools and other agencies.

7.9 On 23rd December 1983, aged one year old, Mr D was referred to and admitted to a paediatric ward for children with eating difficulties. He had not been eating properly for three months, and had been reluctant to eat any foods during the previous three weeks. He was vomiting once or twice a day at the time of admission and had suffered from intermittent diarrhoea for three weeks.

7.10 Three years later, on 15th May 1986, a respite care admission was arranged in order to give his mother a short break. He was reported to be overactive and restless with behaviour problems that were mainly aggression and temper tantrums. His father died shortly after this admission.

7.11 During 1986, 1987 and 1988 Mr D had phases of improvement, but at other times he was challenging, irritable and had a return of faecal soiling. He continued to see a psychologist. On transfer to junior school in 1987, it was suggested that he would be better placed at another school due to his disruptive behaviour. In class he sometimes banged his head with his fists, or hid under shelves or tables. In 1988 he allegedly stole at school during what was reported as a "bad phase".

7.12 In October of 1988 Mr D, aged 6 years, was admitted for respite to a Child Psychiatry Unit Ward at Queen Mary's Hospital for Children in Carshalton, a residential unit for children with behavioural problems. He was soiling himself

daily. The difficulties were thought to be due to "losses that had happened in the family" which appears to refer to the death of his father. From this time the family, and in particular Mr D, received considerable input from the NHS, Education and Social Services. He remained there for two months until December 1988.

7.13 On 30th May 1990 Mr D was reassessed by an educational psychologist from the London Borough of Sutton. At his primary school there had been concerns about him banging his head and hiding under tables. This assessment of Mr D described him as "a very bright boy who could easily become bored if not constantly stretched." His chronological age was 7 years 7 months with a Reading Age of 10 years 2 months and a Number Age of 6 years 10 months (considered to be an under-estimation as it was the last test administered and he had started to lose concentration.) His general IQ estimate was 113-119 (above normal). It was felt he would need to be closely monitored in school so that appropriate provision and behaviour programmes could be made for him. In June 1990 Mr D received home tuition for a few weeks. He started a new school in September 1990.

7.14 Mr D's distress and behavioural problems increased again after the death of his paternal grandmother in January 1991. When assessed by a psychiatrist in March 1991, he was reported to be disruptive at school, described as displaying attention seeking behaviour in the classroom and assembly, disturbing the rest of the class and scratching his arms with his fingernails. There were concerns about the possibility of sexual abuse due to his graphic language about sexual matters and associated behaviour. The school recorded fights, with several children being hurt during his time at the school.

7.15 A child and adolescent psychiatrist concluded that Mr D had a conduct disorder. He was thought to be fearful that his mother would 'disappear'. Mr D was started on individual Jungian psychotherapy. Special schooling was considered, but not a boarding school as this could reinforce his fears of losing his mother. The explanation for his disruptive behaviour appeared to be an increase in Mr D's stress levels due to the recent death of his paternal grandmother, and the lack of a father figure role model. There were also concerns about his sexual awareness and Mr D indicated that older boys had discussed this with him in hospital when admitted aged 6 years. The sexual issues were examined by a child protection officer and hospital social worker and no further action was taken.

7.16 On 21st March 1991 when asked what his three wishes would be Mr D responded that he would like:

- "father to be back to life"
- "nanny to be back to life" (she died in January 1991)

- and "that he could be a good boy."

7.17 Mr D had started using illicit drugs by the age of 12 years and was reported to have misused alcohol during his adolescent years.

7.18 In 1997 Mr D was expelled from school aged 15 years with no formal qualifications. There was little other information available in the notes about Mr D's schooling during this time.

1999 – 2000

7.19 On 13th September 1999 Mr D, now 17 years old, was admitted to the Paediatric Ward at St Helier Hospital via the Accident and Emergency department following an attempt to hang himself with a belt at home after drinking three litres of cider. His mother accompanied him to the hospital and explained that he had been lying on the bed and had tightened a belt around his neck (which had not been suspended from a ligature point). He told his mother that the suicide attempt was the result of longstanding polydrug abuse, mounting debts, threats from drug dealers for payment, the loss of his job and his girlfriend plus escalating problems with the police. He reported wanting to end his life.

7.20 At this time Mr D was living with his mother, his 13 year old sister and 6 year old half sister. Mr D was spending approximately £200 per week on cocaine, crack, cannabis, and more intermittently, amphetamines, ecstasy, solvents and considerable quantities of alcohol. He also inhaled deodorant. Mr D denied injecting drugs or using opiates. The funding of his habit had led to him committing criminal acts which resulted in him being charged with theft and actual bodily harm. He had broken a Probation Supervision Order and a warrant had been issued for his arrest. His youth justice worker had found it difficult to engage Mr D in projects to help him.

7.21 On 16th September 1999, Mr D was transferred to the Woodside Adolescent Unit (Surrey Oaklands NHS Trust), where he revealed that he owed about £1,000 to drug dealers. He acknowledged that he would drink whatever alcohol he could get access to and showed signs of alcohol withdrawal. He reported using drugs since 11 years of age. The plan was to offer Mr D a week's respite admission for assessment by the Merton and Sutton Community Drug and Alcohol Team. The diagnosis was mental and behavioural disorder due to multiple drug usage.

7.22 A discharge summary completed on 21st September 1999 contained a plan for him to be seen by the Sutton Child and Family clinic and the Drug and Alcohol Team in Sutton. When subsequently reviewed he was referred to the youth adolescent project and an organisation for counselling.

7.23 It was later reported that Mr D's mother was dissatisfied that he could not stay longer on the Woodside Unit. He appeared keen to seek help for his drug problem and to make a fresh start, which had not happened before according to his youth justice worker at the time. The only residential detoxification available was in an adult ward at the Trust, but as he would be the youngest there it was considered that he would be at a further risk of being introduced to more dangerous forms of substance misuse.

7.24 The Community Drug Helpline faxed a referral to Sutton Children and Families Department on 1st October 1999 asking them to see Mr D because one of their counsellors was concerned about his drugs use and his mental state. The same day, despite the concerns about his age, Mr D was admitted to the residential detoxification ward, (a recovery and rehabilitation specialist national addiction inpatient service). The plan was for Mr D to undertake a six week programme of treatment and rehabilitation for illicit drug dependence.

7.25 Mr D was worried about mixing with the other residents and was prescribed thioridazine 25mg nocte, (at night). He settled well and joined group activities. During the third week he asked to discharge himself and could not be persuaded to stay. As his mental state was stable he was discharged with the following plan:

- To attend the day programme activities of the ward and complete the six weeks recovery programme.
- He had had one Hepatitis B vaccination and should have the course completed by his GP.

7.26 On 1st November 1999 Mr D decided he would not attend the day programme as planned.

Adult Years – 20 Years Old Onwards

7.27 There is little further recorded in regard to Mr D until 25th July 2003 when he was assessed in the Accident and Emergency department of St Helier Hospital by a liaison psychiatrist. He described mental health symptoms and was diagnosed with a psychotic episode. It was thought that this was due to his considerable cannabis intake. He was very paranoid about his manager and his brother-in-law whom he felt were going to shoot him. He was worried about a police conspiracy against him, had locked himself in the garden that day and told his sister he would kill himself. Diazepam 4mg tds (three times daily) was prescribed to help him sleep.

7.28 Mr D explained that he had broken up with a girlfriend of four years standing two months previously. He had been unable to eat or sleep properly for two weeks and had asked his family not to turn the lights on in the house. He had thought the phone was bugged and that people were listening to his conversations and passing notes about him.

7.29 Mr D was referred to Dr A, an adult consultant psychiatrist. When seen in outpatients on 15th August 2003, he reported feeling people were following him and that he had thoughts being put into his head. He stated that he felt that people's thoughts were communicated to him. He had been hearing voices threatening him and was frightened to be alone. The previous night he had been convinced that there was someone outside with a sword as someone had mentioned the word 'sword'. These thoughts had been present for two or three months but he had not experienced any other similar previous episodes.

7.30 Mr D was reported to have no suicidal intention. He was found to have good insight into his problems and was asking for medication to help him. He said he would not take cannabis again as he had felt worse after using it with the diazepam prescribed in Accident and Emergency.

7.31 Dr A diagnosed Mr D as having schizophrenia and he was prescribed him risperidone 3mg daily and diazepam 2mg three times a day. Mr D was referred that day to the Early Intervention Service, (EIS), and Dr A agreed to admit him to hospital if he or his family felt the situation was getting out of hand. The staff on Dr A's inpatient ward were informed about Mr D and asked to admit him should he seek their help. He was given the Crisis Line telephone number and Dr A's contact details.

7.32 It was arranged by the EIS that an occupational therapist and the specialist registrar (senior psychiatric trainee) would visit him at home on 3rd September 2003. The visit was cancelled by Mr D.

7.33 A letter was sent to Mr D's GP on 16th September 2003 stating that Mr D was very much better from his schizophreniform psychosis although he had had a huge increase in appetite on his prescribed olanzapine. The olanzapine was changed to quetiapine which was to be increased to 150mg mane (in the morning) and 300mg nocte (at night) after three days. The diazepam was to be reduced and then stopped over two weeks.

7.34 Following the cancelled appointment with the EIS two further appointments were arranged but Mr D was not at home when the service visited.

7.35 Three further attempts were made to assess Mr D including enlisting his mother's help. On 21st October 2003 the EIS informed Dr A that no more

appointments were being scheduled but that he could re-refer Mr D at any time. Mr D did not attend his outpatient appointment with Dr A in November 2003 or January 2004.

7.36 Three years later, on 16th August 2006 Mr D was taken to the Accident and Emergency department at St Helier Hospital by the police as he was threatening to commit suicide by jumping from a height. He had taken amphetamines and consumed alcohol. Mr D alleged that his girlfriend was sleeping with his uncle. He was reported to have been non-compliant with medication for an unknown time. His mother later reported that Mr D had been brought down from a ledge on a wall with great difficulty.

7.37 Mr D was assessed by Dr B and said he had been well until the previous night. He took some 'speed' and had had an argument with his girlfriend who had ended their relationship and had threatened to deny him access to their children. When assessed he remembered believing that a helicopter in the area was looking for him. Dr B diagnosed 'acute psychotic episode in the context of paranoid schizophrenia' and acute intoxication with amphetamines.

7.38 Mr D claimed to have had no psychiatric problems since he had stopped taking cannabis. His sister and girlfriend reported that he was often subject to persecutory ideas but could be supported through these. During the last few months he had had more fixed ideas and the erroneous belief that his girlfriend was having an affair. Mr D had been off work for a week. A change of shift pattern had upset him (now working 18.00 to 02.00 hours) and since this he had had ideas of suicide. Mr D had tested positive for cocaine and amphetamines but there was no abnormality found in a full blood count.

7.39 Dr B assessed the risks as being high for suicide and moderate for inadvertent harm to his children. Mr D refused voluntary admission but his girlfriend and sister said they would try to persuade him. He accepted lorazepam 2mg daily. An approved social worker was contacted about undertaking a Mental Health Act 1983 assessment.

7.40 Mr D subsequently agreed to an admission and was prescribed quetiapine 150 mgs bd (twice daily) for 3 days, then 150mgs daily and 300mgs at night. He was also given diazepam 2mgs. While on the ward his risk was identified as; "low risk of harm to him or others". On assessment by Mr D reported that he felt suicidal as he thought he had lost everything, his family and children. A diagnosis of paranoid schizophrenia was made. Mr D discharged himself against advice the following day. He was referred to the Home Treatment Team (HTT) and an outpatient appointment made for 27th September 2006 which was not attended.

7.41 One month later on 27th October 2006 Mr D was referred urgently to Dr A by his GP who was worried about his mood and paranoid thoughts. He did not attend an appointment arranged for 1st November 2006. The GP practice reported that it had been sent to the wrong address.

7.42 In January 2007 Mr D's mother contacted the community mental health services as she was concerned about her son losing his temper. Mr D had been living with his girlfriend but because of his angry outbursts was staying with his sister in Wallington.

7.43 His mother reported that she was concerned about Mr D's two children. She felt her son was not a risk to them but she was concerned because of his anger. His mother had been seeing him twice a day to check how he was doing. He had retained his job at a warehouse and this had kept him going. There had been no problems at work but his mother thought that he needed something more than the diazepam he was currently taking. He was due to see Dr A on 31st January 2007.

7.44 Dr A saw Mr D as arranged on 31st January 2007 with his mother. They informed Dr A that Mr D had been in a couple of fights. He had recently threatened to jump off a wall and had cut his wrists. He had taken cocaine and alcohol, becoming intoxicated. The "on-off" relationship with his girlfriend seemed to be the precipitant for these incidents. His mother considered he was experiencing a return of symptoms of paranoia in a more general sense but he was not hearing voices or feeling paranoid outside the home.

7.45 Dr A thought that Mr D had paranoid schizophrenia as some symptoms were present when not using drugs. His mother felt he was at his best when previously had taken antipsychotic medication. Dr A restarted Mr D on antipsychotic medication. He was prescribed risperidone 3mgs daily and diazepam 2mgs tds (three times daily), the latter to try to reduce his stress levels and episodes of self harm. Dr A ensured that Mr D and his mother knew they could contact the service if they were concerned. Mr D was now back living with his mother.

7.46 In March 2007 Dr A saw Mr D and noted that he was low in mood and using cocaine intermittently. He referred Mr D to the Community Alcohol Team (CAT) but as he had not contacted them by April 2007, it was decided that he would be discharged from CAT if he did not respond to their next letter within three weeks. He did not contact them.

7.47 In March 2008 Mr D presented at Sutton Hospital asking for help. He had been locked out of his flat by his friends and had broken up with his girlfriend that morning and cut his wrists. He stated that he was not suicidal but was generally

depressed. He was regularly using cocaine and had been binge drinking, which comprised of five or six beers plus spirits. Mr D disclosed that he had stopped taking the risperidone and the diazepam about six months previously. He was seen by a psychiatrist who wrote to Dr A outlining the situation as described below. A care plan was agreed for Mr D to recommence risperidone 1mg at night. He refused a referral to the Community Alcohol Team as he denied he had a drink problem and agreed to call his CMHT for a follow-up appointment. Mr D's girlfriend rang to ask for a prescription a few days later as he was about to run out of his medication.

7.48 Later in April 2008 Mr D did not attend his arranged outpatient appointment but his girlfriend requested another prescription of risperidone which was agreed and the GP duly advised. In July 2008 he also did not attend his outpatient or CMHT appointments, and he was discharged from their caseload.

7.49 In November 2008 Mr D attached his car exhaust to the inside of his car and left the engine running for two to three hours. He had left a note for his ex-girlfriend but it was found by a neighbour who assisted Mr D and called an ambulance. He reported feeling down and depressed for the past two months suffering from a broken heart since breaking up with his girlfriend.

7.50 In the Accident and Emergency department of St Helier Hospital Mr D denied any symptoms of mental illness and stated that he was not feeling suicidal at the time of the interview. He and his girlfriend had been apart for two months and he had been feeling increasingly depressed. He described a poor sleeping pattern but had been able to continue working. He was not considered to be psychotic. At the review he reported having had relationship counselling once two weeks ago and had been advised by the counsellor to see his psychiatrist. The care plan for Mr D was:

- To go home with his mother and to stay with her for two weeks.
- To start fluoxetine 20mg mane immediately.
- To be given the Crisis Line number.
- To be referred to the Home Treatment Team (HTT).
- For an urgent referral to be made to the CMHT for a psychology assessment and to inform his GP about the suicide attempt.

7.51 Consideration had been given to refer Mr D's sons to the Children and Family Services but this was deemed inappropriate as their father was not living with his children at that time. He was not available to be seen by the HTT that day but agreed to be at home the following day.

7.52 A referral was made from the duty psychiatrist to the HTT to provide an alternative to admission as Mr D had declined an admission to hospital. Three

days later, 30th November 2008, the HTT made a home visit. He was assessed by the HTT to have acted impulsively and to have an emotionally unstable personality disorder and he reported that he had moved back to live with his girlfriend; she confirmed this and said he was alright.

7.53 During December 2008, the HTT made repeated efforts to meet with Mr D but they failed to have contact with him. He was discharged back to the care of the CMHT. The psychologist also failed to contact Mr D and discharged him from the team's caseload.

7.54 On 9th January 2009 Mr D attended Chiltern Wing at Sutton Hospital. He saw the consultant psychologist there who reopened his case as he had moved into their catchment area and in response to Mr D's history and risk of suicide. Mr D explained that he had been made unemployed, had lost his accommodation, had no money to pay the rent and had again separated from his girlfriend. He had organised bed and breakfast accommodation for himself. He had also broken his hand so was unable to seek work at that time.

7.55 He failed to attend two subsequent appointments but did attend one with a trainee clinical psychologist on 22nd January 2009. He had been placed in new temporary accommodation and expressed an interest in having more psychology sessions but he did not attend a further one booked for 30th January 2009.

7.56 In a subsequent telephone call Mr D agreed he would find psychology sessions helpful but did not attend another arranged for 4th February 2009**.** He was discharged from the psychologist's caseload as he had not attended two appointments.

7.57 On 26th February 2009 Mr D telephoned the team asking to speak to the psychologist. He was not available. He spoke to the trainee and reported that he was having a "really bad day". His ex-girlfriend had told him she was pregnant and he thought she was deliberately trying to hurt him. He had little money and reported sitting at home thinking. He felt unable to attend due to financial problems. The team decided not to reopen the case.

7.58 On 1st May 2009 Mr D alone arrived at the CMHT reception asking to see the consultant psychologist. He was unavailable but Mr D insisted that he needed to talk to someone urgently. He was seen by a community psychiatric nurse who was accompanied by a student nurse. His mother was contacted and reported that she was very concerned for him as he appeared to have been hearing voices. It was reported that he:

- Was homeless as had been asked to leave the bed and breakfast accommodation in Thornton Heath.

- Had returned to his girlfriend – she had then asked him to leave as she had a new man.
- Had lost his job and moved to stay with a friend but was asked to leave as he was upsetting her children.
- Was drinking 24 cans of normal strength lager daily.
- Had had suicidal thoughts.
- Requested admission to hospital as he did not feel safe.
- Had stopped his fluoxetine about two weeks previously as he has not registered with a GP and had nowhere to go.

7.59 After discussion in the CMHT's zoning meeting, which was held to identify patients who may have been at risk or whose mental state was deteriorating, Mr D was referred to the HTT.

7.60 It was then agreed with the consultant psychiatrist, Dr J, that Mr D would be offered an informal admission to the inpatient ward. On admission Mr D admitted to having taken cocaine and cannabis recently, the latter on a daily basis. He was assessed to be in good physical health but tested positive for cannabis and had some symptoms suggestive of alcohol withdrawal.

7.61 The plan was that Mr D, preferably with his mother, would attend Housing Options, but would stay on the ward until an appointment could be arranged. Mr D was assessed as being at risk and assigned to the 'Red Zone' (a categorisation which indicates patients at risk). The plan was:

- To commence intermittent observations every ten minutes.
- Restart fluoxetine.
- To have chlordiazepoxide as required.
- To be observed for withdrawal symptoms.

7.62 On 3rd May 2009 Mr D's observations had been reduced as his risk was assessed as low. During the following day his girlfriend and children came to visit him. They appeared happy and were noticed cuddling.

7.63 Dr J assessed Mr D again prior to discharge. No psychotic symptoms were observed but he was distressed and hopeless about his relationship and housing, and Dr J's impression was that Mr D had a borderline personality disorder, misused substances and had a tendency to deliberately self harm. The plan for him on discharge in two days was to:

- Provide a letter to support his housing application to the Homeless Persons Unit.
- Advise him to register with a GP.

- Prescribed fluoxetine 20mg.
- Follow-up by the CPN later in week.
- Discuss a referral to CAT and drug services.
- Provide him with Crisis and CMHT team contact details.
- Allocate a care coordinator.

7.64 Dr J wrote to the Homeless Persons Unit asking for urgent accommodation as Mr D was homeless and vulnerable, suffered with anxiety and depression and had poor coping skills. The letter states that Mr D posed a low risk to others but an increased risk to himself which would remain higher if not in satisfactory accommodation. It is not clear whether this was written with reference to the letter from housing of January 2009 requesting more specific information. He was discharged from the ward on 6th May 2009.

7.65 Two days later the CMHT spoke to Mr D's mother. Mr D was staying with his mother and the Citizens' Advice Bureau were supporting him to find supported housing. Mr D's mother telephoned the ward asking them to fax her son's discharge summary and his care plan to housing. She reported that Croydon Churches Housing Association were meeting during the next week and would interview Mr D to determine if they could offer him a place to live.

7.66 His new care coordinator attended the Croydon Churches Housing Association with Mr D and his mother on 18th May 2009. Mr D was allocated a tenancy in Sutton. The property was owned by the Carr-Gomm Society and the care was provided by the Croydon Churches Housing Association. This was commissioned by the London Borough of Sutton via the Supporting People Grant. This grant offers low level social care support and was linked to housing benefit.

7.67 On 5th June 2009 confirmation was received that Mr D has been allocated a place in supported accommodation. He took up residency on the 23rd June 2009. The property was supervised by a support worker who assisted all the residents. He helped Mr D register with a local GP which placed him in the catchment area of the Wallington CMHT and arranged a formal meeting with Mr D every fortnight.

7.68 On 23rd July 2009 his care coordinator visited Mr D at the property where he presented as stable in mental health and compliant with medication. His disabled living allowance application was completed, and Mr D was in receipt of all his entitlements.

7.69 Mr D's care coordinator visited Mr D three times during September to November. He appeared to have settled in well and stated that he planned to start a training course. The possibility of discharge from the CMHT was noted.

7.70 The support worker who continued to see Mr D regularly reported that there were no management problems with Mr D. However it was noted that Mr D had no structure to his day although he said he spent most of his time with his family. Staff at the support accommodation reported that Mr D had not spent the time with his family and also reported that Mr D had not spent the time expected in the project. This was not in accordance with the rules of the tenancy. He was warned that he could lose his tenancy. Part of the tenancy agreement was that within two years all tenants would be ready to move on to more independent accommodation and a plan was to be developed to help Mr D achieve this.

7.71 In December 2009 Mr D did not attend his medical review meeting at the CMHT.

2010

7.72 His care coordinator planned to arrange another review appointment and saw him in January 2010. Mr D was judged to be mentally stable and compliant with medication. Mr D failed to attend another medical appointment on 22nd February 2010, but his care coordinator saw him at home again on 11th March 2010. In March 2010 a letter from the CMHT advised Mr D that a CPA meeting had been arranged for 17th May 2010.

7.73 Over the weekend of 1st May 2010, a bank holiday, it was reported by Mr D's family that he was agitated and had run out of medication which they tried unsuccessfully to obtain for him by contacting the duty team and were advised to go to the hospital, but Mr D did not want to do this.

7.74 On Tuesday 4th May 2010, at his supported accommodation during the night, Mr D assaulted a fellow resident and later attacked another resident who died from his injuries. He was arrested at the scene and later charged with murder and actual bodily harm while detained at Sutton Police Station. His care coordinator acted as the appropriate adult during the police interviews. There was no staff cover at the supported accommodation over the weekend and therefore it was not possible to ascertain how Mr D was prior to the incident. Evidence was provided that no animosity had been observed between Mr D and the others living in the house including the victim Mr F.

7.75 On 6th May 2010 Mr D was transferred from court to HMP Highdown where he was assessed by health care staff as low in mood. He reported having schizophrenia and depression, taking fluoxetine and diazepam, and using two bottle of spirits a week. At a subsequent assessment he reported previous suicide attempts. He saw a doctor and admitted alcohol use of up to two bottles of spirits a day, but he was not considered to be withdrawing from alcohol. He

was admitted to the Healthcare Unit and placed in a gated cell. He slept well, but on 7th May 2010 was tearful.

7.76 On 8th May 2010 Mr D supplied urine for drug testing (found positive for benzodiazepines). He was agitated and tearful; He saw the prison GP but the notes were illegible as to their content. At 13:15 hours Mr D put a TV wire round his neck but was found to not be harmed. He was moved to a safer cell where he could be observed every 15 minutes, allowed three conversations per day, and phone links to the Samaritans.

7.77 In the afternoon of 8th May 2010 Mr D had a visit from his mother and sister. Later, after repeated requests for tobacco, a decision to request a full mental health assessment was made and actioned the next day.

7.78 An Assessment Care in Custody and Teamwork (ACCT) was raised the next morning to indicate that Mr D was a prisoner considered to be at some risk of self harm or suicide. He reported his problems were smoking withdrawal and that the attempt to hang himself was a cry for help. It was noted that Mr D was vulnerable and had previous self harm. Mr D attributed this behaviour to family deaths and other issues.

7.79 On 10th May 2010, Mr D was transferred to HMP Belmarsh via the Central Criminal Court. His health records were transferred with him. The recent self harm (hanging attempt) and ACCT were noted, but drug and alcohol issues were recorded as absent. That evening when registered by a nurse there were no concerns about Mr D's mental state but previous self harm (recorded as 'gassing and jumping from a train bridge'), inpatient care, cannabis use and community care were recorded. A locum GP saw Mr D at 20:45 hours. The GP noted a history of schizophrenia and anxiety, but did not feel Mr D was suicidal, and referred him to the prison mental health team. The referral was discussed by the team the next day but no record made.

7.80 Later on 11th May 2010, a letter outlining Mr D's family's concerns about previous suicide attempts and his medication supply was faxed to the governor's office.

7.81 On 12th May 2010 Mr D damaged his cell. He had a segregation psychiatric assessment by the health care team which determined he was not stable enough for segregation. He was admitted to a ward in the Healthcare Unit where after being calm he started banging his head and fist on the door of the ward, demanding a cigarette and threatening to hurt or kill himself. Later that day he was restrained after he attempted to assault a prison officer. A telephone call was made to the health care team to discuss with a mental health nurse whether Mr D could be moved. There were no single cells available in the Healthcare

Unit and Mr D was moved to segregation at about 15:15 hours. He was placed in a gated high control cell with constant watch.

7.82 At about 16:10 hours, 12th May 2010, an ACCT review identified access to money, tobacco and activity as important issues. A segregation algorithm (matrix system) completed at about 18:40 hours determined that Mr D could remain in segregation with 15 minute observations completed to prevent impulsive suicide attempts. Cigarettes as a reward for good behaviour were agreed. At 23:05 hours it was recorded that Mr D spoke of an evil spirit making him cold. He was awake talking to himself until 01:30 hours and slept for less than four hours.

7.83 The following morning Mr D was still cold and at 10:45 hours smeared toothpaste with soap on his head. A further ACCT review was attended by Mr D, healthcare and prison staff. Mr D stated access to tobacco was the cause of his problems. He reported no thoughts of self harm and had future plans. All present agreed he could be moved to a normal segregation cell where he was placed at about 12:20 hours. Fifteen minutes observations were reduced to 24 observations per day.

7.84 At 13:00 hours an officer saw Mr D in his cell with a thick ligature made with a prison sweatshirt round his neck and tied to the window bars. Attempts to revive Mr D failed and he was pronounced dead at 14:36 hours.

8. Outline of Events – Mr F

8.1 The following chronology of events has been compiled from written documentary evidence provided to the independent investigation panel in regard to the victim, Mr F's, contact with psychiatric services.

8.2 Mr F was born in December 1960 and was divorced with two children. He was not in contact with his children and had not been for a number of years prior to his death. At the time of his death, aged 49 years, he had lived in supported accommodation for several years having left his former employment as a postman because of ill health. He was known to have suffered from epilepsy since the age of 18 years and had an average of two fits a year. Mr F reported abusing alcohol consuming 16 units daily. Mr F also had been charged and cautioned for shoplifting in the past.

Contact with Psychiatric Services

8.3 Mr F had minimal contact with psychiatric services. He had reported that he had been admitted to Springfield University Hospital approximately 20 years previously for one week. He had not been able to explain why the admission had taken place or what had been his diagnosis.

8.4 He came in contact with the Trust's mental health services via the Accident and Emergency department of the local hospital when he presented there on 25th January 2010 at 14.26 hours having suffered an epileptic fit three days previously, where he sustained an injury to his wrist.

8.5 He was complaining of a sensation of somebody pulling his stomach out of his body and had not taken his epilepsy medication since the day before as he felt that his medication made the sensation become worse.

8.6 On assessment he was found to be dishevelled in appearance, very anxious but denying active suicidal ideation or intent. He was not thought disordered although distressed and agitated.

8.7 Mr F also stated that "he feels like he is cracking up" but knows this "is mad". He had felt so bad that he thought about harming himself to get away from the feeling. He was referred to the Psychiatric Liaison Team who assessed him. The impression following the assessment was that Mr F's symptoms were as a result of epilepsy and/or alcohol withdrawal. He was prescribed pabrinex, (an injection containing vitamins) and chlordiazepoxide and admitted to the observation bay

in the Accident and Emergency department. It was agreed that if he had not settled by the morning then he would be referred for a further psychiatric review.

8.8 The following morning Mr F was much calmer, he reported that he was no longer experiencing the bizarre sensations of the previous day. It was decided that Mr F could go home and his key worker from his supported accommodation was informed of the situation. A letter was also sent to Mr F's GP. No further contact was made with psychiatric services.

8.9 It is unclear as to when Mr F moved to his supported accommodation but he was already a resident there when Mr D became a fellow resident. Although they are reported to have known each other having lived locally there is no indication that they were particular friends or associates.

9. Analysis of the Evidence – Mr D

9.1 The following analysis has been compiled after an extensive examination of written and oral evidence provided to the independent investigation panel.

Paediatric Services and Developmental Years

9.2 Mr D had a long history of contact with paediatric services from the age of one year. He was reported as being a difficult child, overactive and restless with behaviour problems that were mainly aggression and temper tantrums. These became worse after the death of his father in 1986.

9.3 He had three admissions to hospital aged one, four and six years. The first admission was to a paediatric ward for children with eating difficulties as he was vomiting once or twice a day and had intermittent diarrhoea for three weeks. His symptoms settled and he was discharged home.

9.4 The second admission was for respite care in order to give his mother a short break. Mr D was four years old and known to be disruptive with challenging behaviour, particularly towards his mother.

9.5 Aged six years Mr D was admitted to a Child Psychiatric Ward, a residential unit for children with behavioural problems as he was soiling himself daily. He was discharged after two months.

9.6 Mr D's school years were problematic and he was reported as being disruptive and attention seeking. It is considered by the independent investigation panel that every effort was made by the education and paediatric agencies involved with Mr D to deal with his problems and provide support to his family.

9.7 Mr D received extensive, specialist and holistic care from children's mental health services in his early years. The independent investigation panel believe that the care was committed and consistent. It was aimed at understanding Mr D and his family, and appropriately helped Mr D to mostly remain with his family and in mainstream schooling.

9.8 Mr D appeared not to have received as much care from child mental health services from about the age of 10 to 17 years although it is acknowledged that records for this period are missing. Given the extent of his difficulties (demonstrated by the very young age of issues such as eating problems, aggressive behaviour and self harm), it is unlikely that he was consistently physically or mentally well during these years and therefore it has to be

considered that at the least it was possible that he was using drugs and alcohol to help him manage the symptoms or distress. This may have increased his chance of mental illness later on.

9.9 The independent investigation panel agree with the clinicians at the time that the loss of his father and later his paternal grandmother is likely to have had a large impact on a child who was already emotionally vulnerable.

1999 - 2000

9.10 Mr D, aged 17 years was admitted to the paediatric ward at St Helier Hospital following an attempt to self harm with a belt around his neck. The independent investigation panel consider that the teams involved faced a significant challenge to provide age appropriate care given the predominance of substance misuse in Mr D's case and that the provision of residential and other drug services in the borough was for adults only.

9.11 His transfer to the Woodside Adolescent Unit in Surrey and subsequent admission to an adult residential detoxification ward was as a result of this difficulty.

9.12 Mr D's and his mother's apparent desire to address the substance misuse may have represented an opportunity to engage him early in appropriate services and lifestyle changes, had specialist age appropriate drug services been available. He was not initially admitted to the adult inpatient service due to concerns about the effect of exposure to other drugs and users, and later discharged himself before completing the usual six weeks.

9.13 The independent investigation panel also note that such services are not always available and that the plan for Mr D addressed drug use and other issues. Mr D did not engage consistently with drug services later on. The opportunity for a long term plan to reduce Mr D's dependence on illicit drugs early in his contact with psychiatric services may have been missed.

Adult Years

9.14 Mr D was first assessed as an adult in 2003 having presented as an emergency to the Accident and Emergency department at St Helier Hospital describing mental health symptoms. A psychiatric assessment undertaken by a liaison psychiatrist was adequately detailed with regard to his history, drug use, risks and mental state. He was diagnosed with having a psychotic episode due to his considerable cannabis usage. The overnight admission enabled a slightly more detailed review

and outpatient follow up was arranged in three weeks time. The independent investigation panel consider that a more assertive community engagement in the intervening weeks may have proved more effective in understanding Mr D, his drug use and engaging with him when he felt the need.

9.15 The outpatient assessment three weeks later was thorough, resulting in a referral to the EIS. As an early intervention service for young adults the EIS was the most able to address his psychotic symptoms and other needs. However Mr D did not attend appointments after several attempts to contact him, and it is not clear that any further similar attempts would have usefully engaged Mr D at this stage. Dr A considered that Mr D might have needed an inpatient admission when he referred him to the EIS for ongoing further assessment of Mr D. The independent investigation panel noted the good practice of Dr A who wrote to Mr D asking him to contact him when he was informed that Mr D was not engaging with the EIS. It is considered that a discussion between Dr A and the EIS may have resulted in further different attempts to engage Mr D with the service at this time.

9.16 Three years later in 2006 Mr D was taken to the Accident and Emergency department by the police after threatening to commit suicide by jumping from a height. He was also assessed thoroughly. Although he initially refused, he eventually agreed to voluntary inpatient care, but soon requested self-discharge. The independent investigation panel understand that Mr D's presentations and apparent risks could change rapidly, and support the plan that was made to refer Mr D to the Home Treatment team and outpatients as an alternative to inpatient admission.

9.17 He was reassessed as a low risk to himself and others while on the ward. In the independent investigation panel's opinion that assessment was without a detailed challenge or understanding of this change in his mental state, and despite repeated reports of paranoia and a very recent attempt to jump from a height.

9.18 Mr D did not engage with the initial outpatient or HTT follow up after he discharged himself, but the independent investigation panel believe appropriate steps were taken by the services at this time.

9.19 Over the next two years there are indicators of escalating risks, chaotic behaviour, drug use, mental illness, self harm and some potential opportunities for intervention. Mr D's contact with the psychiatric services at the time was intermittent with his seeking help and attending appointments when he required support. Mr D attended the Accident and Emergency department after cutting his wrists and in November 2008 after a more serious apparent suicide attempt with his car exhaust. He declined admission and was referred to the HTT who did

manage to make contact with him once. Other attempts were unsuccessful and he was discharged from their caseload back to the CMHT.

9.20 During this time it is probable that Mr D's alcohol and substance use was erratic and escalating, it was noted that he was often paranoid about others, and his girlfriend. He was reported to have had intermittent suicidal thoughts and to have been in fights. Mr D had stopped his prescribed medication despite his mother reporting that he was at his best when compliant, and he declined help for alcohol misuse.

9.21 Mr D had intermittent contact with the CMHT, and had attended the Accident and Emergency department with self harm and a suicide attempt. The reactive nature of the care provided is understood by the independent investigation panel as quite standard and in many regards may be desirable and realistic. A more detailed team discussion prior to discharge from the service in July 2008, or in December 2008 after Mr D had failed to engage following a suicide attempt would have provided an opportunity to review his treatment and care.

9.22 The independent investigation panel commend the flexible response to Mr D by the CMHT psychologist who re-opened the case and understood Mr D may have been at risk when he presented in crisis in January 2009. However another CMHT discharge after failing to engage was decided without team discussion and informed by the impression that Mr D had personality difficulties.

9.23 Mr D again received a thorough and flexible response when he presented in crisis to the CMHT base in May 2009 from the CMHT medical and nursing team. During a brief admission a plan for accommodation, allocation of a care coordinator, medical treatment, advice about substance misuse services and access to help in a crisis were all completed. The independent investigation panel also noted that the new care coordinator actively supported with accommodation and benefits. A preferred diagnosis of borderline personality disorder was confirmed by the consultant, Dr J, who had been involved in the decision to admit, and reviewed Mr D on the ward. Under significant time pressure Dr J wrote briefly to support Mr D's housing application. The independent investigation panel believe that it is an omission that details of past risks, history, self harm, paranoia and drug use were not included in this letter.

9.24 Mr D had regular contact with his care coordinator from June 2009 until the incident in 2010. They discussed benefits, housing and other practical matters such as college courses and the possibility of losing his tenancy if he did not adhere to the tenancy rules. The care plan did not address engagement, substance misuse, risk management and other aspects pertinent to Mr D. The independent investigation panel consider this is an omission to ongoing evaluation of his care.

9.25 Despite Mr D having changes in his accommodation, service and professional personnel, including the CMHT manager and responsible consultants, care continuity was maintained as far as was possible at the time. At some points Mr D's care exceeded a more usual standard, in particular when presenting in an emergency or to the out of hours duty team.

9.26 The independent investigation panel found that there were opportunities for mental health services to engage Mr D further and at an earlier stage during his adult years. There were also opportunities for information sharing, inter-team or intra-team discussion that would have prompted a more detailed review of his needs. Mr D's self reports of thoughts of suicide, distress and psychotic symptoms often changed rapidly without a detailed challenge or examination of this change with Mr D. The importance of the examination of Mr D's mental state although often thorough was overlooked at times.

Action taken following the Incident

9.27 After Mr D was taken into custody he was supported by his care coordinator in the role of an appropriate adult during the police interviews. The independent investigation panel were unable to interview this person but were informed that they took on this role alone. It is understood that their continuing contact with Mr D through to and after he was detained in prison was reported as being traumatic, as his care coordinator had built up a supportive relationship with Mr D.

9.28 The independent investigation panel heard that the CMHT team provided emotional support for their colleague through this process but have concluded that this was not adequately formalised with accompanying support from senior colleagues, in particular when visiting Mr D, after the incident whilst he was at HMP Highdown. The absence of senior support in response to this incident is considered by the independent investigation panel to demonstrate inadequate care to the patient, staff and organisation.

9.29 An opportunity was missed to: -

- Assess and treat the patient with clinical intervention
- Support a member of staff through an emotionally difficult time
- Learn any immediate lessons and take appropriate action if necessary
- Provide support to Mr D's family
- Communicate with other agencies and within the organisation

Prison In-reach

9.30 The independent investigation panel reviewed and considered the extent to which mental health services collaborated and informed the prison health care of Mr D's care and treatment. His care coordinator was proactive in visiting Mr D whilst on remand in prison but as already indicated the independent investigation panel were not able to meet with her to ascertain the level of information sharing that occurred. Mr D's mother states that she was extremely worried after she visited her son and was explicit in her concerns that he would attempt suicide and voiced this to the prison staff.

9.31 Mr D had a history of suicide attempts, the most recent whilst on remand at HMP Highdown, and was placed on watch within the prison after displaying disturbed behaviour. This level of observation was discontinued whilst Mr D was on remand in HMP Belmarsh.

9.32 The independent investigation panel could not formulate a view on the assessed level of suicide risk presented by Mr D whilst on remand as none of the prison staff involved were permitted to be re-interviewed as part of this independent investigation. It was apparent that no formal psychiatric review was conducted thus his care and treatment was based on an incomplete assessment. It cannot be surmised if Mr D's full history combined with a formal assessment would have altered the prison management of Mr D whilst on remand, however Mr D's suicide occurred very soon after the level of observations were reduced.

9.33 From the information the independent investigation panel had it is unclear if there are systems or expectations relating to information sharing and collaboration where a person known to mental health services becomes resident within the prison system. It is acknowledged that the Trust did not provide in-reach services to HMP Highdown or HMP Belmarsh.

9.34 From the interviews conducted there was no clear expectation from the prison health care team of face to face liaison, nor was it considered by the Trust that such would occur. However it was acknowledged that such liaison would be beneficial in regards to risk information sharing and the continuing care and treatment of Mr D. The independent investigation panel appreciates that this collaboration may not have existed in any formal agreement but given the severity of the case would have expected more explicit communication.

9.35 It is noted that Mr D's prison health care records were available to HMP Belmarsh from HMP Highdown. It was intimated in one interview that a new electronic system SYSTEM ONE was introduced at this time and his notes to the

investigation team were both handwritten and electronic. It is not known to what extent risk information was relayed between the respective prisons.

9.36 An analysis including the findings of the Prison Ombudsman Report can be found in Section 11.

Family Information

9.37 Throughout Mr D's history with services it was apparent that his mother was the main contact and relation that supported Mr D in seeking and continuing to remain in treatment. The independent investigation panel heard that Mr D's mother was not involved nor informed of the outcome from the investigation conducted by Trust. This resulted in an immediate recommendation that the Trust rectify this oversight with immediate effect and is discussed fully later in Section 10.

9.38 When visited by the independent investigation panel Mr D's mother reported that the Trust had made no attempt to contact either her or Mr D's family and therefore no support was offered to them through this distressing event. It was concluded that support from the Trust was not provided as should have been at the level expected.

9.39 The police did not appoint a family liaison officer to support Mr D's family as he was seen as the perpetrator and not a victim. The independent investigation panel heard that when a suspect is arrested and charged with a serious crime such as murder case there are legitimate reasons why the police do not contact the family of those accused. It may well have been expedient for the police to send a family liaison officer to work with Mr D's family for an initial and short term period. This is not police policy, but due to the exceptional circumstances surrounding the case and the mental state of Mr D at the time this may have been useful.

9.40 The senior police officer in the case agreed with the independent investigation panel that deployment for a family liaison officer, though unusual, may well have had some merit in this particular case, bearing in mind the mental health of Mr D. This was stated by the police as an oversight and they did accept that under the circumstances it would have been relevant for a police family liaison officer to provide support to Mr D's family.

10. Internal Review

10.1 The following section sets out an analysis of the internal review that was completed on behalf of the Trust. It details the internal review's recommendations and the actions taken. The Terms of Reference for this independent investigation panel included a review of the Trust's internal review and set out specific areas to examine:

- Review the Trust's internal review to assess the adequacy of its findings, recommendations and action plans and involvement with both families.
- Review the progress made by the Trust in implementing the action plan from the internal review

Initial Actions

10.2 The Trust, immediately following the incident, informed all of the agencies as required including:

- NHS London's Patient Safety Team.
- The Mental Health Act Commission.
- Care Quality Commission.
- The Trust's Commissioners.

10.3 An incident alert form was completed and followed by a 72 hour initial management investigation report. A liaison meeting was held that included the police and which to a degree met the requirements of the National Memorandum of Understanding between health and police services.

10.4 It does not appear that a senior manager was designated to be the contact person linking all agencies for the purpose of ensuring that communication was maintained.

10.5 The death of Mr F occurred on 4th May 2010. The then Chief Executive of the Trust commissioned an internal review which completed in February 2011. The internal review was set up in accordance with the Department of Health Guidance HSG (94) 27 as amended in June 2005.

The Internal Review Process

10.6 The Trust's internal review followed a clear set of Terms of Reference that were jointly agreed by the Trust, the London Borough of Sutton and the Sutton and Merton Primary Care Trust. They also followed NHS London's Serious Incident Management Policy.

10.7 However the Terms of Reference did not include any reference to providing support and the sharing of information to the families of either Mr F or Mr D. This is of concern under the circumstances particularly as Mr D died whilst on remand in prison.

10.8 The internal review team comprised of:

Chair
Non-Executive Director of the Trust.

Team Members
Executive Director of Nursing and Governance, the Trust.
Director of Social Work, the Trust.
Executive Head of Adults and Safeguarding, London Borough of Sutton.

Project Manager, HASCAS.

10.9 Two team members were from the Trust's senior management together with a non-executive Trust Board member as the chair. Two review members were independent to the Trust, the project manager and representative from the London Borough of Sutton. Administrative support was provided by HASCAS.

10.10 It was agreed that no more than four members of the internal review team would be present at any one interview although the project manager would be present at each. The most appropriate internal review team member/s would attend individual interviews. Each interview was recorded and a transcript of the interview provided to the staff for consideration.

10.11 Nine interviews were undertaken over a period of four days. Those called to interview were in the main staff who had had direct contact with Mr D together with one manager.

Family Support

10.12 The internal review made no contact with either family. Mr D's mother, in particular, was left not understanding or knowing what was happening following

her son's death in custody. This situation was compounded by the circumstances of his death and subsequent Prison Ombudsman investigation.

10.13 The police had not allocated a family liaison officer to Mr D's family as their policy was to only allocate an officer to the family of the victim. They also had advised the internal review to not contact the family of Mr F.

10.14 The internal review's report does refer to the family of Mr D in the following terms:

"The shock of (Mr D) committing a murder and the likelihood of a family member being in prison for many years is difficult to bear, but in this situation (Mr D) committed suicide in prison a few days after the murder."

10.15 At the time the internal review report was written containing the statement above Mr D was not convicted of murder nor at the time of the internal review had an inquest taken place to establish the cause of his death.

10.16 The independent investigation panel are of the opinion that the above statement was unnecessary and could have caused the family of Mr D further distress.

10.17 The Trust did not share the internal review's report with either family and it was not until the independent investigation panel met with Mr D's mother that this omission was found.

10.18 However on the advice from the independent investigation panel Mr D's family were met with by senior members of the Trust and the internal review report shared with them, two years after Mr D died.

10.19 No contact was made by the internal review with the family of Mr F.

Staff Support

10.20 The independent investigation panel heard that some staff received support from the Trust although this was variable. The internal review were able to interview all those who had had direct contact with Mr D.

10.21 They did not interview anyone from HMP Belmarsh where Mr D died. Neither did they interview staff who had been involved with the contact made by Mr F with psychiatric services.

Internal Review Methodology Undertaken

10.22 A Root Cause Analysis process was undertaken and the report included: -

- A list of documents obtained that only contained the case notes of Mr D, no records of Mr F's contact were obtained.
- A timing of Mr D's contacts with psychiatric services, both as a child and adult.
- Investigation of critical issues.
- Contributory factors.
- Findings and recommendations.
- Notable practice.

10.23 The internal review report makes four recommendations all in relation to clinical notes and record keeping. Full details of these together with the independent investigation panel's comments can be found later in this section. The report was presented to and accepted by the Trust Board together with an action plan to implement the recommendations provided.

Findings

10.24 The internal review process was found to be lacking in its understanding of the two individuals involved in this incident and in the examination of their care and treatment. The process appeared to concentrate solely on Mr D and his direct care staff. No attempt was made to gain an insight into his behaviour prior to the death of Mr F by meeting and discussing this with his family. His mother had provided support to her son throughout his contact with psychiatric services and should have been seen as a valuable source of information regarding Mr D.

10.25 The independent investigation panel heard evidence that the internal review team's chair was informed that she did not need to attend the staff interviews and although her name is on the list of interview attendees within the internal review report this is not accurate.

10.26 The internal review chair had only recently been appointed as a Non-Executive Director of the Trust Board, and this was her first experience of participating in an internal review process. This limited her ability to challenge the process being undertaken.

10.27 The internal review report is considered by the independent investigation panel to demonstrate an over reliance on the use of Root Cause Analysis methodology. This has created a report that describes method at the expense of the review's recommendations.

10.28 The recommendations centred mainly on clinical records, record keeping and safe record storage. No mention was made in regard to care and treatment of either individual.

10.29 A tabular format setting out the internal review's recommendations and actions together with the independent investigation panel's view, and in some cases, additional recommendations, can be found below. The first four rows are taken directly from the internal review report and the action prepared by the Trust in response.

Internal Review and its Recommendations

Recommendation One	Action taken by the Agencies	Timescale	Progress
The Trust should undertake an audit of clinical notes to ascertain whether the lack of a clear history and up to date and easily signposted current situation is widespread throughout the Trust. If it found to be widespread there should be some training to ensure that the clinical notes are in future fully fit for purpose in assisting a clinician new to the 'case' being able to quickly and easily understand the history and the current situation in order to respond appropriately knowing the context for the immediate situation.	Data Quality Audit of RiO by Specialist Registrar with Special Interest.	April 2011	Completed

Independent Investigation Panel Comment

The independent investigation endorses this recommendation although this is dependent upon the outcome of the audits and the actions that have been taken and monitored.

Recommendation Two	Action taken by the Agencies	Timescale	Progress
The designated care coordinator must ensure that they review all the available notes about a new patient being allocated to them, and that they contribute to the coherence and completeness of all clinical notes by always reviewing them and ensuring suitable summaries are completed and appropriately signposted within the clinical record.	Updated Community Operational Policy	April 2011	Completed

Independent Investigation Panel Comment

The independent investigation panel consider that updating the policy does not in itself alter practice and that the outcome of the recommendation should be monitored.

Recommendation Three	Action taken by the Agencies	Timescale	Progress
The Trust needs to investigate the location of the medical records created by the Community Mental Health Teams in Sutton as in the case of Mr D some files appear to have been misplaced when the Central Medical Records Department at Springfield Hospital was created. The handwritten notes of clinicians are missing.	Report submitted to the Health Records Governance Group.	April 2011	Completed

Independent Investigation Panel Comment

The independent investigation panel endorses this recommendation.

Recommendation Four	Action taken by the Agencies	Timescale	Progress
The Trust Heath Records Governance Group should urgently review its existing policies and procedures pertaining to the appropriate assessment and recording of risk on RiO. It should then issue clear instructions to all clinicians in order that relevant risk factors are regularly brought up to date and recorded and highlighted consistently in an accessible part of the records following a convention known and accepted by all. Teams should regularly audit the quality of their risk assessments against the standards set by this policy.	Data Quality Audit of RiO by Specialist Registrar with Special interest.	April 2011	Completed

Independent Investigation Panel Comment

The independent investigation panel considers that action needs to include a system of monitoring to clarify if practice continues to be unsatisfactory and to provide remedial action if required.

11. Prison Ombudsman Report

11.1 A clinical review of the events leading up the death of Mr D in HMP Belmarsh was commissioned by NHS Greenwich. The review report was completed in January 2011 and had been set up under the auspices of "undertaking a clinical review following a death in custody, July 2009". Prison and Probation Ombudsman.

11.2 The Terms of Reference were: -

- To examine the provision of care and treatment, including risk assessment and risk management.
- To provide a chronology of the health and social care events leading up to the death.
- To identify any care or service delivery failures along with the factors that contributed to these problems.
- To examine policy and practice.
- To identify any root cause(s) that inform the identification of learning opportunities to be included in the action plan.
- To make clear, sustainable recommendations for the health community and the prison service.
- To provide explanations and insight for the relatives of the deceased.

11.3 The clinical review was undertaken by the following team: -

- Clinical Review Lead and Investigations Manager, NHS Greenwich.
- Independent General Practitioner and Medical Director, NHS Hillingdon.
- Independent Investigator.

Clinical Review Process

11.4 The clinical review followed a process agreed by NHS Greenwich in 2004. Root Cause Analysis methodology was used and a timeline of the events was developed. Seven interviews took place with HMP Belmarsh staff, both prison and healthcare individuals.

Family Support

11.5 The Prison Chaplain and Governor informed Mr D's mother of his death personally at her home. They remained with Mr D's mother and other family members for three hours.

11.6 The clinical review team did not contact Mr D's family and other than information provided to the prison on Mr D's detention no other attempt was made to communicate with the family. The final clinical review report was sent to the family.

11.7 The independent investigation panel found that the clinical review report contained a detailed summary of the events that had taken place following Mr D's arrest and detention in both HMP Highdown and HMP Belmarsh and set out fourteen findings and conclusions using the agreed Terms of Reference as guidance: -

- Records and Record Keeping
- Reception screening
- Mental Health
- Physical Health
- Equitable Care
- Substance Misuse
- Suicide and Self harm
- Communication
- Policies and Procedures
- Incident
- Physical Environment
- Post incident support
- Medicines Management
- Training and staff development

Seven Recommendations were made: -

	Recommendations
1.	Clear clinical leadership and accountability needs to be defined and implemented to ensure quality and clinical governance is maintained and to hold others to account for their responsibilities.
2.	The senior nursing staff should ensure that clinical records are available to clinicians or that the clinician is directed to a suitable terminal before reviewing the patient. A full entry should be made contemporaneously, complying with General Medical Council guidance on record keeping.
3.	The Prison Governor should ensure that there is a fail safe system for receipt and action on faxes.
4.	The Healthcare Department should ensure that there are failsafe processes in

	place for referrals and follow through, in a timely fashion. No satisfactory explanation has been given as to why no assessment was done in this case and the relevant consultant responsible should be asked to ensure that his systems are improved.
5.	Written clinical records must be fully maintained on the computer system in a contemporaneous manner.
6.	All clinical staff involved in care of a prisoner must ensure that they have read their clinical record and take any action to identify and resolve missing or conflicting information.
7.	A review of ACCT panel membership training and random audits by an expert is recommended. Clarification needs to be given to the role of particularly healthcare members and the importance of their specialist knowledge and experience. Confirmation of all panel members being aware of full history and previous ACCT panel minutes and findings is critical.

Findings

11.8 The independent investigation panel made several requests to meet with HMP Belmarsh prison staff and also the clinical review team.

11.9 HMP Belmarsh originally agreed for their staff to meet the independent investigation panel and arrangements were made for the interviews. These were cancelled three times and it was finally agreed that as the prison was not comfortable with participating in the independent investigation information regarding the death of Mr D would be taken from the clinical review.

11.10 NHS Greenwich were contacted with a view to interview the team responsible for completing the clinical review. For various reasons such as staff retirement the independent investigation panel were unable to meet with the team and had no further contact with NHS Greenwich despite several telephone calls and email correspondence.

12. Findings and Recommendations

12.1 The following section sets out the independent investigation panel's findings and recommendations. These have been identified from a detailed analysis of the evidence, both oral and written, that has been presented to the independent investigation panel. The recommendations have been completed for the purpose of learning lessons and for the Trust to put into progress any actions required to prevent a similar occurrence. It also sets out areas where the independent investigation panel have identified notable practice.

12.2 Whilst writing this report the independent investigation panel are mindful of the changes, both in Chief Executives and service provision during the period under consideration and whilst the independent investigation was taking place.

12.3 Service change can be a challenge and the Trust has had this challenge compounded by the senior executive management difficulties. It is acknowledged by the independent investigation panel that changes in large organisations do not happen overnight. The Trust has significantly more to do to achieve their vision for the future.

12.4 The independent investigation panel heard from one of the Trust's commissioners that the Trust has been committed recently to implement the service developments required to make their services safer for the individuals under their care.

Notable Practice

12.5 It is normal process in investigations into tragic circumstances such as the death of a patient to set out areas of notable practice. In this case there were several areas that the independent investigation panel found they specifically wished to single out as examples of good practice. These have been set out as follows: -

<u>Paediatric Services</u>

12.6 Mr D's long history of contact with both general Paediatric and Child and Adolescent Mental Health Services was extensive. He received specialist and holistic care from these services which was committed and consistent with the aim of him to remain mostly with his family and in mainstream schooling.

12.7 During Mr D's late teenage years there were areas that could have been improved and these are dealt with later in this section.

Early Intervention Service

12.8 The referral by Dr A of Mr D to the Early Intervention Service in 2003 was the most appropriate given Mr D's presentation at that time. The independent investigation panel noted the communication between Dr A to Mr D when he failed to attend the appointments with the Early Intervention Service. This demonstrated good practice in persisting in attempting to engage with Mr D.

Psychology Service

12.9 The independent investigation panel commend the flexible response made by the psychology service to re-open Mr D's case when he presented in crisis in January 2009. This was done despite a period of non-engagement and non-attendance for psychology appointments.

Recommendations

12.10 The independent investigation panel's experience of undertaking this investigation was made more difficult by the lack of senior Trust commitment to ensure that the independent investigation process received an appropriately high profile.

12.11 This impacted on the process and participation of staff at all levels of the Trust and has been discussed with the Trust's new Chief Executive.

12.12 The independent investigation panel's opinion was that the degree of responsibility taken and leadership within the Trust for both the internal and external investigation process was not proportional to the gravity of the incident. Trust leadership did not impact positively on the organisation in regard to taking responsibility and accountability for the investigation process or an appropriate level of responsibility and subsequent accountability for Mr D and his care.

12.13 These recommendations are in relation to specific findings working on the basis that the Trust has properly constituted appropriate governance lines to assist the Trust in furthering and improving the quality of their services. The recommendations have not been set out in priority order.

Residential Detoxification

12.14 Mr D, aged 17 years, attempted to self harm with a belt around his neck. Although the services did attempt to provide adequate age appropriate care to Mr D in regard to the predominance of substance misuse and the availability of

residential and other drug services, there were no adolescent services specifically for this purpose.

12.15 A long term plan to reduce Mr D's dependence on illicit drugs was not available.

Recommendation One

It is recommended that the Trust considers how future services and clinical care pathways are established for adolescent substance misusers to address their needs, and that a report outlining appropriate plans to address this issue is presented to the executive committee.

Family Communication

12.16 The independent investigation panel found that up until their involvement Mr D's family had not been contacted by the Trust or the internal review team.

12.17 The family informed the independent investigation panel that the trauma of realising their son may have caused the death of another and then dying whilst in prison, had a profound impact. They reported that they had no support or information except having access to the Prison and Probation Ombudsman Report which was completed in January 2011.

12.18 They did not have access to the Trust's internal review report until requested to do so by the independent investigation panel. It is understood that the Trust have now met with Mr D's mother and offered her counselling. Senior managers have also discussed the internal review report with his family.

Recommendation Two

It is recommended that following a serious incident such as a homicide by an individual receiving mental health services that the Trust's responsibilities are aligned to the expectations set out within the Department of Health guidance HSG (94) 27 and their duty of care. This would ensure that families of the victim and perpetrator are notified of the actions being taken and that support is provided within a timely manner. It is further recommended that the implementation of this recommendation be monitored by regular audit reporting to the Trust's Clinical Governance Committee.

Recommendation Three

It is recommended that following a serious incident such as a homicide a senior manager from the Trust is designated to provide support and information to the family. It is further recommended that the implementation of this

recommendation be monitored by regular audit reporting to the Trust's Clinical Governance Committee.

Recommendation Four

It is recommended that for all serious incidents, such as a death of a patient, that results in the Trust setting up an internal review the family of that individual are given an opportunity to participate in the review process. The family should also have access to the final review report. It is further recommended that the implementation of this recommendation be monitored by regular audit reporting to the Trust's Clinical Governance Committee.

12.19 The independent investigation panel heard that the police investigating Mr F's death did not appoint a family liaison officer to support Mr D's family and keep them informed of the ongoing investigation. It was acknowledged by a senior police officer that although not a routine process in murder investigations, this should have been considered in Mr D's case taking into consideration his mental state and the close involvement of his mother as an informal carer.

Recommendation Five

It is recommended that in cases where individuals with mental illness commit a serious crime causing the death of another that the police consider appointing a family liaison officer to support that person's immediate family.

Engagement with Services and Clinical Care

12.20 The mental health services found Mr D difficult to engage with, frequently not attending appointments and mental health reviews. He was referred to services appropriate to his care needs such as the Early Intervention Service and Home Treatment Team but discharged from their caseloads after not attending appointments as per the protocol and without a team review of Mr D's care and treatment. When allocated a care coordinator in 2010, Mr D received practical support but there is limited documentation regarding his mental state, risk and substance misuse.

Recommendation Six

It is recommended that in complex cases such as Mr D's that a care plan to establish and maintain contact and engagement is agreed between the individual and service. This should include liaison with close family and the support that they can give and consideration of a carer's assessment. It is further recommended that the implementation of this recommendation be

monitored by regular audit of the Care Programme Approach as functioning in the Trust and is reported to the Trust's Clinical Governance Committee.

Housing Applications

12.21 The independent investigation panel were informed that details regarding Mr D's risk to himself and others, his self harm, paranoia and illicit substance misuse were not disclosed on the housing application made to support his housing requirements. The Housing Organisation was therefore unaware as to the potential risk that he posed to other more vulnerable residents.

Recommendation Seven

It is recommended that the Trust reviews its systems and training for clinical staff to ensure adequate focus on mental state, risk assessment and carer's needs. This should be included in regular audit and governance processes.

Recommendation Eight

It is recommended that when professionals write to support an individual's housing application that information regarding potential risk areas is disclosed. Regular audit of this should be undertaken in conjunction with the case record audits. Additionally a review of the application form should take place between the two organisations to ensure it meets the relevant objectives.

Local Action taken following the Incident

12.22 The independent investigation panel heard that Mr D's care coordinator acted as his appropriate adult following his arrest and also visited him in prison on her own. Although this member of staff was not available to interview evidence was provided that this process had a profound impact on that person emotionally.

Recommendation Nine

It is recommended that when staff, particularly junior staff, are required to act as appropriate adults and also maintain support to a patient under tragic circumstances this should be documented in the patient's case notes.

In addition it is further recommended that the member of staff should receive support from their senior managers and this recorded in multi disciplinary team notes and supervision records.

Communication and In-reach Prison Services

12.23 The independent investigation panel heard that there is not a formalised requirement to share clinical information with healthcare professionals once a patient is on remand. However Mr D was a patient of the CMHT and as a patient on enhanced CPA there was a clinical obligation to ensure adequate transfer of relevant information especially in the circumstances when risk has increased.

Recommendation Ten

It is recommended that following a high profile catastrophic event that results in a patient under their care being arrested and on remand, that the Trust, as part of its initial response, will actively consider and follow through the transfer of clinical information, and audited as part of the Trust's monitoring of its response to serious incidents.

Organisation Response

12.24 It was found that the organisational responsibility taken by the Trust after such a high profile and tragic incident was inadequate and a missed opportunity to support both learning and professional obligations to their patients and families.

Recommendation Eleven

It is recommended that the Trust review and establish robust procedures following such catastrophic events to ensure senior leadership oversees their response. This must include support and understanding for the local team, ensure professional medical leadership, organisational learning and awareness of the impact on patients, families, carers and the organisation, and that this response is audited as part of the Trust's monitoring of its response to serious incidents.

12.25 The independent investigation panel have no further comment to make about Mr F's contact with psychiatric services. It is considered that the appropriate care was provided and the decision not to refer Mr F for further psychiatric services and his GP informed of this was adequate and in line with good practice.

In Conclusion

12.26 The independent investigation panel considered whether the death of Mr F could have been predicted and or prevented.

12.27 Both Mr D and his family sought help over the weekend of the incident. However the independent investigation panel are unable to say that a service response would have changed the subsequent event.

12.28 In considering the death of Mr D, if a thorough assessment by a senior psychiatrist or suitable qualified mental health professional had taken place, the level of risk that he posed might have been understood differently and his care needs informed accordingly. Again the independent investigation panel cannot conclude whether this would have altered events, nor to identify causative factors that would have contributed to the events that took place.

Documentation Received Appendix One

- Trust Internal Review Report
- Prison Ombudsman Report
- Press Cuttings
- Clinical Notes
- Trust Initial Serious Incident Notification Form
- Sutton Safeguarding Event – Multi Agency Report – 27th July 2011
- Trust Profile Information
- Sutton and Merton Organisational Chart – October 2009
- Trust Annual Report 2009
- Trust Annual Report 2010
- Trust Policies Current in 2010:
    - Care Programme Approach
    - Observation and Intensive Engagement Policy
    - Risk Assessment Policy and Guidance (NB This is also the current policy)
- Policies Current in 2012:
    - Care Programme Approach
    - Observation and Intensive Engagement Policy
    - Clinical Risk and Vulnerability Training (This was also current in 2010 but was reissued in May 2010)
- Trust Organisational Governance Structure
- Trust Risk Management Strategy 2009 – 10 and 2010 – 11
- Trust Action Plan arising from RCA report
- Police Closing Report
- RiO – Risk Overview

- Reporting, Investigating and Learning from Serious Incidents (Sis) Policy
- Internal Investigation Documentation
- Prison Records
- GP records
- Police – Forensic Medical Examiner Entry
- Quality Report – January 2012
- Quality Report – February 2012
- Clinical Risk Register – 23rd March 2012
- Serious Incident Governance Group Quarter 2 Report (not dated)
- Serious Incident Governance Group Quarter 3 Report (not dated)
- Forensic Medical Examiner Information
- Mr F's Clinical Records
- Mental Health Serious Case Review