Independent Scrutiny and Investigation into the care and treatment of

Mr GK

Commissioned by NHS London

NHS London

Contents Page

Acknowledgements

The scrutiny team did not meet with the family of the victim, however they have been mindful of the fact that this tragic death caused a great deal of sadness and would wish to offer their condolences on the family's loss.

Mr GK did not feel able to consent to the scrutiny team having access to his case records. They therefore wish to thank the Trust's Caldicott Guardian authorising access to his records for the purpose of this scrutiny**.** However the East London NHS Foundation Trust was unable to find any records of Mr GK's care prior to the incident.

Executive Summary

Introduction

On 29th June 2004 Mr GK was arrested and charged with the murder of his grandfather. He had previously been in receipt of mental health services being provided by East London NHS Foundation Trust (the Trust).

This case, together with two others, (known as the Hackney Three), was commissioned in 2004 but in late 2006 the cases were erroneously taken off the Trust's tracking system for Serious Untoward Incident Investigations. This was discovered in February 2008 and the report was completed in April 2008. The Trust commissioned the internal review of this case jointly with two others, all three had substance misuse issues, and one of which was not a homicide. The findings and recommendations were amalgamated for all three cases.

NHS London commissioned this independent scrutiny investigation in January 2010 under HSG (94) 27, "the discharge of mentally disordered people and their continuing care in the community" and the updated paragraphs 33-36 issued in June 2005. An independent scrutiny investigation is a narrowly focussed investigation conducted by one or more investigators who have the relevant expert knowledge. The scrutiny team were asked to assess the Trust's internal reviews and findings and make further recommendations if deemed necessary.

Methodology

The scrutiny team had access to the Trust's internal review report but not the case notes relating to Mr GK's care and treatment.

The scrutiny was separated into two parts as set out in the Terms of Reference. This comprised of a detailed analysis of both the internal review and Mr GK's care and treatment as stated in his case records, this could not be completed in full as the clinical records were not available to the scrutiny team.

The scrutiny team considered interviewing Trust staff involved in Mr GK's care as the notes had been lost and therefore no clear record of Mr GK's care and treatment was available. It was decided not to follow this route given the passage of time and the difficulty staff may experience in recollecting the case without access to Mr GK's notes.

Outline of the Case

Background

Mr GK was born on 5th March 1975. His parents separated in his early childhood and his father died shortly before the incident. His mother remarried and he has an older half-brother and two younger half-sisters. Mr GK lived with his father after the separation for several years in Cambridgeshire.

He is reported to have had an average schooling, leaving at 16 years of age. He was involved in a serious Road Traffic Accident (RTA) in January 1993, aged 18 years, and he suffered significant injuries including head injuries with frontal lobe damage and organic personality change.

Mr GK has three children from three different partners. It is reported that in two of these relationships there was a history of violence towards the partner.

Mr GK has reported illicit drug use, in particular cocaine, over a number of years.

Contact with the Psychiatric and Neurological Services

Mr GK's first contact with mental health services was when he was admitted to a psychiatric ward at Addenbrooke's hospital in Cambridge after he had been involved in the RTA. He was treated for depression with Fluoxetine, an anti-depressant. A brain scan taken in October 2003 reported evidence of bi-frontal haemorrhagic contusions.

Two years later a Clinical Neuro-psychologist at Addenbrooke's hospital reported that Mr GK had difficulties in concentrating and remembering, outside the normal limits for his age and education. An uncharacteristic aggressiveness and poor temper control were also noted.

Mr GK, when aged 20 years, was reported to have presented with both grand mal and partial complex epileptic seizures.

In November 1995 Mr GK moved to East London, and his neurological care transferred to a Newham neurologist. During 1996 and 1997 Mr GK is reported to have been having brief complex partial seizures, and a continuous headache. He was also diagnosed as being moderately depressed and having "unprovoked aggression-associated with seizures."

In 1999 Mr GK attended the Psychiatric Emergency Clinic at Homerton hospital having self harmed. No details are available as to the nature of this injury. During this presentation he reported two other incidents of self harm.

On 6th July 2001 Mr GK's GP referred him to the Drug Dependency Unit, (DDU).

Three days later, on 9th July 2001, he presented to the Mental Health Emergency Clinic at Homerton hospital with symptoms of restlessness and agitation associated with cocaine use. He was complaining of a dislocated shoulder but did not wait for treatment. . He was again referred to the local DDU. They were unable to offer him an appointment at that time as there was a long waiting list.

Mr GK again presented at the Emergency Clinic on 17th July 2001 reporting that he was hearing voices and thought that the police were following him. He was diagnosed as having a Drug Induced Psychosis and prescribed an anti-psychotic medication, Olanzapine.

On 10th October 2001 Mr GK was admitted to Connolly ward at the City and Hackney Centre for Mental Health having reported that he had paranoid beliefs that people in the street wanted to harm him and also that he was hearing a voice belonging to "William Flint". He was diagnosed as suffering from a drug induced psychosis and cocaine dependency. Olanzapine medication was prescribed. Mr GK was discharged after five days into the care of the Community Mental Health Team (CMHT).

On 15th March 2002, Mr GK attended the Emergency Clinic reporting auditory hallucinations, "someone had put a hearing device in his head." Oral anti-psychotic medication, Risperidone, was prescribed and arrangements made for a psychiatric follow up, which he did not attend.

On 8th July 2002 Mr GK was admitted informally to Connolly ward at Homerton hospital having become increasingly irritable and aggressive, kicking in a door and setting fire to an upstairs flat. He reported having auditory hallucinations with multiple voices, both male and female.

Mr GK was discharged on 22nd August 2002.

Three days later the ward were informed that Mr GK was threatening to jump from the 6th floor after drinking heavily and having an argument with his girlfriend.

In March 2003, Mr GK was brought to the A & E department at Homerton hospital having grabbed his father around the throat. He was again admitted informally to Connolly ward and reported experiencing auditory hallucinations.

It is thought that Mr GK had a further admission to hospital in July 2003 but no other details are available. It appears that the CMHT remained in contact with Mr GK but no details of this contact were available to the scrutiny team.

On 29th June 2004 Mr GK was arrested and charged with the murder of his grandfather.

Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review did not present a well prepared, balanced review of Mr GK's care and treatment. It appeared that assumptions had been made about the issues raised in all three cases in the internal review before any proper examination of the cases had taken place. Their decision to follow a themed approach in which the three cases were grouped together hampered a thorough review process.

The purpose of the Trust's internal inquiry was to examine the process failures that led to the case being lost to the system.

Scrutiny Team Independent Findings

As described earlier the scrutiny team were unable to examine the case notes relating to Mr GK's care and treatment. The following findings and recommendations relate to the internal review only.

The scrutiny team had held a workshop with the Trust on two previous investigations, one of which was included in the "Hackney Three Investigation". This provided the scrutiny team with an opportunity to discuss services in general and procedures in place in the Trust. As there were no records to provide specific additional information it was decided not to hold a further separate meeting with the Trust or raise any further issues with them.

The final internal review report provided to the scrutiny team contained notes of the interviews with staff. This is not accepted practice for investigations. From the notes it appears that conflicting evidence was not challenged or followed up by the internal review panel. The scrutiny team would also comment that no external agencies or other external people to the Trust were interviewed.

The findings and recommendations of the internal review were general and tailored to the common themes of the report as a whole. The Trust have progressed and implemented their action plan with the exception of the Ward practice initiative which was being currently reviewed at the time of this scrutiny and it was indicated that this would be completed at the end of May 2010.

The general comment in the internal review report that "*Mental health care professionals are expert at addressing risks arising from mental illness*" may have been an attempt to be supportive to staff. It did not characterise the reality that mental health professionals in all parts of the country frequently find it very difficult to address risks associated with mental illness complicated by other factors. The internal review panel seemed to suggest that addressing the risks posed by the individuals was not the responsibility of the mental health professionals because the risks were related to substance misuse or criminal propensities.

The scrutiny team found that the internal review's recommendations were hard to connect with their findings. In addition the findings were not measurable against their implementation or able to be evaluated against the impact on the Trust's services.

The scrutiny team would comment that the clinicians' apparent reliance on Mr GK's compliance with medication and abstention from drugs and alcohol to manage risk would appear to have been misplaced. Mr GK's risk would have been difficult to assess because of his complex physical and mental health issues (such as the frontal lobe damage following his head injury), use of drugs and alcohol, and his dependency on his girlfriends. Despite this complexity there was no evidence of a multi-disciplinary risk assessment.

The situation in regard to Mr GK's frequent referrals to the Drug Dependency Unit, his non-engagement and their waiting list was noted in the internal review but was explained as a lack of resources. The issue regarding individuals with a Dual Diagnosis who are abusing drugs and alcohol and who express a wish to decrease this dependency, then being placed on a waiting list is not the best option at that particular time. No other therapeutic intervention regarding his substance misuse was either suggested or provided.

The scrutiny team found that Mr GK, contrary to the findings of the internal review, was not compliant with medication. Additionally there was evidence in the documentation provided to the scrutiny team that he did not refrain from taking drugs and alcohol for any sustained period, particularly when under stress. His drug use only decreased once he had run out of money.

The team caring for Mr GK assessed his main problems to be dependency on illegal drugs including cocaine. The DDU was presented as not having as its primary responsibility the management of Dual Diagnosis patients.

Mr GK did have significant periods of florid psychotic symptoms, for example when he set fire to a flat and when he attacked his father after his girlfriend left him.

At no time did there appear to be a consideration of the needs of Mr GK's informal carers or their ability to fulfil the tasks allocated to them by the professionals. For example, despite Mr GK's girlfriend being much younger than him, pregnant and struggling to cope with him Mr GK's consultant noted in February 2003 that she was supportive and would alert the CMHT if problems arose. Mr GK was discharged from the consultant's caseload and referred back to his GP for ongoing medication treatment. Fourteen days later his girlfriend had left him and he was admitted to hospital having attacked his father with a broken bottle and grabbed him around the throat.

The internal review found that record keeping was poor. The scrutiny team would endorse this as it was evident that the internal review panel who had access to Mr GK's case records were unable to identify specific dates or contact from the services involved in his care.

Scrutiny Team Recommendations

The scrutiny team make the following recommendations to East London NHS Foundation Trust.

Investigations of Serious Untoward Incidents

Recommendation One

It is recommended in accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise that all interviews undertaken for internal reviews are recorded and transcribed verbatim. These transcriptions are for the purpose of ensuring the investigation team can also check and validate their findings and not for inclusion in reports. Following NHS London's guidance it is further recommended that an independent investigator is a panel member for all cases of homicide.

Information Sharing

There was evidence that Mr GK's past history was not always shared and formulated.

Recommendation Two - Summary Sheet

It is recommended that a summary sheet is developed to be sited at the front of patients' records and updated on a regular basis. This should include:

- Current and Diagnostic History
- Risk History with a detailed list of all violent incidents and any link to abnormal mental state
- Risk Management Plan
- Changing diagnosis if relevant
- What medication worked well and problems with medication including allergic reactions
- Admission history
- Markers for relapse
- Signs of relapse
- Contingency plans to manage relapse
- Current care team and contact details

Dual Diagnosis

Mr GK had a Dual Diagnosis of substance misuse and mental illness. His management tended to focus on an individual diagnosis of substance misuse. The scrutiny team were informed by the Trust in the workshop undertaken to discuss the other two cases that a dedicated Dual Diagnosis Specialist team service is now in place.

Recommendation Three

It is recommended that the Trust provides Dual Diagnosis training to all clinical staff and that this training is audited as to its effectiveness.

Risk Assessment

There were a number of occasions when Mr GK put others at risk, for example setting fire to a flat with the purpose of killing its occupants, (although these occupants did not exist, others were put at significant risk),

Recommendation Four

Given the recommendation above in relation to Information Sharing, it is recommended that a risk history with details of violent incidents is incorporated in any clinical care planning process. The application of this should be audited as part of the regular CPA audit as set out below.

Safeguarding

The professionals caring for Mr GK were aware of a number of individuals, for example, his partner, grandfather, father and children of his partners were vulnerable. This vulnerability did not appear to have been taken into account in any care planning. Mr GK was himself vulnerable as a consequence of his brain injury and mental illness. The scrutiny team noted that he was awarded £350,000 as compensation from his RTA which should have improved his quality of life. There was no indication that his capacity to mange his finances were considered. In reality Mr GK spent this money on drugs which significantly impaired his quality of life.

Recommendation Five

It is recommended that the Trust ensure that all relevant staff are compliant with the training provided by the Trust that takes into account safeguarding both adults and children when assessing risk and planning care. This should remain part of the initial and subsequent care planning process and audited in line with Trust policy including individual supervision and the application of CPA.

1. Introduction

On 29th June 2004 Mr GK was arrested and charged with the murder of his grandfather. He had been receiving mental health services from East London NHS Foundation Trust, (the Trust).

This case, together with two others was commissioned in 2004 but in late 2006 the cases were erroneously taken off the Trust's tracking system for Serious Untoward Incident Investigations. This was discovered in February 2008 and the report was completed in April 2008. The Trust commissioned the internal review of this case jointly with two others, all three had substance misuse issues, and one of which was not a homicide. The findings and recommendations were amalgamated for all three cases.

NHS London commissioned this independent scrutiny investigation in January 2010 under HSG (94) 27 "the discharge of mentally disordered people and their continuing care in the community" and the updated paragraphs 33-36 issued in June 2005. An independent scrutiny investigation is a narrowly focussed investigation conducted by one or more investigators who have the relevant expert knowledge. The scrutiny team were asked to assess the Trust internal review and its findings and make further recommendations if deemed necessary.

The case was part of a group of legacy homicide investigations that remained from the formation of the new London Strategic Health Authority (NHSL) from its preceding Authorities. As the incident had taken place several years previously and the associated mental health services had developed and changed within that timeframe it was agreed that an independent scrutiny would take place rather than fuller investigation. Should the scrutiny investigation team find that a fuller comprehensive investigation is required then this would be recommended and commissioned by NHS London.

The Terms of Reference for this scrutiny and investigation can be found in Section 2.

2. Terms of Reference

Part One - Internal Review

To undertake a detailed scrutiny of the internal review completed by the Trust including identification of: -

- The methodology undertaken
- Appropriateness of the panel members
- Relevance of the evidence considered
- Relevance of those interviewed and information received
- Recommendations of the report and how these would ensure that lessons are learnt
- Clinical management

To determine the Care and Treatment provided to Mr GK by examination of the clinical information available from the Trust.

To compile a chronology of events.

Part Two

To hold a workshop with the Trust to discuss lessons that have been learnt, any issues raised from their internal investigation and analysis of the clinical evidence in order to understand what has changed within the services provided that will minimise risk and improve care.

To jointly agree recommendations and the actions to be taken by the Trust.

To complete a final report for acceptance by NHS London for publication.

Please Note:
The above Terms of Reference were completed prior to the Scrutiny taking place. Without access to clinical records it was not possible for the scrutiny team to analyse the case notes. Psychiatrist reports compiled after the incident did include quite comprehensive records which the scrutiny team used to expand their understanding of the case.

3. Purpose of the Scrutiny and Investigation

The purpose of any investigation is to review the patient's care and treatment, leading up to and including the victim's death, in order to establish the lessons' to be learnt to minimise a similar incident re-occurring.

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

The scrutiny team have been alert to the possibility of misusing the benefits of hindsight and have sought to avoid this in formulating this report. We hope those reading this document will also be vigilant in this regard and moderate conclusions if it is perceived that the scrutiny team have failed in their aspiration to be fair in their judgement.

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

In addition the scrutiny team is required to make recommendations for outstanding service improvements and if there are further concerns in regard to the Trust and its management of the incident to make a recommendation for a full independent mental health investigation.

The process is intended to be a positive one that examines systems and processes in place in the Trust at the time of the incident working with the Trust to enhance the care provided to their service users. We can nevertheless, all learn from incidents to ensure that the services provided to people with a mental illness are safer, and as comprehensive as possible; that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and delivering the services.

4. Methodology

It was agreed at the start of the scrutiny that the team would examine the internal review undertaken by the Trust. The scrutiny team would set out its findings in regard to the process undertaken and the Trust's progress against their internal review's recommendations. In addition the scrutiny team was to undertake a detailed analysis of Mr GK's case records held by the Trust prior to the death of the victim. Mr GK did not consent to access to these records, however the Trust's Caldicott Guardian did authorise access to the records. The Trust were unable to locate the case notes relating to Mr GK's care prior to the incident, therefore the scrutiny have used the internal review report, psychiatric reports compiled after the incident, and other documentation supplied by the Trust to undertake their scrutiny.

The scrutiny was separated into two parts as set out in the Terms of Reference. This comprised of a detailed analysis of both the internal review and Mr GK's care and treatment as stated in his case records, this could not be completed in full as the clinical records were not available to the scrutiny team. The template used by the scrutiny team for analysing the internal review can be found in Appendix One.

A chronology of the events leading up to Mr GK's arrest was compiled and can be found in Appendix Two.

The scrutiny team considered interviewing Trust staff involved in Mr GK's care as the notes have been lost and therefore no clear record of Mr GK's care and treatment is available. It was decided not to follow this route given the passage of time and the difficulty staff may experience in recollecting the case without access to Mr GK's notes.

A draft report with recommendations was shared with the Trust and their comments considered by the scrutiny team and amendments made where relevant.

This report has been drafted to include an analysis of the Trust's internal review, a brief history of Mr GK and consideration of the care and treatment provided to him by the Trust in so far as the scrutiny team could do so.

5. Scrutiny Team Members

The scrutiny was undertaken by management consultants, two of whom were external to NHS London. The scrutiny team comprised of:-

Jill Cox	Independent Healthcare Advisor, Mental Health Nurse
Dr Clive Robinson	Psychiatrist, Medical Advisor
Lynda Winchcombe Chair	Management Consultant specialising in undertaking investigations of serious untoward incidents

6. Outline of the Case

The following is an outline of the events that relate to Mr GK and his care and treatment. They have been compiled from the limited records available to the scrutiny team. A fuller chronology can be found in Appendix Two.

6.1 Background

Mr GK was born on 5th March 1975. His parents separated in his early childhood and his father died shortly before the incident. His mother remarried and he has an older half-brother and two younger half-sisters. Mr GK lived with his father after the separation for several years in Cambridgeshire.

He is reported to have had an average schooling, leaving at 16 years of age. He started an Agricultural Engineering apprenticeship and continued with this for 18 months up until he was involved in a serious Road Traffic Accident (RTA) in January 1993, aged 18 years old. He suffered significant injuries including head injuries with frontal lobe damage and organic personality change and was subsequently unemployed up until the time of the index offence.

Mr GK has three children from three different partners. It is reported that in two of these relationships there was a history of violence towards the partner. He has reported illicit drug use, in particular cocaine, over a number of years.

6.2 Contact with the Psychiatric and Neurological Services

Mr GK's first contact with mental health services was when he was admitted to a psychiatric ward at Addenbrooke's hospital in Cambridge after he had been involved in the RTA. He was treated for depression with Fluoxetine, an anti-depressant. At this time it was reported that he was non-compliant with his neurological rehabilitation sessions.

In July 1993 a neurological assessment noted that gaps in Mr GK's memory following his brain injury were lessening. A brain scan taken in October 2003 reported evidence of bi-frontal haemorrhagic contusions.

Two years later a Clinical Neuro-psychologist at Addenbrooke's hospital reported that Mr GK had difficulties in concentrating and remembering outside the normal limits for his age and education. He had poor verbal fluency and changes in his personality including lack of initiative, drive and motivation. An uncharacteristic aggressiveness and poor temper control were also noted. It was agreed that there was significant frontal lobe damage to his brain.

Mr GK, aged 20 years (1995), was reported to have presented with both grand mal and partial complex epileptic seizures. At this time he was drinking heavily

and the clinicians involved in his care considered whether his aggression was related to his seizures, alcohol related or his poor temper control. Mr GK was commenced on anti-epileptic medication, he was to reduce his drinking and it was reported that his seizures reduced after this regime was followed.

In November 1995 Mr GK moved to East London, and his neurological care transferred to a Newham neurologist, who wrote to his new GP informing them that Mr GK was not taking his anti-epileptic medication.

During 1996 and 1997 Mr GK is reported to have been having brief complex partial seizures, and a continuous headache. He was taking his prescribed medication of Carbamazepine, Fluoxetine and Dihydrocodine. He was also diagnosed as being moderately depressed and having "unprovoked aggression-associated with seizures," following an assessment at the Neuro-Psychiatry Clinic, Royal London Hospital.

In 1999 Mr GK attended the Psychiatric Emergency Clinic at Homerton hospital having self harmed. (No details were available regarding the nature of this injury).

Mr GK reported that since he had split up with his pregnant girlfriend two months previously he had twice cut his wrists, once because he was refused access to his son and the second because he felt depressed.

Sometime in 2000 Mr GK received £350,000 compensation in relation to the RTA in 1993. It is reported that he spent the whole amount over a two year period on drugs.

On 6th July 2001 Mr GK's GP referred him to the Drug Dependency Unit, (DDU).

Three days later, 9th July 2001, he presented to the Mental Health Emergency Clinic at Homerton hospital with symptoms of restlessness and agitation associated with cocaine use. He was complaining of a dislocated shoulder but did not wait for treatment. He was again referred to the local DDU.

The DDU wrote to Mr GK on 13th July 2001, copied to his GP, that they were unable to offer him an appointment at that time as there was a long waiting list.

Four days later Mr GK again presented at the Emergency Clinic on 17th July 2001 reporting that he was hearing voices and thought that the police were following him. He was diagnosed as having a Drug Induced Psychosis and prescribed an anti-psychotic medication, Olanzapine.

On 20th August 2001 Mr GK was taken to the DDU for help by the police, but this was not available as the DDU still had a long waiting list.

On 10th October 2001 Mr GK was admitted to Connolly ward at the City and Hackney Centre for Mental Health having reported that he had paranoid beliefs that people in the street wanted to harm him and also that he was hearing a voice belonging to a "William Flint". He was diagnosed as suffering from a drug induced psychosis and cocaine dependency. Olanzapine medication was prescribed. Mr GK was discharged after five days into the care of the Community Mental Health Team (CMHT).

The DDU wrote to Mr GK in October and November 2001 offering him an appointment. In December they wrote again thanking him for a urine sample and requesting a second sample by 5th December, following which he would be sent an assessment appointment.

No further information is available until on 15th March 2002, Mr GK again attended the Emergency Clinic reporting auditory hallucinations, "someone had put a hearing device in his head." Oral anti-psychotic medication, Risperidone was prescribed and arrangements made for a psychiatric follow up, which he did not attend.

Mr GK did not attend the psychiatric clinic appointment on 12th April 2002, but was referred to the DDU after he attended an appointment at the clinic on 26th April 2002. He reported that he had stopped taking Rispiridone as it was making him dizzy. Mr GK stated that he was still hallucinating but was not distressed by this.

He was seen at an outpatient clinic on 3rd May 2002 and reported that he hadn't used cocaine for a week. He was advised to use a 'Walkman' to distract himself from the voices.

On 8th July 2002 Mr GK was admitted informally to Connolly ward at Homerton hospital having become increasingly irritable and aggressive, kicking in a door and setting fire to an upstairs flat. He tried to leave the ward and was placed under Section 5 (2) of the Mental Health Act (MHA) and transferred to a Psychiatric Intensive Care Unit, (PICU). He reported having auditory hallucinations with multiple voices, both male and female.

Mr GK was assessed by a DDU nurse on the ward on 18th July. It was noted that no further follow up would be undertaken by the DDU. It was agreed to refer Mr GK to the Hackney Community Drug Team, (Addaction), on discharge for support.

On 26th July when screened for drugs he was negative for cannabinoids but positive two days later although then negative for cocaine metabolities. A brain scan taken on 29th July showed an area of low attenuation in the left frontal lobe consistent with his previous trauma.

Mr GK was discharged on 22nd August 2002 with a plan for outpatient and DDU follow up. His diagnosis was epilepsy with complex partial seizures, organic personality change, polysubstance misuse and asthma. Organic hallucinosis first differential diagnosis with schizophrenia as another.

Three days later the ward were informed by the police that Mr GK was threatening to jump from the 6th floor after drinking heavily and an argument with his girlfriend. When contacted the next day by the Crisis team he reported that all was well.

In September (12th) an entry was made in his CMHT notes that "we need to complete a full needs assessment on this man to identify the extent to which this CMHT can be of help to him and what other services might meet his needs." He was to be reviewed in outpatients and referred to the DDU.

In November 2002 he failed to attend an outpatient clinic appointment and his consultant psychiatrist contacted him on 4th December. Mr GK told his consultant that he was well, was taking his medication and mentioned that he had a new baby. A outpatient appointment was arranged for 14th February 2003, which Mr GK failed to attend. It was noted in his records that no further appointments would be made unless Mr GK or his girlfriend requested one.

In March 2003 Mr GK was brought to the A & E department at Homerton hospital having threatened his father with a broken bottle and grabbed him around the throat. He was again admitted informally to Connolly ward and reported continued auditory hallucinations. He reported that he had been taking his prescribed medication of Amisulpride and Carbamazepine.

Mr GK's girlfriend had left him two weeks previously and he stated that he had been drunk when he attacked his father. He was discharged on 3rd March 2003 to be followed up by the CMHT.

It is thought that Mr GK had a further admission to hospital in July 2003 but no other details are available. It appears that the CMHT remained in contact but no details of this contact were available to the scrutiny team.

On 29th June 2004 Mr GK was arrested and charged with the murder of his grandfather.

7. Consideration of the Internal Review Report

The following comments relate to the internal review report which was completed by the Trust and covers the report layout as well as content. It has been set out in accordance with the first part of the scrutiny team's Terms of Reference.

7.1 Internal Review – Process Comments

Overall the scrutiny team consider that the internal review was not structured in a way which enabled a balanced analysis of Mr GK's care and that this was compounded by the fact that the internal review attempted to deal with three cases in one report. There was no demonstrable analysis of the evidence that facilitated links between the internal review findings and recommendations. The scrutiny team found no evidence that a 72 hour management report had been completed.

As indicated there was not a specific internal review report into Mr GK's case. A report dealing with three cases, including Mr GK, was commissioned by the Trust in 2004 but in late 2006 the case were erroneously taken off the Trust's tracking system for Serious Untoward Investigations. This was discovered in February 2008 and the report completed in April 2008. The Trust did commission a further external inquiry to examine the process failures that led to the case not being investigated according to their standard procedure and also why the Trust were not aware that the three cases had not been reported to their Trust Board.

This scrutiny team found that the assessment of the internal review was complicated by the decision of the Trust to examine the three cases within the same process particularly as one case was not a homicide.

The composition of the review panel, whilst independent of the Trust, did not include anyone who was not a health professional.

The internal review panel interviewed a number of staff internal to the Trust and notes of these meetings were taken and checked with those interviewed. The interview notes were not verbatim and were included in the report. This is not accepted practice for investigations.

The Terms of Reference for the internal review specifically refers to the suitability of care for the victim's family. However there is no evidence that the Trust or the investigation team had contact with the family of Mr GK. It is noted that the investigation team did request that the Trust contact the family to seek their involvement but the scrutiny team could find no evidence that this had occurred.

It is clear from both the internal review and subsequent external inquiry that the Trust had not considered informing the Strategic Health Authority or had

considered the possibility of an independent investigation under the auspices of HSG (97) 27.

The internal review did include information regarding Mr GK's background and childhood history but only examined events in more detail for a period of 12 months prior to the incident.

7.2 Internal Review Report – General Comments

The scrutiny team considered the effects of examining the three cases as a group and how this combination impacted on the final report. Although the three cases were dealt with separately in the first part of the report any analysis and resulting conclusions based on that individual were not separated out. There were no individual findings on each case, this made it impossible to link any issues identified with their respective recommendations. A further consequence of considering three cases together was the focus on similarities of the three cases and in the view of the scrutiny team this led to an overemphasis on substance misuse. This further led to a failure to properly examine Mr GK's clinical and social needs as identified in the case records available to the internal review.

In the opinion of the scrutiny team it was considered that the four year delay in completing the internal review was unacceptable. The external inquiry to identify the problem which led to the failure in the Trust's systems, and the inquiry's report, is welcomed. The scrutiny team were satisfied that the systems in place within the Trust now should prevent similar problems arising again.

Mr GK's contact with mental health services spanned a period of 10 years. The internal review team only identified in detail the last year of contact between Mr GK and the mental heath services. It was not possible to determine why they had decided to concentrate on this short period, although it does appear that this was common practice amongst London Trusts during this period.

The internal review although identifying that Mr GK had a young family did not appear to consider that there might have been a safeguarding of vulnerable children issue. He was known to have bouts of aggression and difficulty with temper control, together with drug and alcohol misuse.

From the evidence provided to the Trust's internal review it was considered that Mr GK's main problem was substance misuse related. This was also reflected by those providing his care by the referrals to the DDU during his inpatient admission and whilst in contact with community services.

The clinicians appeared to consider that as long as Mr GK was compliant with his medication, refrained from using drugs and alcohol and his persistent hallucinations did not distress him then the risks would be managed. He was

never seen as a vulnerable person who presented a serious risk to himself or others as a consequence of his abnormal mental state.

8. Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review did not present a well prepared, balanced review of Mr GK's care and treatment. It appeared that assumptions had been made about the issues raised in all three cases before any proper examination of the evidence had taken place. Their decision to follow a themed approach in which the three cases were grouped together hampered a thorough review process.

The purpose of the Trust's internal inquiry, "the Hackney Three" was to examine the process failures that led to the case being lost to the system.

8.1 Scrutiny Team Independent Findings

As described earlier the scrutiny team were unable to examine the case notes relating to Mr GK's care and treatment. The following findings and recommendations relate to the internal review only.

The scrutiny team had held a workshop with the Trust on two previous investigations, one of which was included in the "Hackney Three Investigation". This provided the scrutiny team with an opportunity to discuss general services and procedural services. As there were no records to provide specific additional information it was decided not to hold a further separate meeting with the Trust or raise any further issues with them.

The final internal review report provided to the scrutiny team contained notes of the interviews with staff. This is not accepted practice for investigations. From the notes it appears that conflicting evidence was not challenged or followed up by the internal review panel. The scrutiny team would also comment that no external agencies or other external people to the Trust were interviewed.

The findings and recommendations of the internal review were general and tailored to the common themes of the report as a whole. The Trust have progressed and implemented their action plan with the exception of the Ward practice initiative which was being currently reviewed at the time of this scrutiny and it was indicated that this would be completed at the end of May 2010.

The general comment in the internal review report that "*Mental health care professionals are expert at addressing risks arising from mental illness*" may have been an attempt to be supportive to staff. It did not characterise the reality that mental health professionals in all parts of the country frequently find it very difficult to address risks associated with mental illness complicated by other factors. The internal review panel seemed to suggest that addressing the risks posed by the individuals was not the responsibility of the mental health professionals because the risks were related to substance misuse or criminal propensities.

The scrutiny team found that the internal review's recommendations were hard to connect with their findings. In addition the findings were not measurable against their implementation or able to be evaluated against the impact on the Trust's services.

The scrutiny team would comment that the clinicians' apparent reliance on Mr GK's compliance with medication and abstention from drugs and alcohol to manage risk would appear to have been misplaced. Mr GK's risk would have been difficult to assess because of his complex physical and mental health issues (such as the frontal lobe damage following his head injury), use of drugs and alcohol, and his dependency on his girlfriends. Despite this complexity there was no evidence of a multi-disciplinary risk assessment.

The situation in regard to Mr GK's frequent referrals to the Drug Dependency Unit, his non-engagement and their waiting list was noted in the internal review but was explained as a lack of resources. The issue regarding individuals with a Dual Diagnosis who are abusing drugs and alcohol, and who express a wish to decrease this dependency then being placed on a waiting list is not the best option at that particular time. No other therapeutic intervention regarding this problem was either suggested or provided.

The scrutiny team found that Mr GK, contrary to the findings of the internal review, was not compliant with medication. There was evidence in the documentation provided to the scrutiny team that he did not refrain from taking drugs and alcohol for any sustained period, particularly when under stress. His drug use only decreased once he had run out of money.

The team caring for Mr GK assessed his main problems to be dependency on illegal drugs including cocaine. The DDU was presented as not having as its primary responsibility the management of Dual Diagnosis patients.

Mr GK did have significant periods of florid psychotic symptoms, for example when he set fire to a flat and when he attacked his father after his girlfriend left him.

At no time did there appear to be a consideration of the needs of Mr GK's informal carers or their ability to fulfil the tasks allocated to them by the professionals. For example, despite Mr GK's girlfriend being much younger than him, pregnant and struggling to cope with him Mr GK's consultant noted in February 2003 that she was supportive and would alert the CMHT if problems arose.. Mr GK was discharged from the consultant's caseload and referred back to his GP for ongoing medication treatment. Fourteen days later his girlfriend had left him and he was admitted to hospital having attacked his father with a broken bottle and grabbed him around the throat.

The internal review found that record keeping was poor. The scrutiny team would endorse this as it was evident that the internal review panel who had access to Mr GK's case records were unable to identify specific dates or contact from the services involved in his care.

8.2 Scrutiny Team Recommendations

The scrutiny team make the following recommendations to East London NHS Foundation Trust.

8.2.1 Investigations of Serious Untoward Incidents

Recommendation One

It is recommended in accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise that all interviews undertaken for internal reviews are recorded and transcribed verbatim. These transcriptions are for the purpose of ensuring the investigation team can also check and validate their findings, and not for inclusion in reports. Following NHS London's guidance it is further recommended that an independent investigator is a panel member for all cases of homicide.

8.2.2 Information Sharing

There was evidence that Mr GK's past history was not always shared and formulated.

Recommendation Two - Summary Sheet

It is recommended that a summary sheet is developed to be sited at the front of patients' records and updated on a regular basis. This should include:

- Current and Diagnostic History
- Risk History with a detailed list of all violent incidents and any link to abnormal mental state
- Risk Management Plan
- Changing diagnosis if relevant
- What medication worked well and problems with medication including allergic reactions
- Admission history
- Markers for relapse
- Signs of relapse
- Contingency plans to manage relapse
- Current care team and contact details

8.2.3 Dual Diagnosis

Mr GK had a Dual Diagnosis of substance misuse and mental illness. His management tended to focus on an individual diagnosis of substance misuse. The scrutiny team were informed by the Trust in the workshop undertaken to discuss the other two cases that a dedicated Dual Diagnosis Specialist team service is now in place.

Recommendation Three

It is recommended that the Trust provides Dual Diagnosis training to all clinical staff and that this training is audited as to its effectiveness.

8.2.4 Risk Assessment

There were a number of occasions when Mr GK put others at risk, for example setting fire to a flat with the purpose of killing its occupants, (although these occupants did not exist, others were put at significant risk),

Recommendation Four

Given the recommendation above in relation to Information Sharing, it is recommended that a risk history with details of violent incidents is incorporated in any clinical care planning process. The application of this should be audited as part of the regular CPA audit as set out below.

8.2.5 Safeguarding

The professionals caring for Mr GK were aware of a number of individuals, for example, his partner, grandfather, father and children of his partners were vulnerable. This vulnerability did not appear to have been taken into account on any care planning. Mr GK was himself vulnerable as a consequence of his brain injury and mental illness. The scrutiny team noted that he was awarded £350,000 as compensation from his RTA which should have improved his quality of life. There was no indication that his capacity to mange his finances were considered. In reality Mr GK spent this money on drugs which significantly impaired his quality of life.

Recommendation Five

It is recommended that the Trust ensure that all relevant staff are compliant with the training provided by the Trust that takes into account safeguarding both adults and children when assessing risk and planning care. This should remain part of the initial and subsequent care planning process and audited in line with Trust policy including individual supervision and the application of CPA.

Scrutiny Template

Appendix One

The Review concerns cases where a homicide has occurred and would have, in other circumstances, triggered an independent investigation into the care and treatment of the perpetrator of the homicide. The initial phase of the review assesses the internal investigation in relation to criteria appropriate to an independent investigation, where possible providing evidence supporting that assessment. Where there is a significant omission, or deviation from good practice within the internal investigation, the independent review makes an assessment based on available evidence. The following table provides a format for this process.

Item under scrutiny	Achieved or not	Evidence	Comments
Was there an Initial Management Investigation within 72 hours			
Was relevant immediate action taken relating to : Staff Notes Equipment Communication with individuals, organizations, carers and families			
In relation to families and carers:			
- was an appropriate member of the Trust identified to liaise with them - was the liaison sufficiently flexible			
- were SHA and other appropriate organizations notified of the homicide			
- was consideration given to an Independent Investigation			

- was there an appropriate description of the purpose of the investigation			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
Did the Terms of Reference include the following:			
To examine all circumstances surrounding the treatment and care of X From …(date).. to the death of …(Victim)… and in particular:			
- the quality and scope of X's health, social care and risk assessments			
- the suitability of X's care and supervision in the context of his/her actual and assessed health and social care needs			
- the actual and assessed risk of potential harm to self and others			
- the history of X's medication and concordance with that medication -			
- any previous psychiatric history, including alcohol			

and drug misuse			
- any previous forensic history			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
The extent to which X's care complied with:			
- statutory obligations			
- Mental Health Act code of practice			
- Local operational policies			
- Guidance from DOH including the Care Programme Approach			
The extent to which X's prescribed treatment plans were:			
- adequate			
- documented			
- agreed with him/her			
- carried out			
- monitored			

- complied with by X			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
To consider the adequacy of the risk assessment training of all staff involved in X's care			
To examine the adequacy of the collaboration and communication between the agencies involved in the provision of services to him/her			
To consider the adequacy of the support given to X's family by the Mental Health team serving the community and other professionals			
To consider such other matters as the public interest my require			

Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
In terms of the conduct of the Internal Investigation were:			
- carers and relatives of victim and perpetrator involved if they wished to be			
- appropriate statutory bodies involved in the process			
- suitable methodologies identified (for example root cause analysis)			
- these methodologies followed in practice			
- appropriate individuals			

recruited to the panel			
- the case notes reviewed systematically			
- significant events included in a chronology			
- appropriate individuals asked to provide statements and/or interviewed			
- views expressed or information contained in external reports such as forensic reports taken account of (if available at the time of the investigation)			
- the case notes scrutinized in terms of accessibility, legibility, comprehensiveness			

- the case notes identified containing a current risk assessment, CPA documentation, care plan			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
In terms of the Internal Report Recommendations do they:			
- make clear the legislative and other constraints thus providing a realistic yardstick against which clinical decisions were assessed			
- recommend a course of action for each problem identified or indicate why improvement is not possible			
- refer to commendable practices			
- acknowledge that all clinical decisions involve the assumption of risk			

- address whether any application of the MHA was appropriate and completed legally			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
Did the Internal Investigation Report receive Trust Board scrutiny and approval			
Did any action plan address the report recommendations			
Is there evidence that the action plan has been successfully implemented and any identified risks reduced if possible			
Is there evidence that there are significant issues not addressed by the internal report			
Is there evidence that there have been failures to adhere to local or national policy or procedure			
Is there evidence that the care provided for X was inappropriate, incompetent or negligent			
Do the Independent review panel think it appropriate to make additional recommendations			

Psychiatric and Neurological Chronology of Events Appendix Two

1992	Mr GK aged 18 years, was involved in a serious road traffic accident where he sustained a head injury with frontal lobe damage and organic personality change. He was in hospital for several months.
June 1993	Mr GK is reported to have been admitted to a psychiatric ward at Addenbrooke's hospital, Cambridge where he was treated for depression with Fluoxetine, an antidepressant.
July 1993	At a neurological follow up assessment on Mr GK it was noted that the gaps in his memory following the head injury was lessening.
October 1993	A brain scan showed evidence of bi-frontal haemorrhagic confusions.
July 1995	A Clinical Neuro-psychologist at Addenbrooke's hospital reported that Mr GK had difficulty in concentration and remembering, poor verbal fluency, changed in personality including lack of initiative, drive and motivation. He also was noted to be uncharacteristically aggressive with poor temper control. Frontal damage was significant.
1995	Mr GK presented with two types of seizures, grand mal and partial complex. He was reported to be drinking heavily and it was debated whether his aggressive behaviour was related to his seizures, alcohol or poor temper control. Mr GK was commenced on anti-epileptic medication and to reduce his alcohol intake. As a result the frequency of his seizures improved, (decreased).
November 1995	Mr GK moved to East London and his neurological care was transferred to Newham General hospital, who, when Mr GK was seen by them, wrote to his GP stating that he was not taking his anti-epileptic medication.
1996-1997	Mr GK continued to have brief complex partial seizures. He was prescribed Carbamazepine, Fluoxetine and Difydrocodine for a continuous headache. At this time he was also assessed at the Neuro-psychiatry clinic, Royal London hospital. He was diagnosed as moderately depressed with unprovoked aggression associated with seizures.
1999	Mr GK attended the Emergency Clinic at Homerton hospital having self harmed. He complained of depression following a separation with his pregnant girlfriend. It was reported that he had twice cut his wrists over the previous two months. Once because he was denied access to his son and the second because he felt depressed.

2000 Mr GK is reported to have received compensation of £350,000 for the injuries he received from the RTA. It was apparently spent within two years on drugs.

6. 07. 2001 Mr GK's GP referred him to the Drug Dependency Unit (DDU).

9. 07. 2001 Mr GK presented at the Emergency Clinic, restless and agitated following cocaine use. He had a dislocated shoulder but didn't wait for treatment. He was advised to attend the DDU but reported that there was a waiting list.

13.07.2001 The DDU wrote to Mr GK copied to his GP stating that there is a waiting list and they are unable to offer him an appointment at that time.

17.07.2001 Mr GK presented at the Emergency Clinic stating that he was hearing voices, and thought the police were following him, he was diagnosed drug induced psychosis and prescribed Olanzapine.

20.08.2001 Mr GK taken to the DDU by the police. He was requesting help, the DDU explained about the waiting list.

10.10.2001 Mr GK admitted to Homerton hospital having been taken there by his mother. It was reported that he was withdrawn and paranoid with psychosis and auditory hallucinations. He had been injecting cocaine for one year. It is reported that he had had paranoid beliefs that people in the street wanted to harm him and also hearing the voice of someone call "William Flint." He was discharged after five days under the care of the CMHT having responded well to anti-psychotic and anti-epileptic medication.

22.10.2001 Mr GK was offered an appointment with the DDU.

5.11.2001 DDU wrote again offering an appointment.

27.11.2001 DDU wrote to Mr GK thanking him for providing a first urine sample asking him for a second sample before 5th December 2001. Once this had been received he would be offered an assessment appointment.

24.12.2001 DDU wrote to Mr GK again regarding a second urine sample and assessment.

15.03.2002 Mr GK attended the Emergency Clinic with auditory hallucinations. He reported that "someone had put an hearing device in his head." Oral Risperidine given and arrangements were made for a psychiatric follow up.

12.04.2002 Did not attend the outpatient clinic appointment.

26.04.2002 Attended outpatients and informed the consultant psychiatrist that he had stopped taking Risperidine medication as it made him dizzy. He was still hallucinating but not distressed. Referred to DDU.

3.05.2002 Attended a follow up clinic appointment and reported having not used cocaine for a week. Advised to use a Walkman to distract from the voices.

8.07.2002 Mr GK admitted informally to Connolly ward, Homerton hospital. He had become increasingly irritable and aggressive, kicking in a door and setting fire to an upstairs flat. He wanted to leave hospital so was placed on Section 5(2) MHA and transferred to a PICU (Bevan ward). Mr GK reported auditory hallucinations with multiple voices, male and female.

18.07.2002 Seen by the DDU nurse on the ward – no further follow up from the DDU. To be referred to Hackney Communication Drug Team – AddAction – on discharge.

26.07.2002 Mr GK negative for cannabinoids but two days later was positive.

29.07.2002 Brain scan taken – an area of low attenuation noted in the left frontal lobe in keeping with previous trauma.

1.08.2002 Care plan meeting held on the ward. Mr GK reported that his "voices were far away."

22.08.2002 Mr GK discharged – for outpatients follow up. Diagnosed with Epilepsy with complex partial seizures, organic personality change, polysubstance misuse and asthma. Organic Hallucinosis first differential diagnosis and schizophrenia as another.

25.08.2002 The police rang the ward stating that Mr GK was on the 6th Floor, (not clear on what building), following drinking and an argument with his girlfriend. Crisis team followed this up with a phone call the next day. Mr GK reported he was well.

12.09.2002 The CMHT notes "we need to complete a full needs assessment on this man to identify the extent to which this CMHT can be of help to him and which other services might meet his needs." For an outpatient review and referral to DDU. Mr GK's girlfriend was reported as being 7 months pregnant and his two sons were aged 7 and 2 years old and living with their mothers.

14.11.2002 Failed to attend outpatients clinic consultant psychiatrist appointment.

4.12.2002 Mr GK's consultant rang him, he reported that he was well, had a new baby. He was sent an appointment for 2 months time.

14.02.2003 Failed to attend outpatients, the consultant noted that Mr GK was receiving support from his girlfriend who would let them know if he was unwell. For no follow up appointments unless requested. Mr GK's care to be left to his GP.

28.02.2003 Admitted to hospital having been taken to A&E by the police. He had been staying with his father and had threatened him with a broken bottle and grabbed him around the throat. Mr GK reported that he had been drunk.

The following day he reported still experiencing auditory hallucinations "in the background" as "always."

3.03.2003 Discharged – the summary stated that he was to be followed up as an outpatient, (CMHT).

17.09.2003 Discharge summary addressed to Mr GK's GP. No details about this admission in the documentation. Mr GK to be followed up by the CMHT.

29.06.2004 Mr GK arrested and charged with the murder of his grandfather.