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

**March 2013**

A report for NHS London
Undertaken by Verita

NHS London

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Verita is a management consultancy that works with regulated organisations to improve their effectiveness and levels of service. It specialises in conducting independent investigations, reviews and inquiries.

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# 1. Introduction

**1.1** Mr G killed his girlfriend, Ms H, at their flat between 1 September and 8 September 2010. The exact date and cause of death are unknown.

**1.2** Mr G was first referred to mental health services in 2008 by his GP. He was under the care of Barnet, Enfield and Haringey Mental Health NHS Trust (the trust) at the time of the incident.

**1.3** Mr G had intermittent contact with the trust until the incident. This included outpatient appointments and home treatment team (HTT) visits.

**1.4** Mr G pleaded guilty to manslaughter on the grounds of diminished responsibility on 7 November 2011. He was jailed for ten years.

**1.5** The trust carried out an internal investigation into the incident, which began in December 2010 and was completed in early 2011.

**1.6** In 2012 NHS London, the strategic health authority (SHA) for London, commissioned this independent investigation into the care and treatment of Mr G. NHS London asked Verita to lead the work, assisted by a forensic consultant psychiatrist. The investigation was initially commissioned as a desktop review (a review of relevant documentation) because the trust's internal investigation was so comprehensive.

**1.7** At the beginning of the investigation we received copies of substantial correspondence that Mr G's estranged wife had sent complaining about the care given to her husband. As a result of her concerns, the SHA escalated this investigation to include interviews of clinicians and managers of the service, so an additional Verita staff member joined the team.

**1.8** The terms of reference for this investigation are set out in the next section. We were mindful in our investigation of the concerns of Mr G's estranged wife and examined many aspects of them within our terms of reference. However, responsibility for answering her specific complaints lies with the public bodies she made them to.

**1.9** Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Tariq Hussain, Dr Sian McIver and Kathryn Hyde-Bales carried out the investigation. Their biographies are included at appendix E.

**1.10** Derek Mechen, partner, peer-reviewed this report.

## 2. Terms of reference

**2.1** This independent review 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.

**2.2** The aim of the independent review is to evaluate the mental health care and treatment provided to Mr G 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 G and the victim as fully as is considered appropriate in liaison with the police
- assess the adequacy of risk assessment and consideration given to safeguarding issues
- an examination of the mental health services provided to Mr G and a review of the relevant documents
- the extent to which Mr G's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- consider other such matters as the public interest may require
- complete an independent review report for presentation to NHS London and assist in the preparation of the report for publication.

**Approach**

**2.3** 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.

**2.4** 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. Executive summary and recommendations

**3.1** Mr G was 32 when he killed his girlfriend, Ms H, at their flat between 1 September 2010 and 8 September 2010. The exact date and cause of death are unknown. He confessed to the killing on 15 October 2010 while he was an inpatient on Avon ward, a trust psychiatric intensive care unit (PICU). Mr G was arrested and taken in to custody. He pleaded guilty to manslaughter on grounds of diminished responsibility and was jailed for ten years.

**3.2** Mr G is Egyptian and came to England in 2004. He met his estranged wife in Egypt and they married in 2003, but had been separated from her since 2007. He continued to have contact with his estranged wife because they have a daughter, whom he visited regularly.

**First referral to trust service**

**3.3** Mr G was first referred by his GP to Barnet Psychiatric Services on 12 September 2008 after expressing suicidal thoughts. He was suffering from acute depression. He was prescribed antidepressant medication and then supported by the trust's East Home Treatment Team (HTT) until 21 October 2008. The HTT team visited him on almost daily until he was discharged. He was discharged back to the PCMHT but did not engage with them and was discharged to his GP from the team in July 2009.

**Second referral to trust services**

**3.4** Mr G's GP referred him to the Barnet Primary Care Mental Health Team East (PCMHT) in June 2009. He was required to complete an opt-in form before receiving a service but he did not do so and the referral was closed on 14 July 2009.

**Third referral to trust services**

**3.5** Mr G was taken by ambulance to Barnet Hospital Accident and Emergency (A&E) department early on 18 August 2009. He told the A&E duty psychiatrist that he had gone

out in his car during the night with the intention of crashing it. The Springwell mental health assessment centre at Barnet hospital was told about his visit to A&E and later that morning tried without success to phone him to invite him to attend for assessment.

**3.6** Mr G contacted the Springwell centre in the early evening and told a member of the nursing staff that he had been feeling unwell and his mood was low. He said he had not been sleeping and was experiencing panic attacks. He said he felt better after taking his clonazepam. He told the nursing staff he had stopped taking his medication shortly after discharge from the HTT. He was advised to see his GP to discuss medication and was given emergency contact numbers.

**3.7** Mr G was seen by a GP on 20 August 2009 and referred for assessment at the Springwell centre because his suicidal thoughts were continuing. He told staff at the centre that the previous day he thought he either had to 'kill the flowers' on his balcony or jump off it, that he was experiencing feelings of hopelessness, was not sleeping and had lost his appetite.

**3.8** The assessment team offered to admit Mr G but he did not agree and they therefore referred him to the HTT. The team visited Mr G almost daily from 21 August until 4 September. He was generally stable towards the end of this period, though he occasionally reflected on his past and was sometimes low in mood. He was taking his medication regularly.

**3.9** Mr G was discharged from the HTT on 4 September and referred to the PCMHT. An appointment was made for him to see the PCMHT consultant psychiatrist on 2 October 2009.

**3.10** Mr G was referred by his GP to the HTT, during the period between appointments, because he was having difficulties at work; colleagues said he was threatening violence, isolating himself from others and having irrational conversations. He told the HTT that he was unable to collect his prescription from the surgery and had therefore stopped taking his medication. Arrangements were made to have his medication delivered to him.

**3.11** Mr G had his initial appointment with the PCMHT consultant psychiatrist on 2 October. The psychiatrist noted that Mr G became quite aroused when talking about his social circumstances. He was working as a caretaker at a school and felt that he had been

unfairly treated and treated like a slave at work. He told the psychiatrist that he had recently ended his relationship with Ms H. He was off work. The psychiatrist assessed his risk as low and advised his GP to increase his antidepressant medication.

**3.12** The PCMHT consultant psychiatrist saw Mr G every four - six weeks after this initial appointment until March 2010.

**3.13** The PCMHT consultant psychiatrist reviewed Mr G on 11 March 2010 and found he had a more positive outlook. He was showing no significant depressive symptoms or suicide ideation. His panic attacks were less frequent and he was living with Ms H again. Mr G said that Ms H was pregnant but we have seen no evidence to support this. The consultant psychiatrist supported Mr G's return to work. As a result of his improved condition he was discharged to his GP. Ongoing medication was recommended by the consultant.

**Referral back to PCMHT**

**3.14** Two months after this discharge from the PCMHT Mr G was signed off work by his GP because he was again having difficulties at work. He was complaining of being bullied and harassed. His GP did not view him as fit to work with children.

**3.15** The PCMHT duty worker contacted him. He recounted the difficulties at work and the distress they were causing him. He said that he had resigned because it was driving him to feel suicidal. He said he would not act on his suicidal thoughts because he had a five-year-old daughter. Mr G told the duty worker he was going on holiday to try to relax and would contact the PCMHT on his return. Mr G was written to and asked to make contact with the PCMHT within three weeks. However, he failed to respond and was subsequently discharged from the service and referred back to his GP on 25 June 2010.

**Arrested**

**3.16** On 23 July 2010 Mr G was arrested and charged with common assault of Ms H. He was remanded into custody at HMP Wormwood Scrubs until 27 July for psychiatric assessment.

**3.17** Mr G attended court on 27 July and the probation service asked the court diversion scheme consultant (CDS)[1] (consultant A), who was also a PICU consultant psychiatrist at the trust, to assess Mr G. He interviewed both Mr G and his girlfriend, Ms H. Consultant A noted that Mr G had frequent arguments and fights with Ms H, owed money to her and had been smoking cannabis. He found Mr G guarded and agitated; there were discrepancies between the accounts of Mr G and Ms H. Mr G was on a combination of antipsychotic and antidepressant medication.

**3.18** Consultant A's assessment was not a commissioned service so he did not have access at the court to the trust electronic patient record and he did not know about Mr G's previous contacts with trust mental health services. He recommended that a psychiatric assessment in the community be a condition of bail. Both the consultant and the police reported to the court their impression of Mr G's developing mental illness.

**Remanded to prison**

**3.19** Consultant A was not present at the court hearing and so did not know that the court rejected his recommendation. Mr G was denied bail and remanded in prison for one month.

**3.20** Consultant A checked the electronic patient record system (RiO) for information on Mr G when he returned to the trust, but his documents contained different spellings to the trust records. Consultant A was therefore unable to access the trust records and so did not know about his mental health history.

**3.21** Consultant A did not know Mr G had been remanded in custody and wrote to him and his girlfriend on 30 July inviting them to have a further assessment.

[1] The court diversion scheme is a service that provides mental health assessments at court. The court is then able to determine what action to take based on the assessment. In this court this was not a commissioned service and was being run by this consultant in addition to his other contracted work as he had an interest in forensic work. This arrangement was known to trust managers and clinicians.

**Granted bail**

**3.22** Mr G was granted bail on 24 August 2010 with conditions to appear at Hendon Magistrates' Court on 2 September 2010.

**Assessed by GP**

**3.23** Mr G went to his GP surgery the next day, 25 August. A trainee GP assessed him and noted that he was suffering from anxiety with depression and that he had difficulty finding accommodation. A mental health link worker also saw him and gave advice on contacting the local authority homeless unit.

**Living with girlfriend in a hotel**

**3.24** Between 27 August and 1 September, Mr G and Ms H stayed at a hotel and then moved into a flat together.

**Arrested and girlfriend's body discovered**

**3.25** Mr G failed to attend his bail hearing on 2 September and as a result was arrested on 9 September at the home of his estranged wife. At this time the landlord of his flat discovered the body of Ms H, who had been killed between 1-8 September. Mr G was arrested on suspicion of murder.

**3.26** The results of the post mortem examination were inconclusive. Mr G was charged with the original assault on his girlfriend and remanded in Brixton prison on 10 September. He remained in Brixton prison until 28 September. His behaviour varied from settled to irate and depressed. He was prescribed mirtazapine, an antidepressant.

**Released from prison**

**3.27** Consultant A attended court on 27 September to undertake an assessment of Mr G at the request of the police. However, Mr G declined to be assessed on the advice of his solicitor. On 27 September Mr G was found guilty of the original assault. He had already served 40 days in prison so he was released but he did not leave Brixton prison until 28 September. Mr G had not at this stage been charged with killing his girlfriend.

**3.28** Consultant A contacted the Haringey PICU ward manager the day Mr G appeared in court, to tell her of his concerns about him. The ward manager wrote to trust staff who might come into contact with Mr G to tell them that Mr G had just been in prison and that his girlfriend had recently died. She said that consultant A was to be contacted before any psychiatric assessment and that he could be contacted at any time.

**Mr G goes to Scotland**

**3.29** Consultant A phoned Mr G on 4 October inviting him and his estranged wife to an appointment. He spoke with her mother who told him that Mr G did not want to see him and that he had gone to Scotland to visit friends. Neither Mr G nor his estranged wife was able to attend the appointment.

**3.30** Mr G's friends found his behaviour erratic and sent him back to England.

**Mr G is admitted to the Dennis Scott Unit**[1]

**3.31** Mr G went to the Dennis Scott mental health unit at Edgware community hospital on 8 October and was transferred to the Springwell mental health unit for assessment.

**3.32** Mr G was assessed there by consultant A, who was approved to conduct Mental Health Act assessments, and an approved mental health practitioner (AMHP). Mr G described suicidal thoughts, sometimes hearing voices and feeling paranoid. He did not want to discuss his recently deceased girlfriend. Mr G was deemed a risk to himself and possibly others. He was detained under Section 2 of the Mental Health Act 1983.

[1] This is a trust mental health unit.

**3.33** Mr G was admitted to the St Ann's Hospital PICU (Avon Ward) where he was placed under continuous supportive observation. He was prescribed medication, regularly reviewed by nursing and medical staff and seen twice by a psychologist.

**3.34** Mr G's mood was generally low and sometimes agitated and angry during the early part of his time on the ward. His mood lifted later and he began to take part in therapy activities.

**Mr G confesses to killing his girlfriend**

**3.35** Mr G was assessed by consultant A and his PCHMT consultant psychiatrist on 15 October. The ward doctor and two ward nurses were present at the assessment.

**3.36** Mr G confessed to the murder of his girlfriend, Ms H. He said the killing was a mistake. They had been arguing and he had called the ambulance and the police but he could not continue the call. Mr G had been asked a number of times how his girlfriend had died.

**3.37** The assessment stopped when Mr G became upset. Consultant A told Mr G that he was going to call the police. Mr G was taken into police custody.

**Findings**

**3.38** The following findings should be read in conjunction with the findings and recommendations of the trust review, which we include in our report and with which we agree.

**F1** The care the HTT gave Mr G in 2008 and 2009 was appropriate, effective and delivered to a high standard.

**F2** The care the PCMHT gave Mr G in 2009 and 2010 was appropriate, effective and delivered to a high standard.

**F3** The requirement for Mr G to complete an opt-in form may at times have been a barrier to his receiving the services for which he had been referred.

**F4** Mr G was asked a number of times during his stay in Avon ward about his possible involvement in the death of his girlfriend.

**F5** **C**oncern was raised by GPs that direct contact between GPs and consultant psychiatrists had become more difficult as a result of changes to referral processes.

**F6** The care Mr G's GPs gave him was of a high standard, as was the partnership between the trust and the GP practice.

**F7** The lack of effective management, governance and administrative support to the court diversion work of consultant A contributed to an inadequate assessment of Mr G's mental health.

**Recommendations**

**R1** The trust should ensure that guidelines for the use of opt-in forms should set out when additional processes such as phone follow-up are needed to effectively assess a person's willingness to engage with the service. Opt-in forms must be clearly written and available in other relevant languages.

**R2** The trust should use the facts of this investigation to run a multi-professional learning event to examine what ethical, professional and legal issues arise if a patient who is a suspect in a criminal case could incriminate himself or herself by answering staff questions.

**R3** The trust should examine whether a route for direct consultation by GPs with consultants is needed and whether this can be offered without undermining the general referral processes.

**R4** Trust managers must ensure that all trust court diversion services are effectively organised, resourced and subject to suitable agreements with the court. There must also be effective management and governance arrangements in place, whether the court

diversion service is commissioned or not. If the Hendon court diversion service cannot be so organised it must not continue to be provided.

**Predictable or preventable**

**3.39** Mr G's main problem during most of the time trust staff were caring for him appeared to be depression, anxiety and suicidal ideation. In the latter stages of his contact with the trust assessing staff detected an emerging paranoia.

**3.40** The only evidence of violence during Mr G's care was his assault of his girlfriend. Consultant A interviewed her and after Mr G's appearance at court she was still content to live with him. She did not report any fear that her life was in danger.

**3.41** The trust panel concluded that those involved in caring for Mr G could not have predicted the killing, though some aspects of his care and treatment needed to be addressed. We agree.

**3.42** We considered whether any actions or inactions on the part of staff could have prevented the killing, we do not think so. Our review of Mr G's care shows whenever he presented in distress or with mental health concerns he was appropriately assessed, treated or provided with a service. When he failed to engage with the mental health service he was referred back to his GP with whom there was good partnership working. Until Mr G's final admission he was never so ill that he needed to be detained or treated against his will either for his health or the protection of others.

# 4. Approach

**4.1** The investigation was held in private. We interviewed seven staff from the trust. We also held phone interviews with two GPs. A list of those interviewed is attached at appendix D.

**4.2** We met Mr G to explain the purpose of the investigation and to see what he thought about his care. He agreed in writing to give us access to his medical and other records. We told him that the SHA was likely to publish the report. We saw Mr G again to give him an opportunity to comment on the draft report.

**4.3** We also met Mr G's estranged wife who provided us with a series of letters she had written to various NHS and regulatory organisations complaining about the care Mr G had received.

**4.4** We wrote via the police victim and family support team to Ms H's family in America and to Mr G's family in Egypt, inviting them to meet with us. Neither responded.

**4.5** We saw the trust's papers produced at the time of the internal investigation. This included notes of interviews with practitioners and managers.

**4.6** The trust's analysis of Mr G's care was comprehensive and covered a wide range of relevant issues. Where we agree with this analysis, we do not cover the issues in depth but include the findings and conclusions of the trust investigation. We make clear where we disagree.

**4.7** In our report we have sought to quote accurately from documents and transcripts of interviews and from the electronic patient record. Staff making entries in the electronic patient record do so in a busy environment, not expecting to be quoted in official reports. Some of our quotes from the electronic patient record contain a high number of spelling and grammatical errors. We have not corrected any quotes and have not used the convention of including 'sic' to highlight errors as in some cases this might detract from the content of the quote.

**4.8** A number of teams were involved in offering care to Mr G and we provide a brief description of the roles of each in appendix A.

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

## 5. Chronology of Mr G's care and treatment

**5.1** Mr G was 32 when he killed his girlfriend, Ms H, between 1 September 2010 and 8 September 2010. The cause and exact date of death are unknown. He confessed to her killing on 15 October 2010 while an inpatient on Avon ward, St Ann's Hospital. He was arrested and taken in to custody. He pleaded guilty to manslaughter on grounds of diminished responsibility and was jailed for ten years.

**5.2** This chronology has been developed from the one in the trust internal investigation report. The information contained in the chronology has been cross-checked against Mr G's clinical records and further information has been added where necessary.

**5.3** We divide this chronology in two. The first part is from 2008 until the end of June 2010; the second from July to October 2010. We separate this latter period because it requires a more detailed chronology to identify whether the actions of mental health and primary care staff when Mr G's mental health had deteriorated were appropriate.

**2008 to June 2010**

**5.4** Mr G is Egyptian and came to England in 2004. His parents and siblings live in Egypt. He met his estranged wife in Egypt and they married in 2003. They separated in 2007. He and his estranged wife continued to have contact because they have a daughter, whom he visited regularly.

**5.5** Mr G's GP first referred him to Barnet Psychiatric Services on 12 September 2008 after he had expressed suicidal thoughts. He was assessed by the mental health liaison team, who referred him to the East Home Treatment Team (HTT) where he was diagnosed as suffering from acute depression. He was initially prescribed clonazepam[1] and then mirtazapine[2] as well.

**5.6** The RiO[3] notes show that Mr G was being supported by the HTT almost daily between 12 September and 21 October. The entry for 18 October records: *"Inform* [Mr G]

[1] clonazepam is typically used to treat anxiety disorders
[2] mirtazapine is an antidepressant
[3] electronic patient record

*of PCMHT appointment on the 20.10.08"*. We found no record of this appointment being made or progressed.

**5.7** Mr G was discharged from the HTT on 21 October 2008. The RiO note says this was a result of a decision at the HTT meeting that morning but does not say why.

**5.8** A psychologist records on 24 October 2008 that after a referral from the HTT psychiatrist he scheduled an assessment appointment for 27 October 2008 but nothing in the notes shows that this assessment took place.

**5.9** Mr G was referred by his GP to the Barnet Primary Care Mental Health Team East (PCMHT) in June 2009. An assistant psychologist screened the referral and diagnosed mild to moderate depression. Mr G was invited for short-term treatment. He was sent an opt-in form, which he was required to complete with background information. He did not complete it so the referral was closed on 14 July.

**5.10** Mr G was taken to Barnet A&E department by ambulance early on 18 August 2009. He told the A&E duty psychiatrist that he had gone out in his car during the night with the intention of crashing it. He was discharged and referred to his GP. The Springwell mental health assessment centre at Barnet hospital was told about the visit to A&E and later that morning attempts by staff from the Springwell centre were made to contact Mr G by telephone to invite him to attend for an assessment, but without success.

**5.11** Mr G contacted the Springwell centre in the early evening and told a member of the nursing staff that he had been feeling unwell and his mood was low. He had not been sleeping and was experiencing panic attacks. He said he felt better after taking his clonazepam. He told the nursing staff he had stopped taking his medication shortly after discharge from the HTT. Nursing staff advised him to see his GP to discuss medication and was given emergency contact numbers. He went off sick from work.

**5.12** A GP saw Mr G on 20 August 2009 and referred him to the Springwell centre for assessment. Mr G told staff that the previous day he had thought that he either had to 'kill the flowers' on his balcony or jump off it. Mr G told the assessment team that he was experiencing feelings of hopelessness, was not sleeping and had lost his appetite.

**5.13** The RiO recording shows that a psychiatrist carried out a comprehensive assessment. The summary impression recorded was:

> *"recurrence of depression after period of non-compliance with medication. Moderate-high risk of suicide."*

**5.14** The psychiatrist sought advice from a colleague who was designated as the 'bleep holder'[1] and it was concluded that:

> *"…admission probably not necessary (pt says he'd rather not be here anyway as it's like a prison)"*

He was referred to the HTT for review and prescribed clonazepam and mirtzapine.

**5.15** The HTT visited Mr G almost every day from 21 August until 4 September. The RiO entries in the last ten days of August show that Mr G was generally stable, though he was reflecting on his past, sometimes low in mood and taking his medication and living with his girlfriend.

**5.16** Mr G was visited by a senior member of the HTT nursing team on 4 September. He appeared calm and pleasant. He told the assessor he was intending to return to work. He said that he was upset about issues with his daughter and that he was having problems in his relationship with his estranged wife who was making constant demands on him. He was advised to contact the Citizens Advice Bureau, which he said he was planning to do.

**5.17** Mr G was told that he was being discharged from the HTT but that an appointment had been made with the PCMHT on 30 September. He was given a note of this appointment, a list of emergency contact numbers and a 14-day supply of medication. He was told that his GP was being informed of his discharge.

**5.18** Mr G's GP contacted the HTT on 25 September 2009, outlining concerns from Mr G's work colleagues; his colleagues said he was threatening violence, isolating himself from others and having irrational conversations.

[1] The bleep holder needed to be contacted to discuss bed availability.

**5.19** The HTT contacted Mr G twice on 25 September 2009. Mr G was described as angry in the first call, saying he felt unable to collect his medication prescription from his GP surgery. The GP subsequently arranged for the local pharmacy to deliver the medication. The note of the second phone call describes Mr G as being considerably calmer. He told the HTT that he had not taken his medication for a number of days but was going to start that evening. He was reminded of his appointment with the PCMHT scheduled for 2 October 2009.

**5.20** Mr G had his initial appointment with the PCMHT consultant psychiatrist in outpatients on 2 October. The psychiatrist noted that Mr G became *"quite aroused"* when talking about his social circumstances. He told the psychiatrist that he had recently ended his relationship with Ms H. He was working as a caretaker at a school and felt that at work he had been unfairly treated and treated like a slave. He was off work until 15 October. His risk was assessed as low. His GP was advised to increase his mirtazapine from 15 to 30 mg at night.

**5.21** The PCMHT consultant psychiatrist saw Mr G every four to six weeks between early October 2009 and March 2010 after this initial appointment. His GP retained responsibility for his medical prescriptions of clonazepam and mirtazapine. Mr G was generally noted to be in a positive mood and started going back to work for a few hours in the morning.

**5.22** There was a slight relapse when Mr G requested and attended an emergency appointment with the consultant psychiatrist in November 2009. He described experiencing panic attacks and feeling less motivated. At an appointment on 15 January 2010, he was at first positive but became upset when he talked about his parents. He told the psychiatrist that he was taking his medication erratically at this time.

**5.23** The consultant psychiatrist reviewed him on 11 March 2010. He was described as having a more positive outlook. He was showing no significant depressive symptoms or suicide ideation. His panic attacks were less frequent and he was living with Ms H again. Mr G said that Ms H was pregnant but we have seen no evidence to support this. The consultant psychiatrist supported Mr G's return to work, discharged him from the PCMHT to his GP and recommended medication.

**5.24** Mr G's GP contacted the PCMHT on 11 May 2010, two months after this discharge, asking for the case to be reviewed. The GP had seen Mr G on 7 May 2010. He said he was

being bullied and harassed at work. His GP did not view him as fit to work with children. The GP provided him with a social security sick certificate and referred him to the PCMHT again.

**5.25** The PCMHT duty worker contacted Mr G, who recounted the difficulties at work and the distress they were causing him. He said he had resigned because work was driving him to feel suicidal. He said he would not act on his suicidal thoughts because he had a five-year-old daughter. He told the duty worker he was going on holiday to try to relax and would contact the PCMHT on his return.

**5.26** Mr G was written to by a community psychiatric nurse/GP link worker and asked to make contact with the PCMHT within three weeks but failed to respond. He was subsequently discharged from the service and referred back to his GP on 25 June 2010.

**July to October 2010**

*Arrested*

**5.27** Mr G was arrested and charged on 23 July 2010 with common assault of Ms H. He attended court the next day and was remanded to HMP Wormwood Scrubs until 27 July for psychiatric assessment. The prison mental health in-reach team contacted the PCMHT duty team on 26 July requesting information the PCMHT held about his diagnosis, medications, assessments and other care information. The PCMHT sent the information by fax the same day.

**5.28** Mr G attended court on 27 July and the probation service asked the court diversion scheme consultant (CDS) (consultant A), who was also a PICU consultant psychiatrist at the trust, to assess Mr G. He interviewed both Mr G and his girlfriend, Ms H. The consultant noted that Mr G had been having arguments and fights with Ms H, owed money to Ms H and had been smoking cannabis. He found Mr G guarded and agitated; he found discrepancies between the accounts of Mr G and Ms H. Mr G was on a combination of antipsychotic and antidepressant medication.

**5.29** As the work being done as court diversion consultant was not a commissioned service the consultant did not have access to RiO whilst at the court and was therefore not

aware of Mr G's previous contacts with trust mental health services. The consultant recommended that a psychiatric assessment in the community be a condition of bail. Both the consultant and the police reported their impression of Mr G's developing mental illness.

*Remanded to prison*

**5.30** Consultant A was not at the court hearing so he did not know the court had rejected his recommendation and remanded Mr G in prison for a month.

**5.31** Consultant A checked the electronic patient record system (RiO) for information on Mr G when he returned to the trust, but his documents contained different spellings to the trust records. Consultant A was therefore unable to access the trust records and so did not know about his mental health history.

**5.32** Consultant A did not know Mr G had been remanded in custody and wrote to him and his girlfriend on 30 July inviting them to have a further assessment.

*Granted bail*

**5.33** Mr G was granted bail on 24 August 2010 with conditions to appear at Hendon Magistrates' court on 2 September 2010. The conditions included his having no contact with Ms H. These conditions were not relayed to his local police station because the liaison officer was working with a trainee on this day and both assumed the other had passed on the information.

*Assessed by GP*

**5.34** The next day, 25 August, Mr G went to his GP surgery. The trainee GP who saw him noted:

> *"Anxiety with depression. Multiple problems, lost job in April 2010, accused domestic violence by partner, remained in prison since late July, released*

*yesterday, can't see partner; slept in hotel last night; feels isolated and angry, no job, no accommodation…says mood is OK, denies suicidal thoughts…says main reason of coming to see me is to help find a job and accommodation… has somewhere to sleep tonight, booked a hotel; Plan I will dw* [discuss with] *…Mental health link worker."*

**5.35** He also completed a hospital anxiety and depression scale assessment which showed Mr G as borderline for anxiety (10) and just over borderline for depression (11)[1].

**5.36** The trainee GP consulted with the psychiatric link worker in the presence of Mr G who advised him to attend the Barnet Homeless Unit.

**5.37** The trust did not interview the psychiatric link worker but he did provide a written account of his involvement. He consulted with the GP and Mr G in the GP's consultation room. He told the trust panel:

"[The GP] *informed me that* [Mr G] *had recently been released from prison and was looking for accommodation for the same day.* [Mr G] *said that he had sufficient funds to rent a place privately however, as he had just been released from prison I advised him to present himself to Barnet House Homeless Person's unit. I recall* [Mr G] *mentioning previous difficulties with his girlfriend prior to his imprisonment. He reported that his girlfriend had accused him of physical abuse at the same time he mentioned having a wife in Egypt. It was left with* [Mr G] *to present himself at Barnet.*

*At no point was I asked by any of the Doctors at the Practice to undertake a mental health assessment on* [Mr G] *nor did I receive a formal referral from them. All the GP's at the surgery have briefed about the PCMHT referral pathway through GP liaison meetings. As this was not an assessment but an advice regarding* [Mr G] *social circumstances, I did not record this information on RIO, as* [Mr G] *was not a current patient of our service."*

[1] Non case 0-7, Borderline 8-10, 11+ case

*Living with girlfriend in a hotel*

**5.38** Mr G and Ms H stayed at a hotel between 27 August and 1 September and then they moved into a flat together.

*Arrested and girlfriend's body discovered*

**5.39** Mr G failed to attend his bail hearing on 2 September. As a result of his failure to attend court, Mr G was arrested on 9 September at his estranged wife's home. At this time the landlord of his flat discovered the body of Ms H who had been killed between 1-8 September. Mr G was arrested on suspicion of murdering her. The police submitted a request to the mental health service for an appropriate adult to be present at the police interviews on 10 September and arranged for a forensic medical examiner to assess Mr G. The request for an appropriate adult was received by the PCMHT administrator but not circulated to the wider team and therefore they were not aware of his arrest.

**5.40** The results of the post mortem examination were inconclusive. Mr G was charged with the original assault on his girlfriend and remanded in Brixton prison on 10 September. Mr G registered with the prison medical service on 11 September, although he refused to be interviewed. Mr G remained in Brixton prison until 28 September. His behaviour varied from settled to irate and depressed. He was given mirtazapine.

**5.41** A member of the mental health team contacted consultant A on 22 September to let him know that Mr G had been arrested.

*Released from prison*

**5.42** The police requested that consultant A attend Hendon Magistrates' Court on 27 September to assess Mr G. He did not undertake a formal assessment because Mr G declined on the advice of his solicitor. On 27 September Mr G was found guilty of the original assault. As he had already served 40 days in prison he was released but did not leave Brixton prison until 28 September. At this stage no charges had been brought against Mr G for the killing of his girlfriend.

**5.43** The forensic psychiatrist at Brixton Prison faxed a letter on 28 September to the PCMHT consultant, requesting community follow-up with Mr G.

**5.44** Consultant A contacted the Haringey PICU ward manager the day Mr G appeared in court to tell her of his concerns about him. The ward manager then wrote to trust staff who might come into contact with Mr G to tell them Mr G had just been in prison and that his girlfriend had recently died. She said that consultant A was to be contacted prior to any psychiatric assessment and that he could be contacted at any time day or night and at weekends. Her memo was inaccurate in part as it said that Mr G was not on RiO and his GP was not known.

**5.45** As a result of the contact from Brixton prison the PCMHT administrator sent a referral on 4 October to Mr G for a *'New Patient Assessment'* appointment on 17 November. The PCMHT were unaware of the suspicion of Mr G's involvement in Ms H's death or the involvement of consultant A at this time.

Comment

***The referral was for a new patient assessment, even though the PCMHT consultant psychiatrist had previously seen Mr G regularly. If Mr G's RiO notes had been reviewed before he was sent the appointment, the notes would have shown his history with the service.***

*Mr G goes to Scotland*

**5.46** Consultant A phoned Mr G on 4 October inviting him and his estranged wife to an appointment. He spoke with her mother who told him that Mr G did not want to see him and that he had gone to Scotland to visit friends. This was the same day that he was sent an appointment by the PCMHT. Neither Mr G nor his estranged wife was able to attend the appointment.

**5.47** Mr G was subsequently sent back to England by his friends who found his behaviour erratic.

*Mr G presents at the Dennis Scott Unit[1] and is admitted*

**5.48** On 8 October Mr G presented at the Dennis Scott mental health unit, at Edgware community hospital. He was screened and the manager contacted consultant A. They agreed that Mr G should be taken to the Springwell mental health unit for assessment. The Springwell unit manager picked him up and drove him there.

**5.49** At the Springwell unit, Mr G was assessed by consultant A, who was approved to conduct Mental Health Act assessments and an approved mental health practitioner (AMHP). In the assessment Mr G described suicidal thoughts, sometimes hearing voices and feeling paranoid. He did not wish to discuss his recently deceased girlfriend. Mr G was deemed a risk to himself and possibly others. He was detained under Section 2 of the Mental Health Act 1983. Mr G was asked if he would like an advocate. He said he would, but we saw no evidence that one was provided.

**5.50** Mr G was admitted to the Haringey PICU (Avon Ward) where he was placed under continuous supportive observation. He was prescribed zopiclone[2], lorazepam[3] and haloperidol[4]. The nurse responsible for drawing up a 72-hour care plan was off sick, so no plan was completed.

**5.51** Mr G's estranged wife visited him on 10 October – a visit described on RiO as not having gone well. Mr G was assessed again on 11 October, by consultant A, a ward doctor and a nurse and prescribed mirtazapine.

**5.52** A psychologist assessed Mr G on 12 October 2010 and described him as *"difficult to assess"*.

**5.53** Mr G remained on continuous observation for a further day. Consultant A assessed him on 13 October and placed him on intermittent supportive observations every 15 minutes.

**5.54** Consultant A interviewed Mr G's estranged wife on 14 October. The RiO notes contain no record of this interview.

[1] This is a trust mental health unit.
[2] Sedative medication
[3] Anti-anxiety medication
[4] Antipsychotic medication

**5.55** Mr G had another psychology assessment on 14 October. The psychologist noted that he found it difficult to gain clear information from Mr G because he was defensive and guarded. The psychologist planned a follow-up meeting on 19 October 2010.

**5.56** During the early part of his time on the ward, Mr G's mood was generally low and sometimes agitated and angry. At the latter part of his stay his mood lifted and he began to take part in therapy activities.

*Mr G confesses to killing his girlfriend*

**5.57** On 15 October Mr G was assessed by consultant A and his PCHMT consultant psychiatrist. There were three other persons present at this assessment, the ward doctor and two ward nurses.

**5.58** The RiO note of this interview was completed by the ward doctor and a separate note was made by consultant A. Mr G talked about his relationship with his estranged wife and girlfriend. A large section of the note describes Mr G's developing paranoia

**5.59** During this assessment Mr G confessed to the murder of his girlfriend, Ms H. He said that the killing was a mistake as they were arguing and that he called the ambulance and the police but that he could not continue the call.

**5.60** Mr G could not continue speaking because he became upset and the assessment was stopped. Consultant A told Mr G that he was going to call the police, which he did.

**5.61** Mr G's dosage of mirtazapine was increased and he was given risperidone[1]. Mr G was placed under continuous observation until the arrival of the police, who arrested him, at which point he was discharged from Section 2 of the Mental Health Act.

**5.62** On 16 October the forensic medical examiner contacted consultant A requesting information on Mr G's mental illness and medication.

[1] Antipsychotic medication

**5.63** Consultant A was told by the police on the 18 October that Mr G had been formally charged with murder. The PICU ward manager contacted the police to ensure that a formal discharge summary and medication details for Mr G were available.

# 6. Key issues arising from the chronology

**6.1** In this section we examine the themes arising from the chronology that relate to our terms of reference. We include a summary of the context around each of the themes while avoiding too much repetition of the chronology.

**Care by the HTT and the PCMHT**

**6.2** Mr G's care was principally shared between his GPs and the PCMHT. The HTT cared for him on two occasions. In this section we assess the effectiveness of those contacts.

*HTT*

**6.3** Mr G's first contact with HTT was between 12 September and 21 October 2008 after his GP referred him to the Barnet Mental Health Liaison Team because he was expressing suicidal thoughts. He was diagnosed with acute depression and referred to the team.

**6.4** Different members of the team phoned Mr G regularly and visited him nearly every day. The RiO notes of the visits are comprehensive and show that staff had formed a supportive relationship with him and were alert to possible deterioration in his mental health. The following extract of a RiO entry (19 September 2008) shows the support offered to Mr G:

> *"T/C and home visit to* [Mr G]. [Mr G] *was out the house but came back shortly and said that he went to the shop. He appeared fairly settle in his presented, pleasant and appropriate in his interaction. He informed that his girlfriend had return home to Poland as she couldn't cope with his at present but he has spoken to her and she plans to return back to him at a later stage… [Mr G] said that… he got very challenging when he attended the Housing Dept but he also knows that's not the way to get help…"*

**6.5** The entry closes with a plan to:

- phone him on Saturday because he said he did not need a visit over the weekend
- arrange a medical review the following week.

**6.6** A medical assessment took place on 25 September 2008 and a full record appears on RiO. The assessment included a plan that made changes to Mr G's medication, proposed a referral to a psychologist and a continuation of HTT visits, but on alternate days. Contact details were to be given to him if he needed extra support or advice.

**6.7** Mr G was offered a psychology appointment for 27 October 2008. He was sent an opt-in form that asked him to provide some initial information about his problems, he did not return the form and as a result the referral was closed.

**6.8** The second period of care with the HTT was between 21 August and 4 September 2009. Mr G had been referred by his GP to Springwell centre for assessment as he had been complaining of suicidal ideas. He had told his GP that he had to either *"kill the flowers on his balcony or jump off it himself"*. Following assessment and as he was not willing to be admitted to hospital, he was offered support by the HTT.

**6.9** Again during this period Mr G received support from the HTT almost daily. Most of the visits and contacts recorded show that Mr G was coping well, that he was socially interacting and able to agree with the team when visits fitted with his other appointments.

**6.10** The RiO entry of 26 August 2009 shows that while Mr G was coping socially he had underlying mental health stresses. He said he was preoccupied with abuses that had occurred at home in Egypt and racial abuse that he was experiencing in England. He sometimes felt suicidal but had no plans to kill himself and that he could not anyway because he would go to hell.

**6.11** Another RiO entry records on the same day that Mr G was told that he was going to be referred to the PCMHT and that he was pleased with that arrangement. Staff from the HTT saw him at home on 4 September 2009 and found him calm, pleasant and brighter. He was planning to return to work. The team told him this was their last visit and that an

appointment with the PCMHT had been arranged for 30 September 2009. He thanked them for their support.

Comment

***We believe the HTT cared effectively for Mr G. The record-keeping in the RiO notes is good and the records show that staff who supported him gave attention to his social circumstances as well as his mental health. Staff were flexible in the way they kept in touch with him, ensuring regular contact and support.***

**6.12** The trust investigation report notes improvements that should be made to the way the HTT works. They are set out in the trust report's executive summary:

- *"HTT assessments are not independent of the Initial Assessment. There should be regular re-evaluations of the individual's needs based on the information contained within the Initial Assessment supplemented by further enquiry.*
- *It is good practice for HTT Workers to have contact with Carers/Significant others whenever possible and with the patient's consent. Carers/Significant others should also be given the opportunity to speak with HTT workers on their own as well as with the patient*
- *There is no regular recording of HTT discussions at the MDT reviews and this includes when the decision was made to remove CPA."*

Comment

***The improvements the trust suggests cover some important issues, which will undoubtedly improve the work of the HTT, and we endorse them. Neither the trust nor we suggest that the improvements identified had any causal link with or impact on the killing of Ms H.***

Finding

**F1** The care the HTT gave Mr G in 2008 and 2009 was appropriate, effective and delivered to a high standard.

*PCMHT*

**6.13** Mr G was first referred to the PCMHT in June 2009 by his GP but because he did not complete his opt-in form his referral was closed and he was not offered a service.

**6.14** Mr G was re-referred to the PCMHT by the HTT when they discharged him on 4 September 2009. The PCMHT consultant saw him every six weeks or so. The RiO entries show that he had returned to work part time and still occasionally experienced panic attacks.

**6.15** The PCMHT consultant discharged Mr G back to the care of his GP on 11 March 2010. The RiO entry is a copy of the discharge letter to the GP:

> *"I was pleased to find that* [Mr G] *has continued to progress. He is more positive in outlook and free from significant depressive symptoms. His panic attacks are much less frequent. He is living again with his girlfriend and has found out that she is pregnant which makes him very happy. He has no significant suicidal ideation."*

He then advises on medication and says he supports Mr G's return to full-time work

**Was Mr G appropriately referred to the PCMHT?**

**6.16** We consider here whether the referral from the HTT to the PCMHT was appropriate. We interviewed Mr G's consultant psychiatrist at the PCMHT:

> *"He was appropriate for our service. At the first appointment with me it was clear that he certainly did not have what I would call a very significant depression. He was animated. He was communicative. He was not flattened in his affect or anything like that. He was emotional actually and, over the time that I saw him, I*

*would always note that if he started talking about his past, he was quickly moved to tears and became quite emotionally upset, and I just felt that that was always troubling him actually. This unresolved difficult childhood that I think he had had was always there for him."*

*"He was relatively socially isolated I think when I first met him. He was an emotional man. I think I used the word 'histrionic' in some ways. He was never suspicious or guarded towards me. He had quite an open style of communication. I never felt that he was holding anything back."*

*"…I always felt that I understood him clearly enough. There was never any suggestion of psychotic symptoms when I saw him, nothing delusional. There was no evidence of hallucinations or anything like that. So I suppose my impression was of someone who had clearly been more depressed earlier on in his care path, but it was improving, it was resolving. I thought that there were important psycho-social aspects. He was isolated. His relationship had broken down. I think he felt deeply dissatisfied actually with his lot in life. He felt that he should have achieved more in his life." He spoke about how he had a degree in history I think. He had ended up as a caretaker. I think he felt that he was under-valued in his work as a caretaker, and I think all the while in the back of his mind there were unresolved issues about a difficult earlier life.*

*"Over a period of time he began to re-engage with work, which seemed to be a very positive step, and actually he spoke quite positively about work to me. He felt that they were quite supportive towards him now despite other things…"*

*"I thought the overall pattern was one of improvement in his mood and then at this last appointment he seemed to be in a very positive state of mind. He told me that he was back with the girlfriend. He told me that she said she was pregnant. He said he was feeling much more content about things, and he was happy to be discharged at that time."*

*Comment*

***Our interview with the PCMHT consultant, Mr G's GP records and our interview with Mr G's GPs lead us to conclude that those caring for him communicated well, that they assessed him effectively and put appropriate plans in place for him.***

**Re-referral to PCMHT**

**6.17** In May 2010 Mr G had an appointment with GP A at the surgery. He was suffering stress-related issues and had resigned from his job. GP A re-referred him to the PCMHT.

**6.18** The PCMHT duty worker phoned Mr G and noted that he sounded distressed and was reporting suicidal thoughts. Mr G said *"…that he was planning to go away for a short break with his family to try and relax."* He had resigned from his job as a caretaker because he *"...felt that this was the right thing to do because of the stress it was causing him, stated that he was being bullied and people were being racist to him. And would make contact on his return."*

**6.19** Mr G was sent a letter by the duty staff advising him to make contact with the team in three weeks. He did not do so and was discharged back to the care of his GP. Both he and his GP were sent letters confirming this action.

*Comment*

***The duty worker knew that Mr G had been discharged from PCMHT two months earlier and that he had been primarily treated for depression and had a number of social stressors. Mr G also spoke of getting away to reduce his stress, which appeared to show reasonable insight and self-management.***

***The PCMHT consultant had previously seen Mr G regularly. The duty worker could have contacted the consultant at this point for advice. Mr G appeared to have insight and was arranging to go away, so the decision not to contact the consultant was acceptable based on the information available at the time.***

***At various times Mr G was required to complete opt-in forms after he was screened for services. He was not accepted for a service when he failed to do so. Some trusts use these forms as a filter and avoid offering appointments to clients who do not complete them because they are considered unlikely to attend. Opt-in forms used too rigidly can become a barrier to services rather than a filter. When a referral is received it needs to be assessed to determine whether there is a need to supplement the opt-in form process because for example the individual is known to be difficult to engage. This could be with a phone interview because some individuals may be unwilling or unable to complete a form but still be in need of a service. Forms must be clear, easy to understand and available in other relevant languages.***

**6.20** The trust investigation report identifies the following improvements in the work of the PCMHT and we endorse its suggestions:

- *"Some patients are held in the PCMHT for many months until they can access therapy because other services operate a waiting list, or because referrals have not been accepted.*
- *Medical staff are not always making a formal record of their Mental State Examinations.*
- *The PCMHT (E) Consultant is not part of the process where new patient referrals are considered, and no longer has the opportunity to prioritise the most complex cases and then allocate them to the most experienced clinician.*
- *Confusion may be caused to people who are re-referred to the PCMHT, when they receive a standard letter offering them a "New Patient Assessment".*

Comment

***The improvements the trust suggests will undoubtedly improve the work of the PCMHT. Neither the trust nor we suggest that the improvements identified had any causal link or impact on the killing of Ms H.***

*Findings*

**F2** The care the PCMHT gave Mr G in 2009 and 2010 was appropriate, effective and delivered to a high standard.

**F3** The requirement for Mr G to complete an opt-in form may at times have been a barrier to his receiving the services for which he had been referred.

*Recommendation*

**R1** The trust should ensure that guidelines for the use of opt-in forms should set out when additional processes such as phone follow-up are needed to effectively assess a person's willingness to engage with the service. Opt-in forms must be clearly written and available in other relevant languages.

**Admission to hospital**

**6.21** Mr G went to the Dennis Scott unit on 8 October 2010 and after a phone call with consultant A, he was taken to the Springwell centre for assessment.

**6.22** He was assessed under the Mental Health Act 1983[1] (MHA). The record of the assessment says *"He felt like a dead man walking"*. He was deemed to be a risk to himself and others and was detained under section 2 of the MHA. He was admitted to Avon ward, a psychiatric intensive care unit. The consultant for this ward is consultant A, who had been involved in assessments of Mr G at Hendon magistrates' courts and in this assessment.

**6.23** The RiO notes covering this admission are comprehensive and provide a full account of the care given to Mr G during his stay. The medical record of his admission assessment, recorded at 00.43hrs on 9 October, covers two A4 pages. The record was completed by a ward doctor. This assessment covered his background, family history,

[1] The 1983 Mental Health Act was amended in 2007 but the act is still referred to as the 1983 Act because it was amended rather than repealed.

personal history, risk history and mental state examination at the MHA assessment. The notes record the following plan:

- *"MSE (mental state examination), physical examination, ECG, Bloods TMRW* [tomorrow]
- *Close Obs* [observations] *1:1*
- *Urine drugs screen*
- *Collateral history*
- *Senior Review"*

**6.24** The nursing assessment made on the same day records a summary of Mr G's background and reason for his presentation at the Dennis Scott unit. The note records that he "*is presently on remand for allegedly murdering his girlfriend in August 2010*". This was not true, though he was a still a suspect in the continuing case related to his girlfriend's death and on unconditional bail. A RiO note on 14 October corrects this error and subsequent entries that were also incorrect on this point.

**6.25** The nurse included a plan that set out Mr G's observation levels, the need to formulate a comprehensive care plan and for him to have his rights explained to him. A leaflet was given to him about these and he was to have a physical check-up.

**6.26** Mr G was on continuous observation and the RiO notes record his condition hourly. Most show that he generally slept or stayed in his room during the first few days and kept mostly to himself. From 13 October the notes show he started to interact with other patients, joined a music therapy session and took more interest in his appearance.

**6.27** A ward doctor reviewed Mr G at 13:30hrs on 9 October. The ward charge nurse was also present. The notes state:

> *"MSE [mental state examination]*
> *A 30-something year-old looking Arab male.*
> *Not looking depressed and seemed to recognise his situation – demonstrated a presence of mind to decide on what to say and what not say.*
> *Spoke in heavily accented English but reasonable understood.*
> *He did not seem psychotic and was not suicidal.*
> *He was cognitively intact.*

*Insight not an issues as illness not quite clear."*

**6.28** The note then says in capitals:

*"IMPRESSION-VERY DOUBTFUL FORENSIC CONTENT OR REAL MENTAL ILLNESS; NEED FOR FURTHER EXPLORATIONS SHOULD BE PERSUADED TO TALK."*

**6.29** Mr G was again assessed in a ward round on 11 October. Consultant A, a ward doctor and a nurse were present. The RiO entry says Mr G had a high level of paranoia and also had a degree of depression. He also blamed consultant A for being sent to prison. He told the consultant:

*"…when I told you about my paranoia, you told the court and where did I end up!"*

**6.30** The ward round concluded with a plan for Mr G to start on mirtazapine, an antidepressant, 15mg once daily, continuous observation levels to remain; consultant A to see Mr G's estranged wife and a referral to the ward psychologist.

**6.31** The ward psychologist saw Mr G on 12 October as part of a ward support group. He was fairly quiet initially in the meeting but did make a contribution suggesting that the meeting discuss why people were in hospital. He spoke a little about himself including his difficulties with accommodation and coping.

**6.32** Consultant A reassessed him on 13 October in the presence of a ward nurse. The consultant recorded that Mr G was angry about being on continuous observation and blamed him for not helping him in court in July. He denied any suicidal intentions.

**6.33** Consultant A downgraded his observation from continuous to intermittent. He also advised Mr G to appeal against his detention and arrangements were made to interview him with his PCMHT consultant two days later. We asked consultant A why he wanted to involve Mr G's previous consultant:

*"…I asked* [the PCMHT consultant] *to come and join me to do this assessment, to see whether my impression was similar to what he had or it was different, or his presentation was different from how he saw him before.*

**6.34** Mr G gave permission for consultant A to interview his estranged wife and this happened on 14 October. Consultant A told us he wanted to meet her because:

> *"The reason for meeting her was because knowing that this man, possibly mentally unwell, killed someone – although there was no confirmation – I was worried about, because he went to stay with her, and she told me that she had a daughter by him. I was worried that this man might do another thing, that's why I asked her, would she believe that he has killed his ex-girlfriend."*

**6.35** Mr G's estranged wife told us that consultant A had called her from his home to encourage a meeting. She did not know why he was involved in Mr G's case. She described the meeting with the consultant as *'dreadful'*; that he was very dismissive of Mr G. She felt that police were pressuring consultant A to get a confession from Mr G.

**6.36** We put Mr G's estranged wife concerns to consultant A. He told us:

> *"I must say that when I saw her I was very friendly with her, I don't know where she got this impression that I work with the police…"*

**6.37** The ward psychologist saw Mr G again on 14 October in a one-to-one meeting. The psychologist had some difficulty because Mr G sought to *"take over the session"* and if the psychologist tried to summarise what Mr G was saying, he said his interpretation was wrong. The session covered: Mr G's low mood; his alleged assault on his girlfriend; prison experience; feeling let down by Britain and never having been given a proper chance; his court case and his mental illness. The psychologist arranged to see him early the next week.

*Comment*

***Medical, nursing and psychology staff assessed Mr G regularly throughout this period of care. The care plans devised as a result of the assessments were appropriate and the levels of observation were appropriate to the levels of risk he posed at various times. The records of this period were comprehensive and show that Mr G's mental health and other needs were properly addressed.***

**Ward round 15 October 2010**

**6.38** A ward round took place on 15 October. Consultant A, Mr G's previous PCMHT consultant, the ward doctor and two nurses were present. The PCMHT consultant had been invited to provide a second opinion.

**6.39** We asked the PCMHT consultant whether having fewer than five people present - perhaps just him and consultant A - would have been a better approach:

> *"I think he was probably feeling frightened and vulnerable actually, and I think the point that the fewer people seeing him might have been better."*

**6.40** Consultant A told us:

> *"There might be some other better ways of doing that, but I didn't think about it at that time."*

**6.41** We asked the PCMHT consultant how the interview was conducted:

> *"I felt that there was nothing harassing or coercive about it at all actually. The style of all of us was to be as warm and empathic and non-judgemental as we possibly could be. Obviously we needed to understand his mental state and what his mental state had been in the weeks and months leading up to the alleged offence at that time. We didn't go straight in with "Did you kill her?" It was nothing like that."*

*Comment*

***Interviewing Mr G with five people present in the room was not best practice.***

**6.42** Two records of the interview appear in RiO - one by the ward doctor and one by consultant A. Both record the high level of paranoid ideation that Mr G expressed.

**6.43** The following is an extract by the ward doctor which shows the level of Mr G's paranoia:

> *"…he then said that he had cut up his old expired Egyptian passport as when he looked through it there were many stamps from countries 'that I had never been to' 'Maybe some one was faking my identity…my gf might have lived with this person while I was in prison…''…I think she was trying to get me paranoid… I told her please stop'"*

**6.44** The doctor goes on:

> *"Patient then confessed 'I killed her…it was a mistake...the day she died they were arguing..'"*

**6.45** Consultant A recorded that during the assessment Mr G *"…appeared slightly agitated but he managed very well with the assessment which lasted for over an hour."* He also describes the level of paranoia expressed by Mr G and then writes:

> "[Mr G] *suddenly told us that he was in the wrong place at the wrong time when the victim was killed. When asked directly if he has harmed her,* [Mr G] *answered 'I killed her'. When asked how and why he did so,* [Mr G] *claimed his memory was not clear about the sequence of events."*

**6.46** We asked the PCMHT consultant how this confession came about:

> *"…my recollection is that it just seemed to reach a natural point in the discussion with him where it was obvious just to ask him what happened, and he said "I killed her". One felt that he almost wanted to say it. I think he was relieved in some ways to get this information off his chest."*

**6.47** During this admission there were repeated attempts by nursing and medical staff to find out whether Mr G had killed his girlfriend. We set out below other extracts from the admission RiO records which detail when Mr G was asked questions about the death of his girlfriend:

**6.48** The RiO record of the MHA assessment says:

> *"When asked by the CDS/PICU consultant 'Did you kill her', he responded 'I don't want to talk about it…everybody tells me not to speak about it'."*

**6.49** A nurse assessed Mr G on 9 October and recorded:

> *"However he was reluctant and unwilling to talk* [about] *his dead girlfriend."*

**6.50** A junior doctor assessed him on the same day and noted:

> *"He refused to discuss his 'case' pleading instructions from his lawyer."*

**6.51** Mr G was assessed on 11 October by consultant A, a ward doctor and a nurse. The RiO record says:

> *"[consultant] talking to patient regarding the death of his past girlfriend and asking if he felt guilty but patient said he did not want to talk about this."*

*Comment*

***The question of whether Mr G had killed his girlfriend was in the minds of the consultants and ward staff assessing his mental health and ensuring that he was receiving appropriate care. Knowing whether Mr G had killed his girlfriend was a relevant feature of a risk assessment and plan. If his paranoia had led to the killing, it might lead to further homicides.***

***Knowing if Mr G had killed his girlfriend was a relevant factor in his risk assessment but it raises the issue of how far mental health staff should go in asking a patient about matters that may incriminate them in a criminal case.***

***Clear professional guidelines from nursing and medical regulatory bodies cover the duty of staff who have information that suggests a patient has committed a crime to assist the police. The guidelines do not make clear how persistent medical and nursing staff should be in asking patients whether they have committed a crime,***

***particularly in the absence of a patient's legal representative or protection under the Police and Criminal Evidence Act (1984), such as the presence of an appropriate adult as would have been the case at a police interview.***

***Mr G's solicitor had advised him not to be assessed by consultant A before his court appearance on 27 September 2010 because it was not in his interest. The staff caring for Mr G were faced with the competing demands of what is in the best interest of their patient and the need to help detect a crime. These are important ethical, professional and possibly legal principles not currently the subject of professional guidance.***

*Finding*

**F4** Mr G was asked a number of times during his stay in Avon ward about his possible involvement in the death of his girlfriend.

*Recommendation*

**R2** The trust should use the facts of this investigation to run a multi-professional learning event to examine what ethical, professional and legal issues arise if a patient who is a suspect in a criminal case could incriminate himself or herself by answering staff questions.

**Care Programme Approach assessments**

**6.52** The trust's Care Programme Approach (CPA) policy in force in 2010 says that all individuals admitted directly to hospital are subject to CPA. It also says:

> *"Once the decision to place the person on CPA has been made a CPA Health and Social care plan – CPA Form 1 will be fully completed on RiO, together with the risk history, and Relapse and Risk Management Form,"*

**6.53** Part of that assessment would be for the care coordinator (the named nurse whilst in hospital) amongst other matters:

- *"To carry out core assessment and complete documentation on admission*
- *To complete initial and ongoing risk assessment"*

**6.54** We have seen no record of CPA entries in the RiO records. We reviewed a copy of an updated risk assessment first completed on 12 September 2008 and updated on 8 October 2010 and then again on 16 October 2010.

**6.55** The trust investigation report identifies the following shortfalls in respect of the hospital admission, which we endorse:

- no core assessment was completed, at any stage, including after Mr G's admission to hospital which would have provided a clear base line formulation of care needs for all teams involved
- discussions were not documented onto RiO when feedback was received from a carer
- There was no 72-hour formulation[1] on Mr G following his admission to PICU

**6.56** Suggestions for improvements of these issues are set out in the trust reports recommendations. We comment on these in a later section.

[1] A formulation is made to help describe the service users presenting problems/symptoms and brings the results of the various assessments into a coherent overview of their needs.

# 7. Primary care involvement of GPs

**7.1** Mr G's GP practice supported him from 2008 until late August 2010. He had numerous consultations in relation to anxiety and depression but was mainly seen by two GP partners, GP A and GP B, both of whom we interviewed.

**7.2** We examine in more detail the following contacts with the GP practice because they identify the nature of the joint working with the trust and relate to decisions about Mr G's care just before the death of Ms H.

**Referral from GP practice to PCMHT**

**7.3** In June 2009 Mr G was referred to the PCMHT. He was assessed as requiring cognitive behavioural therapy but following the screening of the referral he was not offered a service because he had not returned his opt-in form. When his GP practice was told of this, GP B wrote a letter of complaint to the PCMHT consultant psychiatrist. The substance of his complaint was that "[Mr G] *was too anxious to deal with form and was subsequently admitted to the Springwell Centre."* GP B also said that Mr G had given his mobile number but that the team had not tried to contact him on it.

**7.4** GP B repeated in the letter that he had previously offered to help patients complete the form and that he had also complained that the form discriminates against people who do not speak English as a first language or have a poor command of it.

**7.5** This letter led to a series of letters between GP B and a consultant clinical psychologist. The psychologist said the reason for using an opt-in form was the large number of referrals to the PCMHT and the psychology service. He added that patients completing a form were more likely to engage with the service. He agreed to look at having the opt-in forms translated.

*Liaison with PCMHT August 2009-May 2010*

**7.6** Mr G was subsequently taken on by the HTT and the PCMHT. From August 2009 until May 2010 liaison between the trust and the GP practice was good, with trust staff

keeping the GP practice appraised of treatment and care plans and the GP practice referring Mr G to trust services at times when he appeared to be deteriorating.

*Referral to the trust 11 May 2010*

**7.7** Mr G had a consultation with GP A and told him about his stress and the fact that he had resigned. GP A re-referred him to the PCMHT and the duty worker contacted him. We set out earlier in our report the detail of the contact. We asked GP A why he made that referral:

> *"I was worried about his mental state because I felt he was a man in great distress. He was known to the psychiatric services because he had been with them up until March, and was only discharged a matter of five or six weeks before I saw him again. I just thought it was reasonable to ask them to see him back. Our link worker for the practice was [X], who responded appropriately and said they would see him."*

*Assessment by GP registrar 25 August 2010*

**7.8** We set out in some detail in our chronology the GP registrar's assessment of Mr G on 25 August. This assessment was carried out after Mr G had been discharged from HMP Wormwood Scrubs. The GP carried out a thorough mental health assessment, including a depression and anxiety scale assessment. He also consulted with the mental health liaison nurse who joined him and Mr G in his consultation room.

Comment

***Mr G presented at the GP practice and was properly assessed. There were no grounds to conduct a MHA assessment. One option was for the GP to refer him formally to the PCMHT. The liaison nurse was present, so that could have been expedited if needed. The GP assessed his needs primarily as needing advice about accommodation. The decisions of the GP and the mental health liaison nurse were appropriate based on the presentation they were faced with that day.***

**Working relationships and communication between the trust and the GP practice**

**7.9** Our review of letters, documents and interviews shows that the GP practice and the trust were sometimes in dispute, mainly over referral processes and the difficulties GPs felt about having direct access to consultants rather than duty staff (who may be community nurses or social workers). Despite these difficulties, the trust had sought to build good working relationships with the practice. However, GP A told us that direct clinician-to-clinician contact was still difficult:

> *"I think there has been a change in the relationship between the clinicians; the doctor-trained clinicians never talk to each other. It used to be that if one had a patient that one was worried about one would phone and speak to the consultant, and then having spoken to the consultant, the consultant would then take on the responsibility for providing an opinion, the same as in other areas.*
>
> *However that is quite difficult to achieve. There is a very solid reception area for referrals for mental health, and it is quite difficult I find, to talk to a consultant – not impossible, but it takes a lot of commitment to speak to somebody who has had the same training as we have, and then we talk the same language."*

**7.10** GP A told us the following about joint working with the primary care services:

> *"We have an allocated primary care liaison worker, and that has been re-instated just recently. Then the Trust also have a very nice form for the referrals which are signed (or the last lot we have had are signed) by the associate specialist saying what the plan of campaign is for the referral that we have sent, which I think is very useful, otherwise you become lost in what is going to happen."*

*Comment*

***As we say elsewhere, the GPs were effectively involved in the care of Mr G. They carried out thorough primary care assessments and referred Mr G to trust services as necessary. We found ample evidence that trust staff also kept the GP practice***

***informed of any changes to his care. We make no criticism of the care he received from this practice and set of GPs.***

***Achieving effective joint working between primary care and secondary services always requires hard work and sometimes re-adjustment. We saw evidence that the trust sought to improve its links with primary care and that the current arrangements for liaison via the mental health liaison staff are appreciated and helpful.***

***We think the trust should examine how GPs can have greater direct access to consultant staff when that is deemed important but that the general route for referrals should be followed in most cases.***

*Findings*

**F5** Concern was raised by GPs that direct contact between GPs and consultant psychiatrists had become more difficult as a result of changes to referral processes.

**F6** The care Mr G's GPs gave him was of a high standard, as was the partnership between the trust and the GP practice.

*Recommendation*

**R3** The trust should examine whether a route for direct consultation by GPs with consultants is needed and whether this can be offered without undermining the general referral processes.

# 8. Court Diversion Scheme and care in prison

**Overview of Hendon Magistrates' Court Diversion Scheme**

**8.1** Consultant A told us the court diversion scheme at Hendon Magistrates' Court originally started as a part of a mentally disordered offender (MDO) service in 1997. The staffing for the MDO was consultant A, a junior doctor, three community psychiatric nurses and a social worker.

**8.2** The MDO service closed in 2006. Consultant A continued providing a court diversion service to the Hendon Magistrates' Court alongside his work as a community forensic consultant psychiatrist and latterly as the consultant for the PICU.

**8.3** Consultant A told us he received experience and training in forensic psychiatrist as a senior registrar to a consultant psychiatrist in a medium secure unit. He was also involved in the court diversion scheme for Horseferry Magistrates' Court.

**8.4** Consultant A's court diversion work from 2006 at Hendon Magistrates' Court was not commissioned by the primary care trust, neither was it part of his job plan, so it was a voluntary addition to his other work. He told us:

> *"I think everyone knew I was doing it, there was need to continue with it, but there was no formal discussion about funding or anything, or how to run it. It's really very much appreciated by the court, appreciated by the probation service, because it's like having a central point for this type of referral, and it's not taking much of my time, I am managing it, I'm not overwhelmed by referral."*

**8.5** The court diversion scheme at Hendon Magistrates' Court was not a commissioned service so no support arrangements were in place. The consultant had no assigned room to use for assessments, no access to the trust's electronic patient record system at the court and no secretarial support. The consultant typed up any assessments needed or wrote them by hand. He had to return to the trust to check whether a person he was seeing was already known to the trust services. These factors were important in this case, as we set out below.

**8.6** Consultant A told us his work at Hendon Magistrates' Court was minimal and that he saw on average two to three offenders a month. Any further assessment needed could be done by the court remanding the offender to prison or hospital. In some cases the court might order a community assessment.

**Mr G first court appearance and remand to HMP Wormwood Scrubs**

**8.7** On 23 July Mr G was arrested for common assault and appeared at Brent Magistrates' Court. He was remanded to HMP Wormwood Scrubs to appear at Hendon Magistrates' Court on 27 July to be assessed by consultant A. The probation service at the court asked consultant A to see Mr G. He assessed Mr G and interviewed his girlfriend, Ms H.

**8.8** Mr G talked of the difficulties in his relationship with his girlfriend, his financial difficulties, and said he had been smoking cannabis for the last two months.

**8.9** His girlfriend said he spent a long time out with friends and confirmed his use of cannabis. She also said that he had borrowed £20,000 from her, which he had not repaid.

**8.10** Consultant A came to the conclusion that there were not grounds to justify a MHA assessment but that Mr G might be developing a mental illness. He wrote a note for the bench saying that Mr G would be offered a further outpatient appointment to complete the assessment if he were released on bail.

**8.11** The magistrates did not accept his advice and Mr G was remanded to HMP Wormwood Scrubs because the police said he wanted to continue contact with his girlfriend, the victim of the alleged assault for which he was being charged.

**8.12** Consultant A was not told that Mr G had been refused bail. On return to trust premises consultant A checked Mr G's name on RiO. He told us he did not have the correct spelling of Mr G's name and could not find his electronic records so he did not know that he was already known to the services. Consultant A arranged for a letter to be sent to Mr G for an outpatient's appointment on 30 July 2010.

*Comment*

***If consultant A had access to RiO at court and could not trace Mr G's mental health records because of difficulties with spellings or his date of birth he would have been able to check these details with court staff. Administrative support might also have helped in tracing Mr G's previous contact with the trust services.***

***The information on RiO would have shown that Mr G had been referred to the mental health team in mid-May, although had not been seen because he was about to go away. Consultant A might have seen entries relating to the care and treatment Mr G had had in the preceding two years and also might have noted from the core assessment that Mr G had a five-year-old daughter to whom he had access.***

***Consultant A would have been able to share with the court information about Mr G's psychiatric history. The court might then have made a more explicit direction that Mr G should attend for an outpatient appointment. Alternatively, the court could have remanded him in custody pending preparation of a psychiatric report.***

**8.13** Mr G was sent to HMP Wormwood Scrubs. The in-reach mental health service run by another trust sent a letter to the PCMHT while he was in prison requesting background clinical information on him. Mr G's records do not include notes related to his stay at HMP Wormwood Scrubs.

**8.14** Mr G attended Hendon Magistrates' Court and was granted bail on 24 August with the conditions that he return to court on 2 September 2010 and have no contact with Ms H.

**Remanded to HMP Brixton**

**8.15** Mr G did not attend his bail hearing on 2 September and he was arrested a week later at his estranged wife's home. He was also detained on suspicion of the murder of his girlfriend, whose body had been discovered in their flat the day before.

**8.16** Mr G attended court and was remanded to HMP Brixton.

**8.17** Mr G's estranged wife wrote to the prison governor on 15 September about her concerns regarding his mental health and asked the prison governor to refer him to the prison *"acute mental health facilities"*. She gave a brief account of her husband's deterioration and said he had *"gone rapidly downhill since May of this year"*. Mr G's solicitor also made contact with the prison on 22 September to convey concerns about his mental health and about his psychiatric treatment.

**8.18** The prison nursing record of 21 September describes Mr G's mental health:

> *"appears to be auditory hallucinated adopted listening posture and appears to be responding to fantasies by giggling. His mood appears to be flattening of affect, emotional incongruity or inappropriate affect. Also appears tearful at time and does not like being on his own……he appears oblivious to his surroundings at time and at other time confused and perplexed…..he complains of hearing voices from someone called Ali, and that has been disturbing."*

**8.19** As a result of the nursing mental health assessment, he was transferred to the prison acute mental health wing (D Wing) on 22 September. We have seen no evidence that the prison staff knew that in addition to being in prison for assault on his girlfriend and non-appearance at a bail hearing, he had also been arrested on suspicion of murder.

**Consultant A interview with police**

**8.20** Shortly after Mr G was sent to prison, the police asked consultant A to provide information about Mr G because he had been previously involved with him. He attended Colindale Police Station on 23 September to give them information, which he had authority to do because it was to assist with the detection of a crime. He was told that Mr G would appear in court on 27 September and agreed to reassess him then. Consultant A did not make a record of this interview or consult with others before attending.

*Comment*

***The information that consultant A was being asked to provide was in relation to a crime so it would have been prudent at this point for him to discuss the matter with***

***his medical director, the trust legal department or his own defence union. This would have allowed him to consider carefully what he told police, whether it was appropriate and proportionate and to have made a record of what he had told them.***

**Assessment by specialist registrar in HMP Brixton**

**8.21** A specialist registrar assessed Mr G at HMP Brixton on 24 August. The doctor noted that he could not get a coherent account from Mr G because of "*his poor English, him being frustrated and due to his preoccupation with current circumstances*".

**8.22** Despite the difficulties, the registrar completed a comprehensive note of his assessment and the information he had been able to gather. The note covered:

- his mental health history including contact with the PCMHT and medication.
- a mental state examination with his impression of Mr G's mental health as *"depressive episode of moderate severity. No psychotic symptoms. Probable underlying personality traits-paranoid, borderline type."*

**8.23** He concluded the assessment with a plan that Mr G's mental health was not sufficiently serious to warrant transfer to hospital, that he should remain on D wing with general observations. Night medication was also prescribed. Further collateral information was to be obtained from his previous mental health team and Mr G was to be reviewed in a week.

*Comment*

***This psychiatric assessment was on someone who had committed a violent assault on a partner and who was known to have a psychiatric history, albeit that the details were not available. The registrar came to the conclusion that Mr G had no psychotic symptoms and said*** **"probable underlying personality traits-paranoid, borderline type"**. ***Ascribing a probable diagnosis to Mr G at this stage without collateral information was inappropriate. The registrar should have ensured that he had obtained information from Mr G's community team as soon as possible so that he could complete a more thorough assessment and test his initial impressions.***

***Mr G's confinement in the hospital wing presented an opportunity to assess his current offence and mental state in the context of his long-standing mental health problems and the violence he had committed on his girlfriend. The doctor could have tried to have Mr G more fully assessed by communicating with the court and arranging for assessment in hospital in conjunction with the court's legal authority if he had appreciated the extent of Mr G's mental illness.***

**Mr G assessed at court**

**8.24** Mr G attended court on 27 September for his bail hearing relating to the assault on his girlfriend. The post mortem examination on his girlfriend had been inconclusive and he had not been charged in connection with her death. The police asked Consultant A to attend court on that day and to assess him. He saw Mr G in the custody suite of the magistrates' court. He began the assessment but stopped when Mr G's solicitor asked him to do so, saying it was not in his client's interest.

**8.25** Consultant A knew at this point that the police had suspicions that Mr G had murdered his girlfriend but not that that he was likely to be released from prison.

**8.26** We have seen no evidence that the court asked the prison psychiatric service for information about Mr G's mental health or that the prison registrar communicated with the court when Mr G attended for his bail hearing.

**8.27** The police made a referral on 27 September to the social services children and family team as part of the safeguarding procedure because Mr G was known to visit his daughter. The team interviewed his estranged wife. She assured them he had not been a threat to his daughter and she wanted him to maintain contact with her.

**8.28** When the police referred the matter to Children and Family Social Services, they approached the PCMHT who gave them information about his contacts with them. This information would have also been available to social services if the contacts that consultant A had with Mr G had been entered on RiO then.

*Comment*

***The social services children and family team did not have the fullest information on Mr G's mental health but they properly assessed any risk to his daughter and determined that none existed.***

***Consultant A had been unable to find Mr G's records on RiO so he was still not aware that he was a pre-existing trust patient and that he had access to a five-year-old daughter. He might otherwise have provided the court with a report based on his previous assessment and the trust clinical records. This might have led the court to require further assessments before deciding what to do.***

**8.29** The magistrates decided that the 40 days Mr G had spent in prison were penalty enough for the offences he had been found guilty. He was put on police bail (because of the continuing murder investigation), and released from prison the next day.

**8.30** The next day the prison registrar wrote to the PCMHT consultant and Mr G's GP to tell them of his release, to ask for follow-up and for his medication to be continued to be prescribed. He also wrote to the prison psychological service referring Mr G to them.

*Comment*

***It is difficult to understand why the registrar made a referral to the prison psychological service because Mr G was being released from prison that day. The registrar was aware of his discharge, as shown by his letters to the PCMHT consultant and Mr G's GP.***

**8.31** The referral to the PCMHT consultant and the psychological service seem to contain quite different information. The one to the consultant describes him as irritable, angry and having ongoing depressive symptoms and taking mirtazapine. The one to the psychological service describes him as having subtle psychotic symptoms, difficulty in thinking, and "*panic attack like symptoms*" and being started on sertraline (a different antidepressant).

*Comment*

***We have not interviewed the registrar. He properly referred Mr G to community services and Mr G's GP. We believe that his involvement with Mr G could have been better if he had tried harder to collect information from Mr G's community team, but we can see no direct connection between his actions and the subsequent killing of Mr G's girlfriend.***

**Management and governance arrangements of the court diversion scheme**

**8.32** In this section we examine the arrangements in place to offer a court diversion service to Hendon Magistrates' Court. Our focus is to determine whether these arrangements affected the ability of staff to provide a service to Mr G that addressed his mental health needs and whether the arrangements had an impact on the ability of mental health staff either to predict or prevent the killing of Ms H.

**8.33** We examine in detail below the following key issues:

- access to trust clinical records
- administration support
- governance arrangements

*Access to trust clinical records*

**8.34** The prime purpose of a court diversion assessment is to assess the risk the individual poses to themselves and to others and so help the court decide what to do. Therefore it is vitally important that relevant information about any previous psychiatric history is taken into account as part of the assessment.

**8.35** The lack of access to the RiO electronic patient record meant that consultant A could not review Mr G's notes at the court or make entries directly onto the system. When consultant A returned to trust premises and accessed the computer he was not able to identify that Mr G was known to the service. In this case because of the difficulties of

identifying the correct spelling of his name. If he had access at the court he would have been able to cross-reference with other details held by the probation and court service.

**8.36** Not knowing Mr G's previous history meant that consultant A was not aware of the involvement of the HTT and the PCMHT or that he had a daughter who he saw regularly.

*Administration support*

**8.37** Consultant A told us he lost all supporting staff that when the mentally disordered offenders (MDO) service closed and that he had difficulty even accessing clinical records because his hospital secretary was *"not very helpful"* in supporting this aspect of his work as this was not part of her role.

*Governance Arrangements*

**8.38** The service was not commissioned so it was not within the usual trust governance arrangements. The service was not part of consultant A's job plan and work responsibilities so it was not subject to review by his managers.

**8.39** We spoke with the senior manager responsible for the PICU and other services. The PICU was the consultant's full time responsibility. We asked her about the arrangements in place for running the court diversion service. She said that when the MDO service was decommissioned she agreed with consultant A's request to continue attending court on Tuesdays in addition to his full-time responsibilities as PICU consultant. She told us he received some supervision from the North London Forensic Service, which he arranged with them.

**8.40** She said he would divert quite a lot of people from the court straight into the PICU. On the matter of what records were kept she said:

> *"At no point have I ever asked him, because we weren't commissioning the service, whether or not everybody he was seeing – even if they weren't coming in to our services – how he was recording it. I am assuming that he was doing quite a lot of private reports for various people and I didn't have anything to do with it. With*

*hindsight, however, I think I probably should have done. I think I should have said, 'Look, whoever you see, even if they are not coming into our service, you need to record it somewhere on RiO, in case they bounce back at some stage' – but I didn't."*

**8.41** We also asked the manager to comment on a view that having such an informal arrangement outside the usual management and governance arrangements was not appropriate. She told us:

*"My own view, and I will be absolutely honest, was yes. I was very clear that I thought we should stop doing it but I was over-ruled by associate medical directors, directors of North London Forensic, and* [the consultants] *own wish. I don't believe we should be doing things we are not commissioned for."*

**8.42** She then told us that since the implementation of the trust investigation all records of contacts that consultant A had with individuals assessed at the court were now placed on RiO.

**8.43** We interviewed the clinical director for the PICU and asked him about the support and governance arrangements for the court diversion scheme. He said consultant A received formal supervision from a senior consultant from the North London Forensic Service and that a ward clerk helped him to ensure that client's records were uploaded to RiO.

**8.44** We asked the clinical director whether continuing to provide a non-commissioned service outside the trust's management and governance arrangements was sensible. He told us:

*"The answer would have to be no, because I think you need to have a proper governance structure with every service and proper control and proper supervision. I think the more interesting question is, whether having a suboptimal service is better than having no service at all."*

*"I think that it's better to have the service that we have than having no service at all… You could argue that if there hadn't been a court diversion service, and we hadn't been doing this, we would never have found out that this man killed his girlfriend. He might have ended up killing somebody else. We found out what*

*happened because we took great care and because he was admitted to hospital and because he made a confession. If he wasn't in court, then he wouldn't have been involved, he may never have ended up on our PICU, and he might have gone on to murder somebody else for all we know."*

Comment

***We do not criticise the hard work and willingness of consultant A to provide a service to Hendon Magistrates' Court in addition to his full-time work as consultant at the PICU.***

***Our main conclusion is that a consequence of this service's not being properly organised or supported was that minimum arrangements such as access to RiO and other clinical records and administrative support were not available. As a direct consequence the court was not provided with an adequate assessment of Mr G's mental health. Though we make no causative link between this and the subsequent killing of Ms H.***

***Mr G's deteriorating mental health might have been identified earlier and appropriate support offered if consultant A's assessments had been based on his known mental health history. However, we do not believe that Mr G ever reached a level of deterioration that might have resulted in him being detained under the Mental Health Act and given support and treatment against his will. The circumstances that led to the death of Ms H might still have occurred.***

**8.45** The trust investigation report makes two recommendations in respect of the court diversion scheme (see appendix B). The recommendations support a proposal for a commissioned court diversion scheme in Barnet and say that if a service (commissioned or non-commissioned) continued to be provided then *"clinical standards and supervision arrangements"* should be the same as for other court diversion schemes.

**8.46** We asked various interviewees what arrangements were in place for the Hendon Court. We were told that the consultant now had access to a laptop and could access RiO,

that he had been provided with administrative support and continued to receive supervision from the North London Forensic Service.

**8.47** Consultant A has received some extra help with court diversion work but this service is still not commissioned. This part of consultant A's work is still in addition to his full-time other work. The court diversion work is still not subject to other management support arrangements. We are not aware of any formal agreements with the court to accommodate the diversion scheme or of any arrangements to provide space for assessments.

Finding

**F7** The lack of effective management, governance and administrative support to the court diversion work of consultant A contributed to an inadequate assessment of Mr G's mental health.

Recommendation

**R4** Trust managers must ensure that all trust court diversion services are effectively organised, resourced and subject to suitable agreements with the court. There must also be effective management and governance arrangements in place, whether the court diversion service is commissioned or not. If the Hendon court diversion service cannot be so organised it must not continue to be provided.

# 9. Trust internal review

**9.1** The trust conducted a desktop review in November 2010. It commissioned a board level investigation after receiving the review's findings. A panel of seven, including a forensic specialist, carried out the work. All of these individuals were members of the trust. The report was presented to the trust board on 23 May 2011, and it was submitted to NHS London in March 2012. The trust report makes 16 recommendations. These are set out in appendix B.

**9.2** The board level investigation consisted of a documentary review and interviews with 14 individuals, 11 of whom were trust staff. These interviews included a deputy justice's clerk, a magistrate and two staff from the local authority children's services. Notes were taken of all the interviews.

**9.3** The investigation team did not interview Mr G because of the criminal proceedings against him at the time. The trust did not meet the families of either Mr G or the victim. The trust contacted family members in May 2012, advising them of the independent investigation that Verita was undertaking.

**9.4** The trust investigation made a broad assessment of the care and treatment provided to Mr G in its 42 pages. They compiled a chronology of Mr G's psychiatric history and obtained Mr G's probation pack and prison medical notes to build up a picture of the events leading to the September 2010 incident. The investigation review's written terms of reference examined:

- the care and treatment of Mr G (including a forensic history)
- risk assessment and risk management undertaken by the trust
- Barnet Court Liaison service
- the role of care workers in safeguarding the family/the girlfriend of Mr G
- liaison with other agencies
- support to staff and victim's family following the incident
- recommendations and lessons learnt.

**9.5** The trust investigation highlights eight areas of good practice, in particular highlighting the efforts of the HTT to contact Mr G. Similarly, the actions of consultant A are described as *"proactive"*.

**9.6** The recommendations primarily focus on:

- the practices of the HTT
- the engagement/communication between service managers and senior staff across services
- record-keeping, risk chronologies and the use of RiO
- the court diversion scheme.

**Comment**

***The trust investigation report covers all the relevant issues arising from Mr G's contact with trust services. We have not examined in detail all the facts leading to the trust's recommendations but endorse them as valuable lessons.***

**Action Plan**

**9.7** We reviewed the trust action plan drawn up to address the trust panel recommendations. The report shows that all the actions have been addressed. The last completion date on the form is shown as 16 March 2012 for a proposal to be made for a commissioned court diversion scheme. At the time of our interviews we were told that the proposal had not yet been agreed.

**Predictable or preventable**

**9.8** Mr G's main problem during most of the time trust staff were caring for him appeared to be depression, anxiety and suicidal ideation. In the latter stages of his contact with the trust assessing staff detected an emerging paranoia.

**9.9** The only evidence of violence during Mr G's care was his assault of his girlfriend. Consultant A interviewed her after Mr G appeared in court and found that was still content to live with him. She did not report any fear that her life was in danger.

**9.10** The trust panel concluded that those involved in caring for Mr G could not have predicted the killing, though some aspects of his care and treatment needed to be addressed. We agree.

**9.11** We considered whether any actions or inactions on the part of staff could have prevented the killing, we do not think so. Our review of Mr G's care shows whenever he presented in distress or with mental health concerns he was appropriately assessed, treated or provided with a service. When he failed to engage with the mental health service he was referred back to his GP with whom there was good partnership working. Until Mr G's final admission he was never so ill that he needed to be detained or treated against his will either for his health or the protection of others.

# Appendix A

## Description of trust team functions

**Mental Health Liaison Team**

This team is based at A&E and provides emergency mental health assessments, immediate treatment and referrals to other mental health services within the trust.

**Primary Care Mental Health Team (PCMHT)**

The PCMHT is the single point of entry for most referrals to specialist secondary mental health services. The PCMHT is a multidisciplinary team that provides assessment and brief treatment together with an appropriate care plan. The PCMHT provides time limited interventions and care packages.

**Home Treatment Team (HTT)**

The HTT is a multidisciplinary team which provides community based treatment to people who are suffering from an acute mental health episode of mental illness, where the risks involved are such that without the intervention of the HTT they may require admission to an adult hospital ward.

**Psychiatric Intensive Care Unit (PICU)**

Avon ward (PICU) is a 12-bed facility caring for male patients with acute mental health problems with challenging and aggressive behaviour. All patients are detained under the Mental Health Act (MHA) 1983. At the time Mr G was a patient the PICU ward was temporarily relocated to Haringey ward at St Ann's Hospital whilst Avon Ward was being refurbished.

## Appendix B

## Recommendations in the trust's board level investigation report

*"Certain areas where practice can be improved have been highlighted in this report, and the Panel have made the following recommendations.*

- *It is recommend that the current Quality Assurance Programme should be revised to ensure that Home Treatment Teams are producing Care Plans which reflect a comprehensive understanding of the current psychiatric, social and family circumstances of the individual they are treating. These audits should form part of the regular Clinical Governance Team Meetings.*

- *HTT review meetings should be minuted during, or immediately after the meeting. Individual Records on Rio will be revised accordingly to reflect any significant changes in care plan. These notes and the RiO records will be monitored through the Team's Supervision Process.*

- *HTT meeting should be reorganised to ensure that the necessary clinical records have been reviewed prior to the team making decisions about the care of the patient. This will be monitored within the Team Supervision Process as outlined above in recommendation 02*

- *It is recommended that Service managers responsible for the PCMHTs, HTT and CMHTs ensure that patients are properly screened as to their eligibility for CPA. There must be a robust system for dealing with disagreements between teams as to the classification of their clients so as not to disadvantage patients.*

- *It is recommended that Clinical Directors, should issue a reminder to Medical Staff that the outcome of Mental State Examinations must be recorded onto Rio following all initial assessments and at regular intervals, to demonstrate that a patient's mental health has been monitored appropriately and to provide essential information to other practitioners.*

- *The PCMHT (E) consultant is no longer part of the referrals meeting (and as a consequence not part of decisions about which patients he should see. It is therefore recommend that the Clinical Director for Common Mental Health*

*Problems should meet with the Consultant in the context of job planning and with the PCMHT Manager to see how these issues might be addressed.*

- *The Panel supports the proposal that a Court Diversion Scheme should be commissioned in Barnet.*

- *Notwithstanding future commissioning arrangements, it is recommended that while the Barnet Scheme continues to operate, clinical standards and supervision arrangements agreed for the other Court Diversion Schemes operating in the Trust be applied to the Barnet Scheme to ensure the appropriate provision of services for Barnet residents.*

- *It is recommended that whenever referrals are received in the Common Mental Health Service Line, individual Rio Records should be thoroughly checked before appointments are offered.*

- *It is recommended that Mental Health Professionals should actively seek out clinical information whenever referrals are received from the Prison Service.*

- *It is recommended that the Common Mental Health Service Line should now review their Engagement Referral Protocol to ensure that, following referrals, the possibility of misunderstanding is minimised to patients, relatives and referrers.*

- *The Trust should review their procedures for staff who are involved in transporting patients to ensure they are robust and safe for patients and staff.*

- *The Panel noted that information from the doctor's contact with* [Mr G's] *wife was not recorded onto Rio. It is therefore recommended that the regular audit of clinical records includes a section identifying if a collateral history has been obtained from a Carer or Significant Other.*

- *The Panel noted that there is no record on Rio as to the rationale for discharging Section 2, However it is understood that the Trust already has a robust process for monitoring application of the Mental Health Act. It is therefore recommended that this issue should be encompassed within that process.*

- *It is recommended that the Trust Standard Quality Assurance Programme should encompass the presence of up to date risk chronologies*

- *The requirement for updating of risk chronologies must be included in staff mandatory training under clinical risk management."*

# Appendix C

## Documents reviewed

*Medical records*

- Mr G's integrated case notes
- RiO records
- GP records
- HMP Brixton medical records

*Homicide panel investigation*

- Board level investigation report
- Transcripts and records of interviews
- Chronology of care
- Action plan
- Correspondence with perpetrator and victims family

*Reports*

- Independent psychiatric report
- Consultant A's court diversion service report
- Twenty-four hour incident report

*Policies*

- Care Programme Approach, December 2008
- Child Protection Procedures, July 2011
- Risk assessment and management, September 2006

*Correspondence*

- Mr G's estranged wife's complaint correspondence

## Appendix D

# Interviewees

- Clinical director, Crisis & Emergency Service Line
- Assistant director, Crisis & Emergency Service Line
- PCMHT manager
- PCMHT consultant psychiatrist
- HTT consultant psychiatrist
- Avon ward manager
- Consultant A, Avon ward
- GP A
- GP B
- Mr G
- Mr G's estranged wife

# Appendix E

## Team biographies

**Tariq Hussain**

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

**Dr Sian McIver**

Dr Sian McIver is a consultant forensic psychiatrist for West London Mental Health NHS Trust. She is based at Broadmoor hospital.

**Kathryn Hyde-Bales**

Kathryn joined Verita as a senior consultant in 2012. She previously worked at the Care Quality Commission (CQC), and its predecessor organisation, the Healthcare Commission. During this time she primarily held roles in investigations, working and leading on a number of investigations. Her last role at CQC focused on managing the provision of analytical support to standalone projects and regional teams within CQC, covering the NHS, independent and social care sectors.