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ROOT CAUSE ANALYSIS REPORT

Review of a Serious Untoward Incident:

Oxleas NHS Trust

Reference: ECRI/MHRA/JT/1

Report Dated:

6th September 2003

An Investigation into the health care of JT at the Oxleas NHS Trust following a homicide using Root Cause Analysis

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1.0 Introduction

1.1 ECRI is an independent health services research organisation and a Collaborating Centre of WHO.

1.2 ECRI has been instructed by the DH to carry out a Root Cause Analysis (RCA) study following a Homicide on the 8th March 2003.

1.3 This investigation concerns the care of a patient, designated as JT throughout this report.

1.4 JT was cared for by the Oxleas NHS Trust.

2.0 The Investigation of Serious Untoward Incidents in the NHS

2.1 In year 2000 the government's Chief Medical Officer published a document entitled "An Organisation with a Memory". This reported the results of findings by an expert group reviewing adverse incident management and the options for learning from such events. This and a subsequent publication entitled 'Building a Safer NHS for Patients' identified significant opportunities and benefits that exist to reduce unintended harm to patients in NHS care.

2.2 A further Department of Health publication (Draft): 'Doing Less Harm' (August 2001) outlined the infrastructure and key requirements for NHS organisations to manage, learn and administer adverse incidents. The content of the document reflected the requirement for mandatory Department of Health incident and reporting standards.

2.3 There are ten key local requirements:

i. All individuals involved directly or indirectly in patient care are aware of what constitutes an adverse incident.

ii. The incident is managed and reported to the designated person or persons in accordance with local arrangements.

iii. All serious incidents are reported immediately to a locally designated person or persons and, where appropriate, information on these incidents is "fast-tracked" to relevant external stakeholders.

iv. All reported incidents are graded according to the actual impact on the patient(s), and potential future risk to patients and to the organisation and reviewed to establish stakeholder reporting requirements.

v. Adverse patients' incidents are subject to an appropriate level of local investigation and causal analysis and where relevant an improvement strategy is prepared.

vi. Incidents graded as Red are reported to the National Patients Safety Agency within three working days of the date of the occurrence for category *Red adverse incidents only* (i.e. where serious actual harm has resulted). This information is also reported within three working days to a relevant Regional Office of the Department of Health.

vii. For all category Red incidents a full root cause analysis is undertaken by the local organisation and reported to the National Patient Safety Agency within 45 working days of the occurrence of the incident. For category *Red adverse incidents only* (i.e. where serious actual harm has resulted) this information reported with 45 working to the relevant Regional Office of the Department of Health.

viii. Where appropriate, the organisation co-operates with the Department of Health to establish the need for an independent investigation or enquiry and also co-operates with other stakeholders who might be required to undertake investigations and/or enquiries into the circumstances surrounding that particular adverse patient incident.

ix. Aggregate reviews of local incident data/information are carried out on an ongoing basis by the organisation and the significant results communicated to local stakeholders. Aggregate review reports are sent to the National Patient Safety Agency on a quarterly basis.

x. Lessons are learned from individual adverse patient incidents, from local aggregate reviews and from wider experiences, including feed-back from the National Patient Safety Agency and other agency/bodies, and bench marking. Improvement strategies aimed at reducing risk to future patients are implemented and monitored by the organisations. Where appropriate local staff learn lessons and change practice in order to improve the safety and quality care for patients.

3.0 Root Cause Analysis

3.1 Root Cause Analysis (RCA) is a component of the broader field of Total Quality Management (TQM), which has arisen from the world of business management. Many of the "tool-box" problem solving techniques of TQM are overarching concepts with the ultimate aim of continuous improvement in quality[1]. RCA is an integral part of this process. It has been defined as a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it. It incorporates a wide range of approaches, tools and techniques used to uncover the causes of problems.

3.2 The causes of untoward events in large organisations often link together in highly complex interrelationships. These multiple causes can be grouped into first level causes (causes that directly lead to a problem), higher level causes (which do not directly cause the problem, but provide links in the chain that ultimately lead to the problem) and root causes (the "*evil at the bottom*" that sets in motion the cause and effect chain)[2].

3.3 The application of RCA requires familiarity with the variety of problem solving techniques available in order to be able to apply the most useful to the problem at hand. There is presently no prescribed RCA method for investigations in mental health services.

3.4 Rose[3] has described in detail a method of conducting internal investigations in mental health services and the RCA process aims to build on these experiences. The method adopted for this RCA is shown in Appendix A.

3.5 The team "brain storming" process (Appendix A) in a RCA is structured in various ways according to the problem under consideration. A number of techniques have been identified as particularly suitable to a RCA of a mental health service incident.

3.6 The relations diagram is a tool used to identify logical relationships between different ideas or issues in a complex or confusing situation. The strength of the relations diagram is the ability to visualize such relationships, understand how different aspects of the problem are connected and see relationships between the problem and its possible causes that can be further analyzed. One method of determining an unexpected cause is to identify drivers (more outputs than inputs) and indicators (more inputs than outputs can be identified) in the relations diagram.

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[1] Gitlow, H., Oppenheim, A., Oppenheim, R. (1995) *Quality Management: Tools and methods for improvement.* Burr Ridge, IL: Irwin.

[2] Andersen, B,. & Fagerhouse, T. (2000). *Root Cause Analysis: Simplified tools and techniques.* ASQ Quality Press. Milwaukee. Wisconsin.

[3] Rose, N. (2000) Six years experience in Oxford. Review of serious incidents. *Psychiatric Bulletin*. **24**. 2343-246.

3.7 Once the web of inter-relationships has been established from the relations diagram the "five whys" technique can be used to delve more deeply into the higher levels of the cause. For each possible cause the RCA team ask why that event occurred until all the possible higher level causes have been identified. It is so-called because asking the question 5 times, for each first level cause, should be sufficient to determine all higher level causes.

3.8 The National Patient Safety Agency (NPSA) has produced a draft classification system for factors contributing to serious incidents in the NHS (Appendix B). This can be applied in the form of an Affinity Diagram. This allows exploration of relationships among different causes (often at different levels in the cause hierarchy) and it groups related causes into classes that can then be treated collectively.

3.9 The final step in the RCA is for the Trust to use the findings to review their systems and introduce changes at the operational or managerial level where appropriate. An audit process should be developed to oversee their timely review and implementation.

4.0 Brief Case Summary

4.1 JT is a 44 year old man of Turkish Cypriot ethnicity. It is alleged that JT caused the death of DD, a mental health service user, from stab wounds on the 8th March 2003. DD was known to JT and lived in the same supported accommodation provided by SELSA (Southeast London Supported Accommodation) where the alleged homicide took place.

4.2 JT has a history of contact with mental health services since 1985 and was in contact with local mental health services at the time of the alleged murder. He was subject to section 117 aftercare responsibilities under the 1983 Mental Health Act.

5.0 Sources of information

5.1 Psychiatric Reports on JT written by Dr Nigel Pearson, Consultant Psychiatrist, dated 7th May 2002 and 31st March 2003.

5.2 Greenwich Assertive Community Treatment Team (ACT) letter dated 29th August 2002 and Report on JT dated 26th March 2003.

5.3 Management Report into Level 3 Incident by Graham Caren, Joint Service Manager, Adult Acute and Community Mental Health Services, Oxleas NHS Trust & Greenwich Council, dated 25th March 2003.

5.4 SELSA (Southeast London Supported Accommodation) contact sheet from 1st August 2002 to 8th March 2003.

5.5 SELSA Referral Policy undated.

5.6 SELSA Serious Incident Report written by Steve Lonie, dated 31st March 2003.

5.7 Handwritten psychiatric notes dated from 10th March 2000 to 17th October 2002.

5.8 Greenwich District Hospital Discharge undated.

5.9 Psychiatric Report by Dr M Cozzolino undated.

5.10 Commission for Health Improvement (CHI) Report published on Oxleas NHS Trust dated 9th April 2003.

5.11 ECRI interviews were held on the 7th July 2003 with:

i. Dr Nigel Pearson, Consultant Psychiatrist.
ii. Jo Fuller, Assertive Community Team Manager.
iii. Alan Key, Social Worker.
iv. Nuala DHerty, SELSA worker.
v. Steve Lonie, Managing Director, SELSA

6.0 Chronology of Events

6.1 In 1985 JT was first admitted informally to Goodmayes Hospital, London for 2 weeks after he became overactive, elated, argumentative, and preoccupied with kung fu. He was also smoking cannabis. A diagnosis of drug induced hypomania was made.

6.2 In 1987 he was later admitted under Section 2 of the Mental Health Act to Greenwich District Hospital in 1987. JT was violent towards his wife and brother-in-law, whom he accused of interfering sexually with his wife.

6.3 In 1988 he was admitted informally to Greenwich District Hospital for 4 weeks as he appeared guarded and suspicious and was initially unwilling to continue to take his depot medication. JT was also admitted for 5 months to Bexley Hospital under Section 37 of the Mental Health Act after becoming involved in a fight with a policeman. He was experiencing auditory hallucinations and he believed the Devil was controlling him. He was diagnosed with schizophrenia and his wife divorced him.

6.4 **There is evidence of developing schizophrenia, co-morbid cannabis mis-use and violence towards others in the 1980s.**

6.5 In 1990 JT suffered from a further documented psychosis and was detained under section 3 of the Mental Health Act. He allegedly threatened a fellow patient with a knife and was arrested for having a crossbow in his car. JT was subsequently transferred to the Bracton Forensic Unit. A Mental Health Tribunal discharged him in November 1990.

6.6 In 1991 JT was detained under section 3 of the Mental Health Act following a relapse of his psychotic illness. He was discharged after 6 weeks, treated with a depot (injectible antipsychotic) medication and followed up by the Community Mental health Team (CMHT).

6.7 In 1992 JT continued to use cannabis and his mental health relapsed requiring admission to Greenwich District Hospital.

6.8 In 1993 JT was admitted to Kneesworth House (Private Forensic Services) under Section 48/49 of Mental Health Act from Belmarsh prison where he had been held on a charge of arson (to his own flat). Following a court hearing at the Inner London Crown Court on 10 December 1993 JT was placed on Section 37/41 without limit of time.

6.9 In May 1995 JT was subject to a conditional discharge under Section 41 of the Mental Health Act on leaving Kneesworth House Psychiatric Hospital. The specific conditions attached to JTs discharge by the Secretary of State were that he should reside at a specified address, accept psychiatric supervision, social supervision, attend outpatient clinic as directed by the psychiatric supervisor and that he should comply with all medication, supervision and appointments as directed by his supervisor.

6.10 **In the first 5 years of the 1990s there is evidence of further offending behaviour. This included alleged threatening behaviour, possession of offensive weapons and arson. Forensic services were involved. He was detained under Forensic Sections of the MHA.**

6.11 In 1997 JT was admitted voluntarily to Greenwich District Hospital with depression.

6.12 In 1998 JT was discharged from Hospital with a diagnosis of paranoid schizophrenia and was being treated with a depot antipsychotic. It was documented that JT often slept with a knife under his pillow and made threats to others when he was unwell. He was given an absolute discharge from his section 37/41 by the Secretary of State for the Home Office.

6.13 **Despite repeated detention and admissions JT does not appear to have been 'recalled' as allowed by the conditions of his section 37/41 when unwell and in fact was discharged from his forensic section 37/41 in 1998. With hindsight it may have been safer to have kept JT on his section 37/41 with its added safeguards of recall in view of JTs continuing psychotic symptoms and risk of violence when unwell.**

6.14 In 2000 JT was detained under section 3 of the Mental Health Act for 8 weeks and treated with oral antipsychotic medication. JT was found to be poorly compliant with medication, particularly when switched from his depot to an oral antipsychotic medication.

6.15 In April 2001 he was assessed in outpatients on the verge of a relapse into paranoid psychosis. He was noted to be poorly compliant with Olanzepine, which was re-instituted. In 2001 it is documented that JT was also abusing amphetamines and that he became increasingly psychotic when using them. He was living in temporary accommodation. JT was accused of raping a female patient whilst an inpatient but the charge was subsequently withdrawn by the patient.

6.16 On 16 January 2002 he was admitted informally after he complained that people were after him and that he would kill them or himself. He had bought an axe as protection. He had also considered buying a gun. Five days after admission he discharged himself against medical advice. Ten days later, on the 4 February 2002, he was admitted informally again, after a risk assessment showed a risk of aggressive or violent behaviour towards others. He was poorly compliant with medication. He had poor engagement with the ACT. He was using amphetamines. He was keeping a weapon at home. He was psychotic. Five days later he was detained under a Section 3 (presumably after trying to self-discharge). He was held on the intensive care unit for 3 weeks. The date of discharge from this admission could not be determined.

6.17 In March 2002.JT was first referred to local specialist drug mis-use services JT did not attend the appointment made for him and no further appointments are documented as having been made.

6.18 In May 2002 he was moved to the SELSA supported accommodation for a 13 week trial. During the 13 week trial he had a relapse and was re-admitted to hospital. There is no documentation relating to this admission available.

6.19 On 2 June 2002 he was noted to be on an enhanced CPA level. It was noted that he became paranoid after amphetamine use. He often bought a knife as protection when unwell and it was noted that he became sexually disinhibited and aggressive.

6.20 He was formally discharged from hospital on 11 June 2002 when he was noted to be on an IM depot antipsychotic, requiring weekly injections. After discussion he was returned to the SELSA trial. DD (the victim) was also living in SELSA accommodation and asked to move in with JT. This was discussed and allowed.

6.21 On Tuesday 29 August 2002 JT was admitted to hospital again. It is not known whether this was under a section of the MHA. This followed an incident in which he had taken knives into his room and made several threats to harm his flatmate (DD). The day before admission he had gone to his flat mate's room holding a knife and threatened to cut him up. He was regularly using amphetamines and was psychotic. He appears to have been sent out, on home leave, on 1 October 2002, back to the SELSA accommodation, for a further 4 week trial, with DD in still in residence.

6.22 On the 15 October 2002 he was formally discharged from hospital. He requested a reduction in his depot medication. This was reduced from 50 mgs every 2 weeks to the equivalent of 37.5 mgs every 2 weeks. The indication for this reduction is not recorded.

6.23 **A detailed table of the chronology of events between the period October 2002, when he was last discharged from hospital, and March 2003, when the homicide occurred, is shown at Appendix D.**

6.24 On the 17 October 2002 a CPA meeting was recorded in which it was decided to hold a CPA every 3 months. The ACT was to visit him at home twice a week and the Consultant Psychiatrist was to see him every month.

6.25 On the 1 November 2002 he refused his depot medication and on the 9 December 2002 the dose of depot was reduced to the equivalent of 20 mgs every 2 weeks. The clinical indication for this was not recorded.

6.26 On the 11 December a worker from SELSA reported that JT had been observed being verbally aggressive to a neighbour.

6.27 The last dose of depot anti-psychotic medication was on 7 January 2002.

6.28 On the 21 January 2003 the SELSA worker reported that he had a knife on the chair in the lounge.

6.29 On the 3 February 2003 he was assessed by the Consultant Psychiatrist (monthly consultations according to the agreed plan up to this point do not appear to be recorded). The Consultant referred to the episode of the knife being next to JT on the couch 10 days previously. JT was using amphetamines though less often. JT wanted to have a trial or oral anti-psychotic medication. The Consultant decided to stop the depot anti-psychotic medication and convert to oral anti-psychotic medication. The Consultant followed him up weekly.

6.30 **The basis for this decision is difficult to understand, given JT's continuing level of risk and the problem of monitoring compliance with oral medication.**

6.31 On 11 February 2003 JT told a SELSA worker he could use the knife. On the 12 February 2003 he bought another knife because he had misplaced the older large knife.

6.32 On 24 February 2003 he was assessed by the Consultant Psychiatrist. He tried to persuade JT to go back on the depot medication. The Consultant noted that there was no direct evidence of him assaulting members of the public.

6.33 On the 3 March 2003 he was assessed by his Consultant Psychiatrist. He was noted to be more stable. He was noted not to be storing knives and had only used amphetamines once in the past week.

6.34 On the 7 March 2003 a SELSA worker noted he was talking to himself in his room. Reports by SELSA workers, on the same day, but before the homicide, did not indicate any increasing risk.

6.35 **JT was being visited with increased frequency from February 2003 by his Consultant. This increased level of concern followed a decision to change his form of medication from a depot to an oral antipsychotic. This decision was made at a time when the level of risk had not significantly reduced. There was no objective way of ensuring that he was taking this medication. In early February he was noted to be arming himself with a knife.**

6.36 **There was some inconsistency in describing JT's symptoms and mental state at each visit by various ACT team members. Several risk assessment forms in the psychiatric notes were either not completed or undated. There appeared to be no formal risk assessment policy being adopted by the team. There was no consideration of a MHA assessment.**

6.37 **With hindsight, there were indications that the level of risk posed by JT was high in the immediate period prior to the homicide. JT managed to negotiate a change to oral medication, which made it impossible to monitor compliance, he had recently armed himself with a replacement knife and had made vague threats to harm with this knife. With the benefit of hindsight this should have triggered an assessment for detention under the MHA.**

7.0 The Root Cause

7.1 There are inherent limitations in the determination of a root cause in mental health investigations.

7.2 In mental health investigations RCA is unlikely to uncover some hitherto unknown fundamental (root) cause, but rather draw attention to areas of inter-related clinical and managerial processes, which may merit change.

7.3 Inferring causation from this single case study requires a degree of confidence over and above determining an association, which is problematic in the scientific analysis of human behaviour. Determining that a specific activity or omission in the administration of mental health care (a harmful intervention) was the cause of this homicide is almost impossible given the level of scientific evidence required[4].

7.4 Biases have been identified, based on errors in human cognitive processing, associated with inferring causation retrospectively in inquiries. These include, selectively focussing on data consistent with the previously revealed outcome "*hindsight bias*"[5] and speculating on what might have happened, if a different course of action had been taken. Conclusions from the latter may carry a pleasing ring of truth but may be meaningless. This effect has been termed "*counterfactual bias*" [6].

7.5 On the basis of this investigation and the above factors no definitive single root cause or causes were found for this Serious Untoward Incident. A number of associated factors at the first and higher levels were identified and these are discussed in the following section based on the NPSA system of classification (Appendix B).

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[4] Sackett, DL., Haynes, RB., Guyatt, GH., Tugwell, P. (1991) What happens when you apply rules of evidence for causation. In *Clinical epidemiology: A basic science for clinical medicine (2nd edition).* Lippincott-Raven. Philadelphia.

[5] Hawkins, SA,. & Hastie, R. (1990) Hindsight: biased judgements of past events after the outcomes are known. *Psychological Bulletin*. **107**. 311-327.

[6] Reiss, D. (2001) Counterfactual and inquiries after homicide. *Journal of Forensic Psychiatry. 12*. 271-281.

8.0 Classification of Associated Factors

8.1 Institutional Factors:

i. The policy of maintaining patients in the community, who pose a long-term high risk to others, by virtue of a history of seriously dangerous behaviour (in this case arson), psychosis, drug abuse and poor compliance with medication should be reviewed.

8.2 Organisational and Managerial Factors:

i. The acquiescence by the ACT to JT's demands to reduce his depot medication dose and then replace it with an oral medication may reflect anxiety about safety in the community setting by mental health care workers. This hypothesis was not fully tested at interview in the inquiry.

ii. JT had an extremely complicated past history and the ability to assimilate all the aspects of the risk he posed to others from this history is limited from paper records.

8.3 Environmental Factors:

i. JT was living in close proximity to another patient with mental health problems. The potential for friction between them was very high.

8.4 Team Factors:

i. There appears to have been some fragmentation of decision making between SELSA and the ACT. This impacted particularly on the decision to allow JT to live with DD.

ii. There was a lack of consistency in the standard of clinical assessment documented by the ACT team members. As a result, documented information regarding JT's degree of risk was limited and the reliability of the risk assessments at each visit may be suspect.

iii. A re-referral to the Forensic team, when there was recurrence of the risk JT posed to others in 2000 and thereafter, may have improved the accuracy of the risk assessments and the nature of the risk management decisions.

8.5 Individual Factors:

i. The change from depot anti-psychotic medication to oral medication in Jan/Feb 03 was made at a time when there was still a risk posed by JT and the change would have made it more difficult, if not impossible, to monitor compliance. The change was instigated by pressure from JT rather than on clinical grounds.

ii. With hindsight an application for detention under the MHA in January/February 2003 when JT had become interested in knives again and when he was seeking to reduce his medication, may have prevented this homicide. However, JT would have remained a long-term risk to others.

8.6 Task and Process Factors:

i. There did not appear to be a formal risk assessment/management protocol for use by ACT team. If there was such a protocol it was not in routine use

8.7. Patient Factors:

i. JT was suffering from Paranoid Schizophrenia. He showed poor compliance with medication. He abused amphetamines regularly. He had a history of arson and carrying a crossbow. He was the subject of S41 between 1993 and 1998. When he was ill he armed himself with a knife. He became aggressive and made threats to harm other people, including his eventual victim.

9.0 Recommendations

9.1 If not already in place, the Trust should consider introducing a formalised risk assessment and management protocol for use by the ACT team. This should be subject to audit by the Trust to ensure that it is being implemented.

9.2 There should be training in risk assessment and risk management for ACT team members. This should be included in induction courses for new staff.

9.3 Staff perceptions of their personal safety in the community should be surveyed. This may lead to amendments to the Trust policies with regard to the protection of community staff from violence.

9.4 With patients who pose a risk of harm to others there is a need to co-ordinate information about the individual's risk with the police. This is to ensure that:

i. Mis-understandings are not perpetuated between the police and health care staff about their respective abilities to contain dangerous behaviour.

ii. The mental health care staff are informed about the patients history of violence from the police records in order to make an accurate risk assessment.

9.5 Services such as ACT aim to prevent hospital admissions. Changes in the incidence of deliberate self-harm, suicide, harm to others and homicide should be audited following their introduction, to ensure that ACTs are delivering an overall improved quality of care.

9.6 The introduction of information technology, to record and process the information required for an accurate risk assessment, from long and complicated patient histories would be beneficial.

10.0 Key Learning Point

10.1 Patients with a history that is consistent with a long-term ongoing risk to others require an enormous and consistent effort to manage safely in the community. There is a requirement to ensure that all the necessary sources of information, communication, training, protocols and resources are available and subject to implementation, if this effort is to be successful.

a. Define the terms of the investigation

b. Define the boundaries of the investigation in terms of the time frame (the critical event period)

c. Obtain all available documents relating to the past history and the critical event period.

d. Collect and tabulate data in the form of a chronology of events (event specific, person specific or both).

d. Develop a preliminary chronology and person contact list from the available documents.

f. Use the preliminary chronology and contact list to inform which individual interviews (including relatives of the deceased) or additional documents are required.

g. Interviews and site visit with 2 team members.

h. Refine the chronology with information from the additional sources.

i. Team meeting to "brain storm" the analysis, facilitated by the RCA trained team member using RCA techniques.

k. Formulate the findings in terms of a list of recommendations for further consideration.

Factor types	Influencing and contributory factors
Institutional:	Economic/regulatory context, NHS Executive and clinical negligence scheme.
Organisational/ Managerial:	Financial resources/constraints, organisational structure, policy standards/goals, safety-culture and priorities.
Environmental:	Staffing levels/skills mix, workload/shift patterns, design/availability/maintenance of equipment, administrative/managerial support
Team:	Written communication, supervision, help-seeking, team structure (congruence, consistency and leadership).
Individual:	Knowledge/skills, competence and physical/mental health.
Task/Process:	Task design, clarity of structure, availability/use of protocols and availability/accuracy of test results.
Patient:	Condition (complexity and seriousness), language, communication, personality and social factors.

Contact List — Appendix D

Index Patient

JT----------Living in SELSA accommodation

Index Victim

DD----------Flat Mate in SELSA

SELSA

Steve Lonie----------SELSA manager
Nuala DHerty----------SELSA worker
Balvinder Pooni----------SELSA worker

ACT Mental Health Services Staff

Jo Fuller----------ACT Team Manager

Mental Health Services Medical Staff

Dr Nigel Pearson----------Consultant Psychiatrist

Adult Social Services

Peter Toplis---------Team member & Care Co-ordinator

Tabulated Chronology of Events — Appendix D

15/10/02	Designation not recorded	Formally discharged from hospital after period of leave at his flat at SELSA. ACT plan to visit him twice a week at home. JT asked for a reduction in his depot. Changed from 50 mg every 2 weeks to 75 mg Piportil every 4 weeks.
17/10/02	Dr Pearson, Consultant Psychiatrist, Peter Toplis, social worker, Balvinder Pooni, SELSA worker and JT attending.	Care plan approach (CPA). Outreach team to visit JT twice a week, with monthly review by Psychiatrist. CPA to be held every 3 months.
20/10/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'no response'*
24/10/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...everything was OK...'*
27/10/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no reply...'*
31/10/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'... [JT] pleasant...'*
3/11/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no problems or issues raised...'*
11/11/02	Designation not recorded (recorded in psychiatric notes)	*'...Team agree that [JT] presents serious risks when unmedicated...'*
11/11/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...refused his depot...'*
14/11/02	Peter Toplis Social Worker and Care Co-Coordinator (recorded in psychiatric notes)	[Home Visit] *'...he was not in...'*
5/12/02	Peter Toplis Social Worker and Care Co-Coordinator (recorded in psychiatric notes)	[Home Visit] *'...no evidence of anger or aggression....'*
7/12/02	Designation not recorded (recorded in psychiatric notes)	*'...depot reduced 40 mg monthly Piportil...'*
10/12/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no access. Left a note...'*

11/12/02	Designation not recorded (recorded in psychiatric notes)	*'...Balvinder Pooni [SELSA employee] contacted me. She reported that she had just witnessed [JT] being verbally aggressive at the neighbour saying that the neighbour was 'giving him tapeworms'.*
15/12/02	Peter Toplis Social Worker and Care Co-Coordinator (recorded in psychiatric notes)	[Home Visit] *'...slightly agitated... [JT] admitted that he still had a problem with anger...'*
19/12/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...appeared extremely well...'*
22/12/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'... [JT] relaxed...'*
26/12/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no answer from the door...'*
28/12/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no response to doorbell or telephone call...'*
31/12/02	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...he was feeling much better...'*
2/1/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...appears to be coping well at present...'*
5/1/03	Designation not recorded (recorded in psychiatric notes)	*'... [JT] appeared very well...He was entertaining [DD] – [JT] appears to be helpful and supporting of [DD].*
9/1/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'... [JT] was pleasant...'*
12/1/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'... [JT] wasn't in...'*
16/1/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] '[JT] was pleasant and appeared well...'
21/1/03	Designation not recorded (recorded in psychiatric notes)	*'...Balvinder Pooni told him today that [JT] had a knife on the chair in his lounge – information re current risk.*
23/1/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no reply...'*
26/1/03	Designation not recorded (recorded in psychiatric notes)	*'... [Home Visit] mentally very stable...'*
28/1/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...presented very well...'*
2/2/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no reply...'*

3/2/03	Dr Nigel Pearson, Consultant Psychiatrist, Outreach Team	A report from SELSA indicates that he is generally doing well. There was one episode of him being seen lying on couch with knife next to him. He is for a trial of Olanzapine [oral antipsychotic] 10 mg once a day. Depot to be stopped.
9/2/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...[JT] appeared settled'*
11/2/03	Designation not recorded (SELSA contact sheet)	*'...sometimes he cannot control his anger in his head and may do bad things could use the knife...'*
12/2/03	Designation not recorded (SELSA contact sheet)	*'...Has bought another kitchen knife as old large knife is missing...'*
13/2/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...no answer...'*
16/2/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit]
23/2/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'...No evidence of psychotic behaviour...'*
24/2/03	Dr Nigel Pearson, Consultant Psychiatrist, Outreach Team, in letter to Dr Saleem, GP, Abbey Wood, London.	Dr Pearson had been reviewing JT on a weekly basis for the last month after he discontinued his depot medication. He was now on Olanzapine 10 mg at night. Balvinder Pooni, a worker from SELSA, said that JT had been not going out much and tended to be somewhat subdued. She had overheard him talking to himself. He had bought a large knife, which he said he was using in the kitchen, but at one point was keeping it in his bedroom. At times he said he became frightened by people outside and wanted to have a knife with him. He had no ideas of hurting anyone or causing harm to himself. He had not caused any problem with his flatmate and he said he was taking the Olanzapine. JT said he could occasionally hear voices but they did not bother him. JT was concerned about moving into independent accommodation. Dr Pearson advised him that this might be difficult given his poor compliance with treatment and engagement with services in the past. He had been taking amphetamines up to 3 times a week. Dr Pearson discussed the possibility of JT going back on his depot medication. JT said he would think about this next time Dr Pearson saw him. Dr Pearson thought that it was important that the team continued to monitor JT quite closely because he had a history of possession of knives and making threats to others. Dr Pearson stated that *"He has mainly caused damage to property and there is no direct evidence of him assaulting members of the public'.*
27/2/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'... [JT] appropriate...'*

28/2/03	Designation not recorded (recorded in psychiatric notes)	Put a knife back in kitchen. Heard talking to himself at times. Using amphetamines this week.
3/3/03	Dr Nigel Pearson, Consultant Psychiatrist, Outreach Team in letter to Dr Saleem, GP, Abbey Wood, London.	JT was seen in the outpatient department together with his SELSA worker Balvinder Pooni. JT had been more stable than the previous week. He had only been known to use amphetamines once. He felt less restless this week, although it wasn't clear whether this was due to the Procyclidine [medication used to reduce the side effects of antipsychotic medication] or more likely due to his reduced intake of amphetamines. It was planned to continue to review him on a weekly basis given the lability of his mood and the fact that when he is unwell he starts to store knives. This was a major concern for the staff and other residents at SELSA. There is no risk of him storing knives at the moment. JT had no ideas of harm to himself or others. JT was not troubled by voices
3/3/03	Designation not recorded (recorded in psychiatric notes)	Confessed at meeting he had taken speed once last week, but wants to give up with help and support.
6/3/03	Designation not recorded (recorded in psychiatric notes)	[Home Visit] *'... [JT] seemed OK...'*
7/3/03	Designation not recorded (SELSA contact sheet)	*'In his room does not want to come down. Can hear him talking to himself'*
8/3/03	Designation not recorded (SELSA contact sheet)	*'Very loud. Had a knife and fork in his hand... [JT] OK with me...high in mood but pleasant to me'.*
8/3/03	Nuala DHerty & Balvinder Pooni SELSA workers	JT preparing food at his flat for himself and his friend AE who had not yet arrived. JT appeared to be clam.
8/3/03	Nuala DHerty SELSA worker	JT and his friend AE eating food in JTs room.
8/3/03	Nuala DHerty SELSA worker	Other residents reported that JT was heard shouting in his room.
8/3/03	Nuala DHerty SELSA worker	Resident reported that DD had been stabbed.

Report on the care of JT for South East London SHA

Prof Tom Burns

12:09:04

I have been requested to complete a clinical review into the care of JT following the alleged homicide of another patient under the care of Oxleas MH Trust (DD). Before interviewing staff and reading medical notes I have prepared myself by reading:

- The ECRI Root Cause Analysis Report and its appendices
- The Management reports on JT and on DD
- Psychiatric reports by Dr Nigel Pearson on JT and on DD
- Action plan implement by the ACT team on the ECRI recommendations
- Operational policy for the ACT team
- Oxleas CPA guidance and Oxleas risk management strategy plus the Trust's Brief Risk Indicator (AOR1) and Full Risk Assessment form (AOR2)

The SHA is, therefore, in possession of highly detailed, and very well written, reports of all the relevant facts and there is little purpose in my repeating them. I had initially intended to construct my report closely around the ECRI report, comparing my understanding of the evidence they cite and their conclusions and recommendations with those I came to myself. However I found the approach adopted by ECRI, whilst admirably explicit in its structure, difficult to adapt to the complex issues of assessing clinical judgements and making recommendations. I have therefore outlined my observations, conclusions and recommendations from the perspective of a clinician with extensive experience of ACT work and as a 'medical manager' with long involvement in issues of effective documentation for adult mental health care.

My reading of the ECRI report suggests that they had four main concerns:

1. JT should have been urgently considered for a MHA assessment when he made 'vague threats to harm'
2. That the level of risk was inadequately assessed and that that risk was too great for the ACT team who should have been referred him to the Forensic service for an opinion
3. There was fragmentation of decision making between SELSA and the ACT Team.

4. That stopping the depot was the wrong decision, particularly in the absence of robust means to monitor compliance with oral medicines.

The Interviews on 17:08:04

I spent time before these interviews reading JT's case notes. I had two interviews each of just over an hour, the first with Mr Peter Toplis (JT's care co-ordinator) who was accompanied by a colleague from the ACT team and the second was with JT's consultant Dr Nigel Pearson. I was offered the opportunity to have interviews at a subsequent date with SELSA hostel staff and for the team leader at the time of the incident (Jo Fuller) who has since moved on.

I found all three staff at the interviews helpful, co-operative, self-critical and frank. They made no attempt to circumvent issues and gave a clear and convincing account of what had happened leading up to the event and what has happened subsequently. There were no conflicts with the evidence contained in the various reports. As a consequence I did not think anything more would be gained by further interviews with Jo Fuller or SELSA staff.

I formed a clear opinion of well trained, committed staff and a stable team who had worked together for some considerable period. I am familiar with ACT staffing nationally and would rate all three members I met as quite excellent. I will address the issues arising from the ECRI report in order.

1. JT should have been urgently considered for a MHA assessment when he made 'vague threats to harm'

It is clear from JT's history that he had made vague threats on and off over the years. Clinical judgement needed to be exercised to balance safety with engaging him in treatment. Dr Pearson was in weekly contact with him and the team ensured at least one more visit each week (both to work with him but also to support and encourage SELSA). Dr Pearson was clearly aware of the risk that JT could pose (he had admitted him under the MHA on more than one occasion before). With the benefit of hindsight a MHA assessment would have been better, but I can see nothing from the notes or from reports that would suggest that it was an obvious decision that was overlooked. There is no evidence that the team is reluctant to use the MHA appropriately.

2. That the level of risk was inadequately assessed and that that risk was too great for the ACT team who should have been referred him to the Forensic service for an opinion

Assertive Outreach teams have been established nationally to offer intensive support, monitoring and engagement explicitly for patients like JT. Patients with poor compliance and engagement, difficult and disruptive episodes of illness and co-morbidity with substance abuse are their bread and butter. JT was judged by the team not to be exceptional in the long-term risk he posed. Both Peter Topliss and Dr Pearson acknowledged that they had several patients that they still considered posed similar long-term risks. My experience of other London ACT teams is that most have half a dozen patients equally risky. Experience of referring these patients to Forensic teams is that they usually agree with the risk and recommend continued close supervision.

However I do have some reservations about how risk is assessed in this team (dealt with further under recommendations). In most teams where there is a suggestion of escalating risk the usual procedure is to go back again very soon and test out that impression. It is recognised that patients can present a more threatening picture than is the case if one visits them on 'an off day' or one may 'have a feeling' that things are not all right but not be sure why. A second visit may confirm the concern or allay anxiety. In the Oxleas ACT team, however, this was not done and is not done. While frequency of visits is increased at times of concern this is not by the same person but by a series of team members. A patient who is causing concern may be visited daily for some time but this will usually be by a different team member each day. While this does ensure close monitoring it does not refine the risk assessment to any degree.

3. There was fragmentation of decision making between SELSA and the ACT Team.

It is difficult to see how this conclusion was reached. The working relations between the ACT team and SELSA appear to be very good. Indeed the level of contact with JT would in most instances be considered excessive (patients in hostels usually get less contact from ACT teams because they are assumed to be monitored and supported also by the hostel). In this instance the ACT team were investing time and energy to support the hostel. ACT patients are generally unattractive to hostels so this is good practice. The hostels that can accommodate them often have to tolerate disagreements between residents. The suggestion that there should have been consideration of a move because there had been friction

between JT and DD is simply unrealistic. I note also that the ACT staff considered the JT/DD relationship to be not as bad as the report suggests.

5. That stopping the depot was the wrong decision, particularly in the absence of robust means to monitor compliance with oral medicines.

JT's history and his response to antipsychotics is a complex one. There were long periods when he managed well without any medication at all (two years in the 1990s with only a couple of brief voluntary admissions) while on the other hand he had relapsed on depot medication. However the general pattern is overwhelmingly one of him being better on medicines and of having acquired no real insight into his need for them. Dealing with such patients in the long-term inevitably involves a degree of compromise and sometimes even the need to learn the hard way through relapses. What is clear from the notes and from the interviews with Dr Pearson and Peter Topliss is that both believed that it would be better if JT did stay on maintenance antipsychotics. Both, however, judged that the team had made considerable progress in engaging with JT and bringing stability to his life. They were reluctant to risk this with a premature confrontation over medication and believed that a compromise of moving from depot to oral would buy them time in this process of engagement and rehabilitation.

In retrospect this was the wrong decision but I do not believe an unreasonable one. There is often no alternative to making such a decision and all consultant psychiatrists have reluctantly agreed to change from depot to oral antipsychotics, or to stop antipsychotics altogether, when they would rather not. Partly this is because it becomes impossible to defend continuation when patients insist that they *have* improved and a refusal to at least acknowledge this will often result in irretrievable breakdown in the relationship. It is also the case that the patient has the right to refuse.

However there are two aspects of this event that warrant further consideration (see recommendations). Firstly it is not that common in ACT teams for these negotiations to take place solely between the consultant and patient – usually the care-co-ordinator is party to the discussion. (In my experience the care-co-ordinator is usually more emphatic about not reducing medication.) Secondly with a history like JT's the assumption probably should have been made that he would *not* be compliant with oral medicines and direct daily observed medication initiated. This is now more accepted in the team but clearly was not used at the time.

Conclusions

I find no evidence that the tragedy of DD's death could have been anticipated or that clinical interventions which would have prevented it were overlooked. My impression of the ACT team members was that they are of well above average quality both in terms of training, ability and commitment. They are working with an extremely difficult client group where tragic events like this will, inevitably, happen. Staff doing such difficult work deserve support. My comments on practice (recommendations) should not be interpreted as criticisms; they are not.

Recommendations

1. Reconsideration of 'The Whole team approach'

Most UK ACT teams have reviewed earlier recommendations about care-coordinators restricting themselves exclusively to coordination. In most teams the care-coordinator is also a key worker taking on responsibility for the bulk of direct patient care as well as coordination. The care-coordinator has a special (though not exclusive) relationship with the clients on 'their caseload' which does not preclude appropriate involvement of other team members. The Oxleas ACT team should review the role of the care-coordinator. As well a general increase in team efficiency because of less transaction time devoted to sharing information there would have been two significant impacts on this case:

i) The care-coordinator would have seen it as his responsibility to make repeat visits to check JT's mental state if there were concerns. The opinions of a series of case managers on successive days does not materially improve the accuracy of risk assessment.

ii) The care-coordinator as key worker would take more responsibility for an in-depth understanding of their patients. Currently the Oxleas ACT team is overly dependent on the consultant as the only member with any formal responsibility for knowing and representing the patient's whole history. The team has perhaps too much reliance on its oral culture (regular handovers with frequent, but superficial and brief, information transfer) rather than formal presentations of patients at set intervals. An enhanced key worker role would require that person to take greater responsibility for a small number of patients and mean that they ensured that they were present at, and influenced, key decisions (such as the change from depot to oral medicines for JT).

2. Reconsider the shift system

Oxleas ACT team is one of the few in the UK that has stuck to a two shift system. In the context of UK services (with crisis teams and out of hours medical and social emergency provision) this is generally considered a poor use of resources. There appears to be no specific content of 'out of hours visits' that would distinguish them from routine visits. Most patients are unemployed and few have families who need evening visits. Most evening visits appear to be routine because there wasn't time to do them during the day. This is circular because the reduced capacity in the day is because staff are rostered on shifts. This makes it difficult to have a critical mass at any time to offer the immediate, flexible support and back up that are essential in ACT work. A shift system contributes to an increased communication burden to keep everyone up to date. It is also expensive and rather wasteful as it is clear that the last 2 hours or so of the evening shift are never used for visits when it is dark.

The relevance of the shift system to this enquiry into JT is that the habit of Dr Pearson holding an 'outpatients clinic' to which patients are referred (unaccompanied) by care-coordinators arose because organising joint assessments is made so difficult because of the shift pattern.

3. Risk assessment and CPA documentation

There have been some positive changes in practice in response to the JT incident. The ACT team is more willing to use close supervision (there are currently between 5 – 10 patients on Section 25 where there were none at the time of the incident and direct medication monitoring is an accepted practice). However there were two innovations that cause concern. The 'improved' risk assessment documentation introduced since the ECRI report and the very voluminous CPA documentation may repay attention.

On the positive side staff have taken the documentation more seriously and are conscientious in filling them in very thoroughly. As a consequence they think through the issues more carefully. However it is clear that while the documents are filled in carefully, they are not consulted regularly to inform decision making. A balance always has to be struck between comprehensiveness and usability. Shorter, more user friendly documentation (and documentation that is seen to support routine clinical practice rather than to fulfil central reporting requirements) will sharpen thinking, improve communication

and improve care. There is a risk that the current excessive documentation will give a false sense of security, not be consulted and distract time from necessary clinical tasks.

Tom Burns
Oxford 12:09:04