

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

March 2013

A report for **NHS London**
Undertaken by
L Winchcombe and Associates

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Acknowledgements

The members of the independent investigation panel in this case were asked to examine the care and treatment provided to two individuals prior to the tragic death of one of them in an acute admission mental health ward managed by East London NHS Foundation Trust.

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

Those who attended to give evidence were asked to account for their roles, and provide information to the independent investigation panel. All have done so in accordance with expectations, and frank openness for which they must be commended. We are grateful to all of those who have given evidence directly, who have supported those giving evidence, and who granted access to facilities and individuals throughout this process. This has allowed the independent investigation panel to reach an informed position from which we have been able to formulate conclusions and set out recommendations. In particular the independent investigation panel would like to express their appreciation of the support, timeliness in response to requests and general helpfulness of the Lead Nurse for Serious Incidents, East London NHS Foundation Trust.

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

Condolences to the Family and Friends

The independent investigation panel would like to take this opportunity, at the outset of this report, to publicly offer their condolences to the families and friends of the individual who died. We were unable to meet the immediate family of either person although did invite them to meet us. The family of the victim provided consent to access his records and the perpetrator agreed to his records being made available to the independent investigation panel.

Executive Summary

Introduction

On the 9th April 2010, a little after 19.45 hours on a ward, (ward A), at the Mile End Centre for Mental Health, a patient, Mr E, was found collapsed in his room after suffering multiple injuries to his face. The emergency team were called. Another patient, Mr C had been observed leaving Mr E's room by a nurse who asked him what he had been doing in another patient's room. Mr C informed her that he was going to "cut him" and when asked if he had done something to Mr E gestured that he would be put in handcuffs. The nurse found Mr E lying unconscious on his bedroom floor.

Mr E was taken to hospital by ambulance but later died of his injuries. The police were called to the ward and on examining the evidence arrested Mr C on suspicion of attempted murder. He was later charged with murder when the police were informed that Mr E had died. Both patients had been in receipt of community and inpatient mental health services provided by East London NHS Foundation Trust, (the Trust).

The Trust commissioned an internal review of the incident and the review completed their report in September 2010.

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

Contact with Psychiatric Services – Mr C

On 9th December 2006, aged 16 years, Mr C had his first contact with the adolescent psychiatric services provided by East London NHS Foundation Trust. He was admitted as an inpatient initially under Section 2, later converted to a Section 3 of the Mental Health Act (MHA) to the Psychiatric Intensive Care Unit at the Coborn Centre for Adolescent Mental Health.

He was rambling and thought disordered focusing on religious themes and was convinced he had special powers being possessed by "Djinn", (supernatural creatures mentioned in Middle Eastern mythology and the Qur'an), but appeared to be unable to discuss what these were.

Five weeks later, on the 18th January 2007, he was discharged from the Coborn Centre with a diagnosis of bipolar disorder, prescribed medication to take at home and to be followed up as an outpatient by the Community Adolescent Mental Health Team. This was under the supervision of a consultant adolescent psychiatrist, Dr P, and a community psychiatric nurse, (CPN). There are reports that he remained stable and adherent with his medication over the next few months.

On 22nd November 2007 he apparently deteriorated mentally and on examination the next day his consultant found that Mr C was manic and irritable. He was noted to be elated in mood, singing and being over familiar. It was decided to admit Mr C as an emergency admission to the Coborn Centre under Section 3 of the Mental Health Act. He remained there for several months and was discharged home in April 2008.

Later in April 2008 it was requested that he transfer to adult psychiatric services as he would be 18 years old in July 2008. His medication was to remain the same and a care coordinator was allocated. No episodes of mental health deterioration were noted until 2010.

On 1st April 2010 Mr C's father contacted the community team as the family were becoming very concerned about his son's behaviour. Mr C's father reported that his son had been behaving oddly, not sleeping well, not eating and spitting food out when he tried to eat. He was not aggressive but being described as a nuisance in the house. No action was taken by the services at this time. Mr C's care coordinator was on extended leave and the arrangements were that contact was to be made with the mental health service duty team if any support was required. The police were contacted but did not take any action.

Five days later on 5th April 2010, during the evening, Mr C apparently hit his brother and the police were called to the house for a second time. He agreed to attend the Accident and Emergency department at the Royal London Hospital for a psychiatric assessment. Following the assessment he was admitted to a ward, (ward B), at the Mile End Centre for Mental Health, in Tower Hamlets, and placed on 15 minute nursing observations.

On 7th April 2010 Mr C was involved in two serious altercations with other patients on ward B. It was decided to separate him from the other patients on the ward to defuse the situation and ensure the safety of Mr C. A bed was not available on the Psychiatric Intensive Care Unit (PICU) so it was agreed to transfer him to a bed identified on ward A, a ward next door to ward B. Mr C was transferred to the ward in order to maintain his own safety. Mr E was a

patient on ward A at that time and as far as is known had had no previous contact with Mr C.

Later that day a member of staff saw Mr C in the kitchen area of the ward with Mr E. Mr C was apparently bending Mr E's thumb back, and the staff intervened and separated the men. Following this episode Mr C was observed kicking Mr E in the face who was kneeling in front of him at that time. Mr E sustained a cut lip. It was also at this time that the staff observed that Mr C was wearing Mr E's ring which they ensured was immediately returned to Mr E. The men were kept apart for the rest of the day. Mr C was observed intimidating Mr E at times on the 8th April 2010 and during the daytime the next day.

Just after 19.45 hours on 9th April 2010 the ward panic alarm was activated and on investigation Mr E was found lying on the floor in his room covered in bedding. On examination he was found to have multiple injuries to his face. The emergency team were summoned and commenced emergency treatment.

Mr C had been observed leaving Mr E's room by a nurse who asked him what he had been doing in that patient's room. Mr C informed her that he was going to "cut him" and upon being asked if he had done something to Mr E gestured that he would be put into handcuffs. The nurse entered Mr E's room and on seeing Mr E had raised the alarm.

Contact with Psychiatric Services – Mr E

Mr E had involvement with a Community Drug Team prior to his first contact with the psychiatric services that were provided by East London NHS Foundation Trust. He was known to have used heroin, crack cocaine and cannabis on a regular basis.

On the 22nd January 2003, Mr E, accompanied by his brother-in-law, attended the Accident and Emergency department at St Bartholomew's Hospital. The community drug team had advised him to go there as he had been reported to have tried to jump out of a first floor window. It was noted that he was scared to be alone at home as "there were too many noises". It was also reported that he was using threatening behaviour towards his sister and brother-in-law and had smashed a door and damaged furniture with a knife.

The family informed staff that he had appeared unwell for approximately six months with his behaviour becoming increasingly erratic and unpredictable. His father had "thrown him out" of the family home three weeks earlier and he had been living with his sister and brother-in-law since.

He agreed to an informal admission to hospital and was admitted to St Clements Hospital, Tower Hamlets, where he continued to be extremely disturbed. He remained there until 25th June 2003, a period of six months and was diagnosed as having a schizoaffective disorder. He was referred to the community services and the Early Intervention in Psychosis Service, (EIS).

A second admission under Section 2 of the Mental Health Act took place on 24th August 2007, following a Mental Health Act Assessment. Two days after admission, 26th August 2007, Mr E appeared anxious and mentally distressed although compliant with medication. He was paranoid and suspicious. Over the next few days he became more settled on the ward.

The plan was to have a change of medication, to consider a transfer to the Psychiatric Intensive Care Unit (PICU) and a referral was made to the PICU for an assessment. During the late evening his behaviour became more inappropriate, he was aggressive and agitated and threatened to throw a table at a member of staff. During the night he needed to be restrained by the rapid response team and the following day was transferred to the PICU after becoming very violent. He was later placed on Section 3 of the MHA.

His mental state improved and he was transferred back to ward A on 11th December 2007, however seven days later he was transferred back to the PICU as his behaviour had become threatening and he was difficult to manage on the ward. He also tested positive for cocaine on a routine drug screen. He remained there for a few days and then transferred back to ward A.

Mr E remained in hospital until November 2008, a period of fifteen months. He had long periods in the PICU and Mr E had become extremely hostile and aggressive needing to be placed in seclusion whilst on the ward. His medication had been changed to Clozapine which appeared to be effective in treating his mental illness. He was then discharged under a Community Treatment Order (CTO) that required him to have regular monitoring by the community team and to attend the Clozapine clinic for regular blood screening tests.

Mr E had several hospital admissions over the next two years, mostly as a result of non-engagement and breach of his Community Treatment Order. On 30th March 2010 Mr E was taken to the Accident and Emergency department at St Bartholomew's Hospital by his brother-in-law after an apparent deterioration in his mental state. He was seen by the psychiatric liaison team and recalled to hospital under the CTO process and admitted to ward A, Mile End Centre for Mental Health.

On 7th April 2010 Mr C, who later killed Mr E, was transferred from ward B to ward A at the Mile End Centre for Mental Health.

On 9th April 2010 Mr E was attacked in his bedroom by Mr C and later died of his injuries.

Findings and Recommendations

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

The independent investigation panel were impressed with the improvements that had been made by the Trust since the death of Mr E. It was clear that the shock following the incident reverberated throughout the Trust and extended to their commissioning organisations.

Service change can be quite a challenge and the Trust appears to have risen to this, assessed what needed to be done and responded in a timely manner. Reviewing the staff culture and supervision has become a priority and the independent investigation panel acknowledge the ongoing review that is taking place across all services. However as with all large organisations these changes do not happen overnight and it is acknowledged that there is still more to be done.

The independent investigation panel heard evidence from the Trust's commissioners that the quality of the services being provided in 2012 were improved compared with those in 2010. The independent investigation panel welcomed the commitment and determination by those responsible for implementing the service developments.

Notable Practice

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

Communication – Mr C

The independent investigation panel heard that a number of the patients accessing services at the Mile End Centre for Mental Health came from the Bengali community. Many did not have a clear understanding of the English language which created difficulties in communicating with them, in particular regarding medication regimes.

It was noted that Dr M, (Mr C's consultant psychiatrist), had learnt key phrases in Sylheti, which assisted him in communicating with his Bengali patients, if an interpreter was not available. This was considered as responding to the need in Dr M's patient base and must have enabled better relationships between the consultant psychiatrist and patient.

Family Support – Mr C

There were some concerns raised in regard to the support that had been provided to the families of both Mr C and Mr E that are dealt with later in this section.

However the independent investigation panel were pleased to note the conscientiousness of Dr P, (Mr C's consultant adolescent psychiatrist), who made a determined effort to visit and provide support to Mr C's family after the death of Mr E. Her ability to communicate with the family was extremely helpful under the circumstances even though Mr C had been transferred to adult services in July 2008.

Transition between Services – Mr C

The independent investigation panel were impressed with the standard of the transition between the adolescent and adult psychiatric services once Mr C reached 18 years old. In particular this applies to the action taken by the family therapist who was covering for Mr C's care coordinator whilst they were on leave.

The transition followed good practice guidelines in that a nine month transfer period took place with the adult services slowly taking on responsibility for Mr C's care. In addition Mr C's family were involved in the process and Mr C's language needs were acknowledged. The member of staff was able to relate to the differences of patient experiences when transferring to adult services and how this affects not only the individual but also their family who may have been very involved in that person's care prior to transfer.

Management Ward Visits

The independent investigation panel were informed of an initiative that has been instigated by the medical director and director of nursing to undertake unplanned visits to individual inpatient services across the Trust. This has provided an opportunity for those areas that require additional attention to be identified and dealt with. These visits are to be commended and the intention to extend these visits to other service areas is welcomed.

Findings and Recommendations

The following findings and recommendations are made to assist the Trust in furthering and improving the quality of their services. The recommendations have not been set out in priority order and relate to not only the Trust, and the service that they provide, but also to the local police service. Each recommendation has been set out in relation to the two individuals. They identify to which particular service or organisation the recommendation relates.

Communication – Mr C

The independent investigation panel heard a great deal of evidence in regard to Mr C's poor command of the English language. This would have created difficulties in ensuring that Mr C understood the treatment that he was being provided with. It is acknowledged that the lack of understanding and communicating in both individuals' native language might have contributed to the situation whereby Mr C was apparently deliberately intimidating Mr E. Staff were powerless to understand exactly what was occurring between the two men and therefore were unable to intervene meaningfully in the situation.

A full analysis of risk and management will necessarily include a comprehensive assessment of a patient's mental state and can not be completed without being able to communicate effectively with the patient. This in particular applies to someone who has limited command of the English language.

The independent investigation panel found that the Trust did fund and provide interpreting services particularly for ward rounds and patient Care Programme Approach (CPA) reviews. Staff indicated that they never had a problem with having agreement to gain access to interpreting services from their managers. However it was sometimes the case that staff omitted to request an interpreter or the interpreting services were unable to provide a service for the requested

time or venue. The independent investigation panel do wonder whether the use of an interpreter was addressing staff needs rather than patient needs.

During Mr C's management in the community it appears that an interpreter was only used for CPA reviews.

The Trust has implemented a recruitment drive to employ more staff who are able to communicate with their culturally diverse patient population. In the case of Mr C, evidence was provided that on his admission to ward B in June 2010 staff had not arranged an interpreter for the consultant led ward round. As indicated earlier Dr M was able to communicate in a limited way with Mr C but this was not ideal.

Recommendation One

It is recommended that the Trust considers setting up their own interpreting services which could include those staff already employed to provide this additional expertise. It may be advantageous to involve other local Mental Health Trusts in this initiative.

Home Treatment Team

The independent investigation panel found that the Home Treatment Team did not respond adequately to the request for an assessment of Mr C's mental state in April 2010. Additionally Dr M, (Mr C's consultant psychiatrist), was not informed that the requested assessment had not taken place. We are of the opinion that communication was poor and that the Home Treatment Team failed in their responsibility to inform Mr C's consultant of the actions that had not been taken.

Recommendation Two

It is recommended that when a referral is made to the Home Treatment Team that the referrer is informed of the actions taken within 24 hours and that these are documented in the relevant patient records.

Recommendation Three

It is recommended that if a referral for an assessment is made to the Home Treatment Team then either a comprehensive assessment is undertaken or the reasons why not are communicated to the referrer and documented in the patient's record within 24 hours.

Nursing Handover of Mr C's Transfer to Ward A

The independent investigation panel heard evidence that the handover and communication in regard to Mr C's transfer from ward B to ward A was of poor quality. Information relating to Mr C's care was not communicated and adequate time and attention to the transfer of information regarding Mr C's care and treatment not given and neither was it conducted in a professional manner by the nursing staff. The importance of a good handover in regard to a patient transfer was not recognised by the staff involved.

The independent investigation panel have been informed that a protocol is being developed in regard to the transfer of patients.

Recommendation Four

It is recommended that all transfers of patients should follow a comprehensive protocol that sets out a checklist that is audited on a regular basis to include:

- ***Risk analysis and management.***
- ***Level of Observations.***
- ***Management Plan.***
- ***Physical Health.***
- ***Medication Concordance History.***
- ***Allocation of Primary Nurse Role.***
- ***Diagnosis.***
- ***Health care needs.***

Nursing Staff Handover and Communication

The independent investigation panel heard that the nursing staff, particularly those working on ward A, were arriving on duty at different times. This appeared to be in relation to agency staff who would cover for the ward during busy periods. It is acknowledged that staff arriving at differing times on a ward present a challenge in relation to ensuring that a comprehensive handover takes place and that staff are aware of the risks associated with patients and any activities that would be taking place. Evidence was seen that this did not take place on ward A during the period of Mr C's admission to the ward.

It was also reported that routinely healthcare assistants did not participate in the handover process and this was of particular concern when considering that they undertook most of the patient observation processes. On the day of Mr E's

death there was evidence to suggest that only one member of staff on the afternoon shift had been given a handover of the patients on the ward which was then not shared with the other staff on duty.

Recommendation Five

It is recommended that the Trust devises a system whereby key information about patients is communicated to all staff on duty at any given time and that this follows a standardised, structured and documented process.

Observation Levels

It was found that the observation policy was not followed in the case of Mr C on ward A following his transfer from ward B. The action plan produced by the Trust after the death of Mr E shows that the observation policy itself was to be reinforced and the system audited. Despite this fact the independent investigation panel were told that a 'drop in' audit of one ward after the death of Mr E revealed that observations were still not being carried out and a nurse was removed from their duties as a result of the audit.

There were several factors that impinged upon the fact that Mr C was not properly observed during the time he was on ward A. These were:

- The poor handover and communication of his observation status on transfer from ward B to ward A on 7th April 2010.
- The lack of robust systems for the documentation and supervision of the observation procedure at that time.
- The lax culture of undertaking patient observations and recording on the ward at the time.
- The lack of clarity in terms of management of the ward on the 9th April 2010 and the absence of a senior nurse to ensure that the observation procedure was being completed correctly.

Recommendation Six

It is recommended that the Trust further review their observation policy to include supervision of the person conducting observations and changing the format of their observation form to ensure that:

- *Clarity in regard to observation responsibility is added and staff responsible for the agreed tasks are identified and documented on the form.*
 - *A robust competency framework is implemented for measuring the ability of nursing staff to carry out this intervention safely.*
 - *A senior member of staff agrees and approves that the observations have been completed and signs the form appropriately.*
 - *That qualified nursing staff undertake a minimum of one third of the observations within a shift.*
-

Roles and Responsibilities

The independent investigation panel found that there was a degree of confusion in regard to the roles and responsibilities of the modern matron and practice innovation nurse, both of whom have a senior management role to undertake on ward A. This was reiterated both by senior management of the Trust, nursing and medical staff and those employed in the actual posts.

Recommendation Seven

It is recommended that there is a review of the job descriptions of the modern matron and practice innovation nurse that clarifies the individual roles and allocates different responsibilities within each. In addition the Trust should consider reverting back to the title of ward manager for one of these roles.

Competency and Skill Mix

The independent investigation panel saw evidence that some nursing staff on ward A were undertaking tasks that were above their individual level of competence. It remained unclear as to how staff are able to function safely within their respective roles. Evidence was heard that regular supervision, appraisal and reflection are now in place which is reassuring.

Recommendation Eight

It is recommended that the Trust develops and implements an Objective Structured Clinical Examination (OSCE) framework for the assessment of particular competencies such as observations, medical devices, physical health and medication administration. The further development of Reflective Practice Groups should also be considered.

Medical Leadership

The independent investigation panel found that there was not a clear structure in regard to medical leadership. The Trust has since developed clinical leads on each ward who take responsibility for reporting up through the Trust medical structure any concerns regarding the inpatient services. However it appears that these posts are not consistently filled and that many consultant psychiatrists are reluctant to undertake this additional work without remuneration.

Evidence was provided that prior to the death of Mr E a number of issues of concern in regard to nursing practice on ward A had been escalated by email to the clinical director. This did not appear to have resulted in any action being taken although it is acknowledged that the email was received and noted.

Recommendation Nine

It is recommended that the Trust reviews its clinical lead process on each ward and sets out a clear structure of responsibilities and the procedure to report concerns through the Trust's governance system. All concerns should be documented, with agreed outcomes and the process to achieve these monitored and reported back to the relevant professionals/service areas.

Medical Functional Team Model

The independent investigation panel were informed that a "functional team model" whereby inpatient wards were managed by a single consultant had been considered by the Trust and found lacking. Evidence heard by the independent investigation panel suggested that the main opposition to this model came from the consultant body who favoured the existing model which was seen to provide greater continuity of care. However this has an impact on nursing time within the inpatient service. For example there were four ward rounds a week held on ward A by four different consultants which involved a great deal of preparation and took at least one qualified nurse away from direct care for up to three-four hours on each of these days. The current model can often be seen as detrimental to multi-disciplinary working.

The independent investigation panel understand that the Trust have commenced a pilot functional team model in Hackney and welcome this initiative.

Recommendation Ten

It is recommended that the Trust gives serious consideration to the implementation of a Functional Team Model by discussing the process with their colleagues in neighbouring Trusts, medical professional bodies and their own consultant body. The opinion of other professionals such as nursing should also be sought and evaluation of the pilot model in Hackney undertaken.

Risk Management

The incident that took place on 9th April 2010 and the environment in which it happened has raised several concerns for the independent investigation panel. The nurse who found Mr E raised the alarm by activating their personal alarm after having encountered Mr C in the corridor who had just viciously attacked Mr E causing fatal injuries. Very little has been mentioned about the risk to this member of staff who was on her own in the male corridor undertaking close observations on another patient who was very disturbed.

The independent investigation panel did note that the Trust has installed alarms in patient bedrooms since the incident and welcome this action.

Single Sex Wards

Ward A is a mixed sex ward and the potential vulnerability of the female patients also raises concerns. The independent investigation panel were not satisfied that the present system provides single sex areas which are fit for purpose. The layout of the wards at the Mile End Centre for Mental Health dictates that both sexes will be in close proximity at all times.

Recommendation Eleven

It is recommended that serious consideration is given by the Trust to develop and implement single sex inpatient services.

Incident Reporting

Mr E sustained an injury to his face and mouth two days before his death when Mr C was observed kicking him in the face. No one contacted the police although a nurse did state that she had tried to telephone the police liaison officer to ask their advice as to what to do but could not get hold of them. So the attack was

not reported either, via the Trust's serious incident process, or to the local police. The ward staff did not complete an incident form in regard to the injury to a patient.

Such a lack of communication was certainly unfortunate in light of future events. It appeared that a culture of acceptance of minor assaults was perceived to be in existence at this time on ward A. It was not surprising to learn therefore that this assault on Mr E was not followed up in terms of investigation and action.

The independent investigation panel were told by one nurse that a culture of asking "How serious does it have to be before we call the police about an incident", had grown up amongst staff on ward A. This referred to assaults on staff as well as patient on patient assaults it seems. This may explain the reason why this particular assault was not investigated and followed up appropriately.

The independent Investigation panel firmly believes that the assault on Mr E should have been followed up and were pleased to hear evidence that the situation with regard to reporting incidents on ward A has improved since 2010. However, it seems that it was not only the staff on the ward who left incidents un-investigated. One nurse gave evidence that the attitude of some of the less experienced police officers in particular who attended the ward in response to reports of incidents, left a lot to be desired. It was reported that the perception was "this happens in mental health services".

Recommendation Twelve

It is recommended that the Trust and their local police force should agree the criteria and level of service that can be provided to the Trust in terms of on-call and out of hours support to Trust members of staff when an assault on either another patient or member of staff has occurred. In addition the organisations should also ensure that proper training is given to those officers likely to be asked to attend incidents at the Trust.

Police Input to the Trust and Incident Investigation

The independent investigation panel have no doubts that the investigation of the death of Mr E was well carried out by the police. However, it is sad to see that the enormous amount of work that obviously went into the production of a protocol, or National Memorandum of Understanding for dealing with such cases more efficiently, was not used by either the Trust, or the police themselves. The National Memorandum of Understanding provides guidance on the process that

needs to be taken following an incident such as that discussed in this report. This guidance includes:

- Advice on the process to be set up, such as an incident coordinating group.
- Example agendas for managing meetings.
- Liaison and support to families.
- Establishing communication strategies between statutory organisations and the media.

Recommendation Thirteen

It is recommended that any future incidents of this type and subsequent police investigation should be conducted under the auspices of the National Memorandum of Understanding and that the Trust ensures that the National Memorandum of Understanding is attached as a standard Appendix to their Serious Incident Policy and included in staff training into the use of the policy.

Ward Environment

The independent investigation panel had an opportunity to visit ward A and meet some of the patients and staff there. They were also able to see where the incident happened. Whilst it is acknowledged that the Trust has made essential alterations to the ward including relocating the nurses station there are still concerns in regard to the narrow corridors within the patient bedroom areas. All bedroom doors in the Tower Hamlets Centre for Mental Health have anti-barricade devices installed in the door frames. These are large metal buttons that are depressed to enable the door to swing outwards. There is a reset button which, when pressed, extends the button out and acts as a stop meaning the door can only swing open into the bedroom. If these are not reset as they should be, then the doors will be able to swing in both directions, creating a potential hazard in the corridor.

Recommendation Fourteen

It is recommended that the Trust liaise with their designated fire safety officers and estates department to undertake an environmental risk assessment in order to ascertain whether it would be desirable or feasible to alter the opening mechanisms of the bedroom doors on ward A, and to provide the Trust with an assurance that the exit routes from the bedroom area are adequate in the event of a fire.

In Conclusion

The independent investigation panel debated the issue of whether Mr E's death was predictable or preventable. We came to the conclusion that Mr E's death was not predictable and that no one action alone would have made the event preventable. However, it would have been preventable if all or several of the following measures had been taken:

- Mr C had been assessed under the Mental Health Act and admitted to hospital on 1st April 2010 before his mental state had deteriorated further.
- Mr C transferred to the PICU at the Mile End Centre for Mental Health on 7th April following the altercation with other patients on ward B instead of being transferred to ward A.
- Mr C being placed on 15 minute nursing observations on arrival on ward A.
- A comprehensive handover completed by ward B to ward A staff in regard to the risk posed to others.
- The use of the available interpreting services to understand what was going on between the two men, and the content of their conversation.
- The nurse undertaking close observations two doors away from Mr E's bedroom had actually heard the attack and was able to summon help to stop it continuing.

1. General Introduction

- 1.1 On the 9th April 2010, a little after 19.45 hours on a ward, (ward A), at the Mile End Centre for Mental Health, a patient, Mr E, was found collapsed in his room after suffering multiple injuries to his face. The emergency team were called. Another patient, Mr C had been observed leaving Mr E's room by a nurse who asked him what he had been doing in another patient's room. Mr C informed her that he was going to "cut him" and when asked if he had done something to Mr E gestured that he would be put in handcuffs. The nurse found Mr E lying unconscious on his bedroom floor.
- 1.2 Mr E was taken to hospital by ambulance but later died of his injuries. The police were called to the ward and on examining the evidence arrested Mr C on suspicion of attempted murder. He was charged with murder when the police were informed that Mr E had died. Both patients had been in receipt of community and inpatient mental health services provided by East London NHS Foundation Trust, (the Trust).
- 1.3 The Trust commissioned an internal review of the incident and the review completed a report in September 2010. This review was chaired by an independent consultant psychiatrist from outside the Trust. A second review which covered the mental health services at the Mile End Centre for Mental Health was commissioned from the then National Patient Safety Agency. That review was completed in August 2010, the scope of which was to undertake a desktop review of the recent internal inquiry reports that had been completed by the Trust.
- 1.4 This Independent Mental Health Investigation was commissioned from L. Winchcombe Associates by NHS London on 9th January 2012 under the auspices of Health Service Guidance (94) 27. *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.
- 1.5 The Independent Mental Health Investigation Panel is referred to as the independent investigation panel throughout this report and the Trust's internal review as the internal review team.

2. Purpose of the Investigation

- 2.1 The purpose of any independent 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.
- 2.2 The role of this independent investigation is to gain an understanding of what was known, or should have been known at the time, by the relevant clinical professionals regarding both patients. 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 and further action based on the findings identified by the independent investigation panel.
- 2.3 The independent investigation panel have been careful not to misuse the potential value of 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 if it is perceived that the independent investigation panel have failed in their aspiration to be fair in their judgement.
- 2.4 We have remained conscious that lessons may be learned from examining the care of the individuals, associated with the incident and more generally from the detailed consideration of any complex clinical case.
- 2.5 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. We can nevertheless, all learn from incidents to ensure that the services provided to people with a mental illness are safer, and as robust as possible and that the lessons learnt are understood and appropriate actions are taken to inform those commissioning and providing the services.

3. Terms of Reference

Commissioner

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

Terms of Reference

- 3.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr C and Mr E.

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

Approach

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

- 3.4 The investigation panel will follow established good practice in the conduct of interviews, ensuring that the interviewees are offered the opportunity to be accompanied and given the opportunity to comment on the factual accuracy of the transcript of evidence.
- 3.5 If the investigation panel identify a serious cause for concern then this will immediately be notified to the Manager, Homicide Investigations, NHS London.

4. Panel Membership

4.1 The independent investigation has been undertaken by a panel of professionals independent of the services provided by East London NHS Foundation Trust and its preceding bodies.

4.2 The panel comprises of:

Panel Chair: Lynda Winchcombe, a management consultant who specialises in investigations within the NHS and Social Care Services, Director of L. Winchcombe Associates.

Panel Membership: Dr Vaughan Williams, Consultant Adult Psychiatrist and Medical Director, Mental Health Service for North East London NHS Foundation Trust.

Panel Membership: Sue Smith, Head of Nursing, South London and Maudsley NHS Foundation Trust.

Panel Membership: Philip Wheeler, former Detective Chief Inspector, Metropolitan Police.

Administrative Support: Louise Chenery, LC Transcription Services.

5. Methodology

- 5.1 NHS London commissioned the independent investigation under the Terms of Reference set out in Section 3.
- 5.2 The independent investigation panel held an initial meeting on 31st January 2012 and agreed the process that would be taken to complete the independent investigation. Diary dates for future meetings including interviews were set. The independent investigation panel then identified the written documentation that it required, although as the investigation proceeded they became aware of other documentation which it subsequently requested. Detailed timelines of the events following contact with psychiatric services relating to both men were compiled and can be found at Appendix One and Two.
- 5.3 As each document was received it was indexed and paginated. An outline of the critical events for both cases being investigated was compiled and are contained within this report, (Sections 7 and 9). A full list of the documentation considered by the independent investigation panel can be found at Appendix Three.
- 5.4 A presentation was provided to the independent investigation panel on 24th February 2012 by senior managers of the Trust. The purpose of this was for the independent investigation panel to:
- Gain an understanding of the services provided by the Trust and their partners at the time of the incident.
 - Learn about the plans for future service development.
 - Understand the actions taken following the death of Mr E.
 - Provide an opportunity to meet the Trust's senior managers and discuss the investigation process.
- 5.5 An informal staff meeting was also held following the above presentation. Those invited had been involved either directly or indirectly with one or both of the patients. This was to provide an opportunity for staff to ask questions about the process and the purpose of the investigation. Further aims were to reassure those that might be called for interview that the process was not one of blame but one of examining systems and processes that could be improved and to set out lessons for action by the Trust to prevent a similar occurrence happening.
- 5.6 Evidence was received from a total of 27 individual witnesses over a period of days during April, May and June 2012. Many of these provided statements about their involvement prior to being interviewed. Representatives from related agencies, such as the police, commissioners and the chair of the internal

review were also seen. Everyone requested to attend an interview was able and willing to do so.

- 5.7 A letter detailing the areas of questions to be discussed was sent to each individual prior to the interview together with copies of the Terms of Reference and the investigation procedure being followed, (see Appendix Four). Each interview was recorded and transcripts sent to the individuals to provide them with the opportunity to check the transcripts for accuracy and amend as necessary. The amended version is the one that the independent investigation panel have used to evidence their report.
- 5.8 Analysis of the evidence was undertaken using Root Cause Analysis methodology. The report is divided into the following four sections:
- Section one examines the care and treatment of Mr E.
 - Section two examines the care and treatment of Mr C.
 - Section three examines the internal review report and the subsequent report that was completed by the National Patient Safety Agency. It also includes general comments in regard to the services and agencies involved in delivering them.
 - Section four sets out the independent investigation panel's findings and recommendations including areas of notable practice.
- 5.9 The families of both patients were approached by the independent investigation panel to establish whether they had any concerns that they would have wished to be considered during the independent investigation. However neither family indicated that they wished to be involved. It has to be noted that consent for access to records was obtained from Mr C and the family of Mr E. The independent investigation panel however did have access to the questions posed to the internal review team by the families and transcripts of the meetings that they had with the internal review team.
- 5.10 The independent investigation panel were able to meet with Mr C and his current clinical staff in March 2012. This was an extremely helpful meeting that in part informed the investigation on which areas that they needed to concentrate.

6. East London NHS Foundation Trust

6.1 The Trust, formerly East London and The City University Mental Health NHS Trust, achieved Foundation Trust status in November 2007 under the National Health Service Act 2006. There has been a long period of stability and cohesion between the Executive and Non Executive Directors since 2006. Foundation Trust status brought with it new opportunities such as a Council of Governors with strong user and carer representation. This has enabled the Trust Board to consider ideas for the future development of services direct from service users and other community representatives and to take these ideas into account in negotiations with commissioners. The Trust has based its headquarters in Tower Hamlets area.

Services Provided

6.2 A wide range of community and inpatient services to children, young people, adults of working age, older adults and forensic services to the City of London, Hackney, Newham and Tower Hamlets is provided by the Trust in a variety of settings. The inpatient areas in each of the Trust's localities are sited in the boroughs of City and Hackney, Newham and Tower Hamlets. General Community Health Services are provided in Newham.

6.3 Forensic and Personality Disorder Services are provided at the John Howard Centre, Wolfson House and the Millfields Unit. Outreach Forensic Services are provided to the East London locations of Barking and Dagenham, Havering, Redbridge and Waltham Forest

6.4 Trust Specialist Mental Health Services are provided to patients living in North London, Hertfordshire and Essex. A Specialist Forensic Personality Disorder service serves North London from the Millfields Unit and a Specialist Chronic Fatigue Syndrome/ME adult outpatient service is provided to North London and the South of England Health Authority area. The Trust also has a Specialist Mother and Baby Psychiatric Unit that receives referrals from London and the South East of England. Adolescent Mental Health services are provided from the Coborn Centre which opened eight years ago.

New Service Provision

6.5 In February 2011, the Trust integrated with general community health services in Newham creating a mental health and community health service Trust. This gave the opportunity to increase access to primary care services across the Trust.

- 6.6 The East London areas served by the Trust are the most culturally diverse and deprived areas in England and therefore have significant challenges for the provision of mental health services. These challenges include a highly mobile population with some districts having significant deprivation within their population. The Trust's local services serve a population of 710,000 in East London and the Trust's forensic services are provided to a population of 1.5 million in North East London.
- 6.7 There are also a range of services provided in the community through Community Mental Health Teams, Home Treatment Teams, Crisis Resolution Teams, Rehabilitation Teams and Assertive Outreach Services. The Trust aims to provide people with alternatives to admission, where appropriate, to provide treatment, care and support outside a hospital setting.

Governance Processes

- 6.8 In 2011/12 the development of new priorities and measures of quality and satisfaction represented a fundamental shift in the Trust strategy and a move away from the existing wide range of 'output' focused performance measures. The Trust agreed three main priorities as a framework for delivery of their annual plan to improve service provision:
- Improving service user satisfaction.
 - Improving staff satisfaction.
 - Maintaining financial viability.

Improving Safety on the Wards

- 6.9 The Trust has introduced a range of measures to improve safety in inpatient units. A CCTV trial took place at the Tower Hamlets Centre for Mental Health, also referred to as the Mile End Centre for Mental Health, in consultation with service users. Cameras were set up in communal areas of the ward to improve visibility and surveillance.
- 6.10 Alarm buttons have been introduced across all inpatient areas for inpatients to use if they want to call for urgent assistance.

Improving Service User Satisfaction

- 6.11 The Trust intend to improve the service user experience across their care pathway by:

- Better engagement between staff and service users on inpatient wards and in community services, both in groups and one to ones.
- Better access to information on other organisations/services for service users on inpatient wards and in community services (talking therapies, referral to linked therapies).
- Better coordination between care coordinators and Community Mental Health Teams and GPs.
- Increasing staffing levels and using less agency staff.
- More support and recognition for carers.
- Meeting the needs of groups where services are being cut (i.e. Child and Adolescent Mental Health Service).

Improving Staff Satisfaction

6.12 The Trust has a programme to improve staff satisfaction by:

- Providing more peer support for staff.
- Ensuring the Staff Survey is more meaningful in its feedback.
- Involving service users and carers in staff training.
- Undertaking regular staff appraisals.
- Cutting down paperwork, spending less time on disciplinary issues.
- Staff to receive training to work with Learning Disability clients.

Section One

Care and Treatment

Received by

Mr C

7. Outline of Events – Mr C

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

Mr C - Background

- 7.2 Mr C was born in Bangladesh in July 1990, the second of six children, he has two brothers and three sisters. He attended school in Bangladesh and continued with his schooling when his family emigrated to the UK in 2006. He attended a college in Tower Hamlets to learn English but as his attendance was poor he was not able to complete the course.
- 7.3 There is no family history of mental illness relevant to the case, substance misuse or conflicts with the law. Both of Mr C's parents are alive and his father at the time of the incident was working in Bristol and coming back to the family home on visits. The family live in a three bedroom flat, where Mr C had his own room. He is reported as having a good relationship with his family when well and made a few friends via his college course. He started to smoke tobacco after his first illness in the UK but is not known to abuse drugs or alcohol. His understanding, and ability to speak English, remains limited. His first language is Bengali and he continues to require a translation service for most aspects of his care and daily living activities.

Forensic History

- 7.4 There was no history of recorded criminal activity prior to the onset of his illness, but when unwell Mr C had become physically violent towards family members, professionals and others. He had previously tried to set fire to the family home in April 2010. It is reported that his family would become frightened of him when his mental health deteriorated.

Contact with Psychiatric Services

- 7.5 In December 2006, aged 16 years, Mr C was first seen by psychiatric services provided by East London NHS Foundation Trust. Unconfirmed reports state that he may have been hospitalised for a mental illness prior to the family moving to the UK from Bangladesh earlier in 2006.
- 7.6 At some time during 2006 Mr C had allegedly attempted to jump from the fourth floor of a building but there are no other details regarding this.

- 7.7 On 9th December 2006, Mr C was taken to the Accident and Emergency department at the Royal London Hospital by ambulance accompanied by the police. His family had noticed a change in his behaviour, he was aggressive, and had an unexpected increase in religious beliefs and was having difficulty in sleeping. It was also reported that he thought he had special powers and that voices were telling him to pray and fast. The family had contacted the police for help. He was admitted as an inpatient under Section 2, later converted to Section 3 of the Mental Health Act (MHA) to the Psychiatric Intensive Care Unit at the Coborn Centre for Adolescent Mental Health.
- 7.8 On admission Mr C appeared over active and disinhibited, attempting to touch and kiss the female nurses' hands. He was rambling and thought disordered, focusing on religious themes and was convinced he had special powers being possessed by "Djinn", (supernatural creatures mentioned in Middle Eastern mythology and the Qur'an), but appeared to be unable to discuss what these were. He also said that he was frightened of black people and claimed to be hearing voices. He was diagnosed as having a bipolar disorder and treated with Lithium medication which was increased up to 400mg daily during his admission. There continued to be evidence of sexual disinhibition and he is reported as asking female staff to come to his room for sex.
- 7.9 Five weeks later, 18th January 2007, he was discharged from the Coborn Centre. The diagnosis of bipolar disorder had been made and his medication on discharge was Olanzapine 50mg at night, and Sodium Valproate 600mg at night. He was to be followed up as an outpatient in the community by a tier three¹ Adolescent Mental Health team, under the supervision of a consultant adolescent psychiatrist, Dr P, and a community psychiatric nurse, (CPN). There are reports that he remained stable and compliant with his medication over the next few months.
- 7.10 On 22nd November 2007 Mr C's father contacted the police after his son had become aggressive towards him. Mr C had broken all the light bulbs in the flat during this incident. His adolescent team, the Newham Children and Family Service, were consulted and it was agreed that the police would escort Mr C to the Royal London Hospital's Accident and Emergency department for an assessment.
- 7.11 Mr C reported to the staff there that he had not been taking his medication. After he had settled, the Accident and Emergency department discharged him home later that evening. An outpatient appointment was arranged for the following day with Dr P.

¹ Tier Three Adolescent Mental Health Team is a secondary care adolescent community service.

- 7.12 On examination the next day Dr P found Mr C was manic and irritable. He was noted to be elated in mood, singing and being over familiar. It was decided to admit Mr C as an emergency admission to the Coborn Centre under Section 3 of the Mental Health Act.
- 7.13 In early December 2007 a risk checklist completed by the inpatient staff at the Coborn Unit identified that when unwell Mr C was a risk to others. There was also a plan to assess whether the children in the family were at risk from him during these periods. Throughout his inpatient admission there were repeated reports that he was demanding, pushing boundaries and threatening towards staff, stating that he would kill them and cut their throats.
- 7.14 On 18th December 2007 the nursing report stated that there had been a significant reduction in Mr C's violence and aggressive behaviour. There was still however some level of disinhibited behaviour and over familiarity with staff. This behaviour was sexually inappropriate and particularly targeted at female staff.
- 7.15 The following day a Care Programme Approach (CPA) was completed by Mr C's Primary nurse. Mr C was escorted home by staff and accompanied by his father to spend time with his family but on the way there he became elated and irritable, wanting to stop off at a friend's house. When his father refused he became very angry and it was decided to take him back to the ward.
- 7.16 In April 2008, Mr C was discharged home under the care of his adolescent consultant psychiatrist, Dr P, and community psychiatric nurse. A discharge summary completed on 10th April 2008 stated that his mental state had improved during the admission.
- 7.17 When seen in outpatients by Dr P a care plan was completed, which noted that Mr C was mentally stable. This was confirmed by his father who accompanied him to the appointment. His father continued to work away from home at this time. It was noted that Mr C's mood was much improved and that he was sleeping better. The plan was for him to continue with his medication.
- 7.18 On 23rd April 2008 Dr P sent a referral letter to Dr M, a consultant adult psychiatrist in whose catchment area Mr C was living, requesting that he take over Mr C's care as he would be 18 years old in July 2008. A summary of Mr C's psychiatric history was included in the referral together with information about his recent outpatient appointment with Dr P.

- 7.19 Dr M confirmed on 8th July 2008 that he would accept psychiatric responsibility for Mr C following a transfer CPA to the adult mental health services. This took place on 22nd July 2008 attended by Dr P and the adolescent team's CPN together with an adult service CPN. It was stated that Mr C reported that his mental state was stable and behaviour appropriate. His medication was to remain the same. Transfer to adult services was confirmed and a care coordinator was allocated.
- 7.20 Over the next few months Mr C was found to be mentally stable, and he reported that things were fine. There were no abnormal behaviours assessed or reported by his care team. He also stated that he was no longer being possessed by Djinn and had no special powers. His care coordinator was seeing him on a fortnightly basis. In January 2009 a disability living allowance form was completed and his records state that no relapse was noted.
- 7.21 A CPA review was completed in June 2009, the plan was for fortnightly visits to be continued by the care coordinator. It was reported that Mr C continues to be "mentally stable" and this was confirmed by a personal advisor who had been working with him for a while. Mr C also reported that he was no longer responding to any form of external stimuli and his family had no concerns about him. His father confirmed by telephone that his son was much better and had not displayed any form of aggression or abnormal behaviour. Mr C's care coordinator completed a risk assessment on 22nd March 2010. It did not identify that Mr C was a risk to others.
- 7.22 On 1st April 2010 Mr C's father contacted the community team as the family were becoming very concerned about his son's behaviour. Mr C's father reported that his son had been behaving oddly, not sleeping well, not eating and spitting food out when he tried to eat. He had not been aggressive but was described as a nuisance in the house. The family called the police when Mr C became violent but no other details are known as to who attended from the police or what action had been taken. Neither the ambulance service who were also called nor the police agreed to take Mr C to an Accident and Emergency department or police station in order for an Mental Health Act assessment to be completed
- 7.23 Dr M was contacted by the community duty team who had taken the telephone call from Mr C's father. He suggested that they refer Mr C to the Home Treatment Team² and to arrange for a possible hospital admission as Mr C was known to become unwell very quickly. The duty team contacted the Home Treatment Team and spoke to them. It was then suggested that Mr C be

² Home Treatment Team is also known as a Crisis Resolution Team who gate-keep admissions to inpatient hospital beds

referred to the psychiatric liaison team based at the Accident and Emergency department at the Royal London Hospital and Mr C's father was informed that he could take him to the psychiatric liaison team any time he was worried.

- 7.24 Five days later on 5th April 2010, during the evening, Mr C apparently hit his brother and the police were called to the house again. He agreed to attend the Accident and Emergency department at the Royal London Hospital for a psychiatric assessment. Following the assessment he was admitted to a ward, (ward B), at the Mile End Centre for Mental Health, in Tower Hamlets, and placed on 15 minute observations as per the Trust policy for all new admissions.
- 7.25 The next day after Mr C's admission to hospital his father visited the duty team to inform them that he had called the police for help as Mr C had remained quite unpredictable and in the early hours of the morning became violent, kicking his brother and breaking furniture. He confirmed that Mr C was now a patient on ward B at the Mile End Centre for Mental Health. Mr C was reviewed by Dr M at the routine ward round on 6th April 2010 on ward B.
- 7.26 On 7th April 2010 Mr C was involved in two serious altercations with other patients on ward B. It was decided to separate him from the other patients on the ward to defuse the situation and ensure the safety of Mr C. A bed was not available on the Psychiatric Intensive Care Unit (PICU) so it was agreed to transfer him to a bed identified on ward A, a ward next door to ward B. Mr C was transferred to the ward in order to maintain his own safety. Mr E, who was later attacked by Mr C, was a patient on ward A at that time and as far as is known had had no previous contact with Mr C.
- 7.27 After transfer to ward A it appears that the 15 minute observations as recommended by his clinical team on ward B were discontinued.
- 7.28 Later that day a member of staff saw him in the kitchen area of the ward with Mr E. Mr C was apparently bending Mr E's thumb back, and the staff intervened and separated the men. Following this Mr C was observed kicking Mr E in the face who was kneeling in front of him at that time. Mr E sustained a cut lip. It was also at this time that the staff observed that Mr C was wearing Mr E's ring which they ensured was immediately returned to Mr E. The men were kept apart for the rest of the day.
- 7.29 The following day, 8th April 2010, Mr C was seen to be intimidating Mr E again, whose face was now red and swollen. Mr E's sister visited him in the afternoon and on leaving Mr C was rude and verbally aggressive to her. Relatives of Mr E rang the ward and asked for the police to be informed of the assault on Mr E. It was agreed that staff would make a referral for Mr C to be transferred to the PICU. The assault on Mr E was not reported to the police.

- 7.30 On the morning of 9th April 2010, a nurse came on duty and discovered that the referral to be sent to PICU for Mr C's transfer on the previous day (8th April) had not been actioned and again requested that an assessment be made for a transfer there. An assessment was undertaken by the PICU staff who indicated in the notes that Mr C's level of observations should be increased to 15 minute intermittent observations but found that Mr C's mental state was not acute enough to meet their criteria for transfer to the unit. The PICU staff could not have seen that the previous entry on Mr C's notes completed by staff in ward B indicated that Mr C had already been placed on 15 minute nursing observations.
- 7.31 Mr C and Mr E were observed interacting during the day but as they were conversing in their native language it was not possible to assess what their conversations were about. At that time there were no staff on duty who were able to interpret Bengali.
- 7.32 At 18.00 hours Mr C was observed in the dining room waving his arms around, laughing to himself and appearing restless. The nurse in charge instructed the staff to give him the prescribed PRN medication to calm him down.
- 7.33 Just after 19.45 hours the ward panic alarm was activated and on investigation Mr E was found lying on the floor in his room covered in bedding. On examination he was found to have multiple injuries to his face. The emergency team were summoned and commenced emergency treatment. Mr C had been observed leaving Mr E's room by a nurse who asked him what he had been doing in that patient's room. Mr C informed her that he was going to "cut him" and upon being asked if he had done something to Mr E gestured that he would be put into handcuffs. The nurse had entered Mr E's room and raised the alarm.
- 7.34 Mr C was kept under constant observations whilst the emergency team were with Mr E who was taken to hospital by ambulance where he died from his injuries.
- 7.35 Arrangements were made for Mr C to be transferred to the Trust's medium secure unit and he was initially taken to a seclusion room on another ward. When the police arrived they arranged for him to be transferred to the police station where he was charged with assault and subsequently murder after the police were informed of Mr E's death. Whilst at the police station arrangements were put in place for Mr C's transfer to the Trust's medium secure unit. On 14th April 2010 Mr C was admitted to a High Secure Hospital within another NHS Trust where he remained for several months before being transferred back to the medium secure unit within the Trust's services on 6th June 2011.

8. Analysis of the Evidence – Mr C

- 8.1 The following analysis has been made after an extensive review of the written and oral evidence provided to the independent investigation panel.

Adolescent Psychiatric Services

- 8.2 Mr C's first contact with psychiatric services in December 2006 followed a deterioration in his behaviour which resulted in an admission to the Coborn Centre for adolescent mental health. He remained there as an inpatient for five weeks under the MHA and was diagnosed as suffering from a bipolar disorder that was treated with prescribed medication.
- 8.3 A consultant adolescent psychiatrist, Dr P, was responsible for both his inpatient and community care at that time. Dr P was able to communicate with Mr C in his native language and during the time under her care built up a good therapeutic relationship with both Mr C and his family. Mr C's understanding of English was very poor at the time. Mr C had one further admission under the MHA to the Coborn centre that was initiated by Dr P.
- 8.4 Dr P, together with a community psychiatric nurse, took responsibility for Mr C for a period of approximately 18 months until he was 18 years old. It is considered by the independent investigation panel that Dr P and the adolescent services provided appropriate care and support to Mr C and his family. Dr P, in particular, appeared to have provided a caring and approachable service to Mr C. This was helped by her ability to communicate with all of the family in their native Bengali language.

Adult Psychiatric Services

- 8.5 It was confirmed that when Mr C was well he was a caring, gentle person but if relapsing, quickly became ill and aggressive. Up until this period that aggression had been directed only towards his family.
- 8.6 In July 2008 Mr C's care was transferred to the adult mental health services and his psychiatric responsibility was taken on by an adult consultant psychiatrist, Dr M. A care coordinator was allocated from the Community Mental Health Team who saw him on a fortnightly basis to monitor his mental state and support him with daily activity skills. The independent investigation panel heard that Mr C built up a good relationship with his care coordinator, often appearing unexpectedly at the community team's base to see him.

- 8.7 However, it was unclear as to how the two communicated as the care coordinator did not speak Bengali and Mr C's English was poor. The evidence provided stated that for CPAs an interpreter was always provided but as these were held on a six monthly basis the question remains as to how effective the lines of communication were between Mr C and his care coordinator.
- 8.8 His mental state was reported as being stable over the next few months. He attended a college course to learn English although his attendance was poor and he did not complete the course. His family continued to be supportive of him and he continued to live in the family home. His English remained poor.
- 8.9 A risk assessment completed in March 2010 did not identify Mr C as a risk to others although he was known to be a risk to his family. Mr C's care coordinator apparently saw him on the 19th March 2010 prior to going on a month's leave, although this meeting was not recorded in the records. The explanation for this omission was due to increased workload prior to his leave.
- 8.10 A contingency plan had been agreed with Mr C's father, in the event of deterioration, for contact to be made with the duty team. No other arrangements were made for Mr C to be seen by another member of the community team.
- 8.11 The independent investigation panel consider that this is not acceptable to rely upon Mr C's father to contact the duty team and leave Mr C for one month without contact with the mental health services. However this does explain why in April 2010 Mr C's father contacted the duty team for help with his son's deteriorating mental health.
- 8.12 It is unclear as to whether Dr M was aware of this situation or whether the duty team were able to access the electronic records relating to Mr C. It has to be acknowledged that the last entry in his notes regarding risk and management stated that "he was not a risk to others".

Home Treatment Team

- 8.13 Mr C's condition was reported as starting to deteriorate on 1st April 2010 by his father, who had become concerned about his behaviour. Mr C was not sleeping well, not eating and spitting food out when he tried to eat. He had not been aggressive but was described as a nuisance in the house. The community duty team were contacted by his father according to the contingency plan agreed prior to Mr C's care coordinator taking leave. The duty team spoke to Dr M for advice, who suggested that Mr C was referred to the Home Treatment Team for them to possibly arrange a hospital admission as Mr C was known to become unwell very quickly. The police had also been contacted by Mr C's father.

- 8.14 The Home Treatment Team, when contacted, suggested that Mr C be taken by his father to be seen by the psychiatric liaison team based at the Accident and Emergency department, Royal London Hospital, and Mr C's father was advised that he could contact that team any time he was worried. It is unclear as to whether Mr C's father followed this up or what happened in the next few days. Mr C was not contacted or assessed by the Home Treatment Team and Dr M was not informed of their advice that Mr C should be taken to the Royal London Hospital to be seen by the psychiatric liaison team.
- 8.15 The independent investigation team consider that by diverting the family with advice to take Mr C to the Accident and Emergency department an opportunity was missed to provide appropriate care at an early stage. However this advice was not followed by the family at this time. Whilst the evidence would suggest that an admission would have been appropriate, the lack of an assessment by the Home Treatment Team cannot be condoned and feedback to the referrer should have taken place.
- 8.16 Five days later, 5th April 2010, Mr C became aggressive again and the police were called to his house. He was seen at the Accident and Emergency department, Royal London Hospital, for a psychiatric assessment and admitted to ward B at the Mile End Centre for Mental Health in Tower Hamlets under Section 2 of the MHA.
- 8.17 There appeared to be a difference of understanding in regard to Dr M requesting that the Home Treatment Team take a referral to assess Mr C on 1st April 2010. The independent investigation panel heard evidence that as gatekeepers to the inpatient services assumptions were made that any referral to the Home Treatment Team would result in an assessment being completed on the individual with a possible hospital admission then considered.
- 8.18 The internal review indicated in their analysis of this process that Dr M had asked for Mr C to be admitted, when in fact he was suggesting that Mr C might need to be admitted. However it was expected that the Home Treatment Team would have seen and assessed Mr C and also taken into consideration his consultant psychiatrist's opinion that when Mr C's mental state was deteriorating he could relapse very quickly and need urgent treatment.
- 8.19 It is understood that the role of the Home Treatment Team has been reviewed and referrals to that service should now result in an assessment of an individual's mental health. The independent investigation panel heard that medical staff had concerns that there were still delays in completing assessments by the Home Treatment Team as a result of them not taking place without the involvement of the patient's current consultant.

Admission to Hospital - April 2010

- 8.20 On admission to ward B on 6th April 2010 Mr C was placed, as per the ward policy, on 15 minute observations. He did not appear to have settled and was seen during the routine ward round by Dr M the next day. No interpreter was present. The independent investigation panel heard that this could have created difficulties because of Mr C's poor command of English.
- 8.21 It was unclear as to why the ward had not organised an interpreter for the ward round particularly considering that this was Mr C's first admission on an acute psychiatric ward and he was acutely unwell. Dr M did have a few words of Bengali and it is understood that he had a limited conversation with Mr C. It was agreed that Mr C would remain on Section 2 of the MHA, continue with a CPA review that was due on 20th April 2012 and remain on 15 minute nursing observations. Dr M also requested that Mr C was reviewed on the ward on Friday 9th April 2010 and that an interpreter was to be organised.
- 8.22 The independent investigation panel heard that ward B was a busy unit where incidents do happen between patients which the staff routinely have to deal with. Two days later, 7th April 2010, following two serious altercations with patients on ward B Mr C was transferred to ward A in order to maintain his safety. A referral had been made for him to be transferred to the Psychiatric Intensive Care Unit that was also based at the Mile End Centre for Mental Health but a bed was not available there. It is unclear as to why Mr C was moved to ward A and not either of the other two patients. The independent investigation panel heard evidence that Dr M was not informed of this transfer.

Transfer to Ward A

- 8.23 During the afternoon of 7th April 2010 Mr C was transferred to ward A accompanied by three nurses. The independent investigation panel heard evidence that the staff on ward A were reluctant to take Mr C and informed the transferring nurses of this. A discussion took place in regard to the situation. This appears to have limited the information provided to the staff on ward A and a proper handover which should have included potential risk issues, observation levels and background to the reasons behind Mr C's admission to hospital. It is understood that Mr C was placed on general observations as there is no record of him remaining on 15 minute observations following his transfer although the records are not clear on this point. A detailed analysis of the issues relating to observations and adherence to policy can be found later in this section.

- 8.24 Unusually a bed had not been prepared for Mr C and he was given clean sheets to make his own bed up. It is considered that Mr C may well have felt unwelcome and there was no attempt at that time to discuss his care or to provide an interpreter to help him understand why he had been transferred from ward B. He did not receive information on the standard ward induction process that was taking place within the ward in regard to mealtimes, access to rooms and more general issues neither was he allocated a named nurse.
- 8.25 Mr C's brothers came in to visit him that evening but an opportunity was lost to use them as interpreters to explain the circumstances to Mr C. His father also rang the ward after the brothers' visit and in English asked the staff to look after his son. At the time on that shift there were not any Bengali speaking staff on the ward.
- 8.26 It is documented in the notes that Mr C appeared to intimidate Mr E over the next two days and once again no attempt was made to ascertain why this was happening. There is no documentation that describes any communication by the staff to ascertain the circumstances behind the altercations between the two men.
- 8.27 As indicated earlier the altercation that was observed when Mr C kicked Mr E in the face causing a facial injury and cut lip, did not result in any further action such as informing the police or completing an incident form. The independent investigation panel found that this was a breach of Trust policy.
- 8.28 Mr E's notes do indicate that he remained upset by the incident and considered that the ward staff did not take any action to prevent a similar attack occurring to him. He remained unwell experiencing auditory and visual hallucinations. Attempts were made to keep the two men separate after this and it was agreed to refer Mr C to the PICU. However the referral did not happen until the next day.
- 8.29 The independent investigation panel are of the opinion that there was a serious lack of communication especially the availability of someone interpreting at all times between staff and patients.

The attack on Mr E

- 8.30 The independent investigation panel were informed that the attack on Mr E was not heard by staff on the ward. In particular, the nurse undertaking a one to one observation on a sleeping patient, two doors away from Mr E's room, was adamant that she did not hear Mr E being attacked although did acknowledge

that there were noises in the region of his room that sounded like furniture being moved.

- 8.31 The injuries that Mr E received were consistent with a sustained attack over several minutes. It is hard to understand how some noises such as screams and other verbalisation were not heard as Mr E was assaulted. The Trust's internal review has gone into a detailed examination of the clinical notes setting out extracts from those records. It is not the intention of this independent investigation to replicate that.
- 8.32 The independent investigation panel had access to the questions posed by Mr E's family to the Trust which included the query as to why no one heard the attack. Unless Mr E lost consciousness immediately, it is improbable that sounds of the assault would have not been heard from outside the room. The nature of the injuries sustained by Mr E strongly suggest that Mr C was in an extremely disturbed mental state.
- 8.33 The independent investigation panel had been assured by the modern matron and other clinical staff that the male and female corridors were segregated by a locked door. During a visit to ward A by the independent investigation panel it was possible to walk unimpeded through the loop from the day room via the male and female corridors, without having to unlock any doors, despite assurances by the modern matron that this was not a regular occurrence and that the only time the doors may be unlocked is whilst the cleaners were in that area.
- 8.34 The independent investigation panel heard that Mr C was not seen entering Mr E's room, although he would have had to pass the nurse sitting in the male patient bedroom corridor undertaking one to one observations on a patient two doors from Mr E's room. Therefore Mr C might possibly have had access from the day room via an unsecured female corridor. This may have been the case on the day of the incident and gone unnoticed by the staff. This practice would have created a potentially serious risk with male patients having access to the female patients' bedroom area.

Observation Policy

- 8.35 One of the Terms of Reference for the internal review into the death of Mr E was to review the observation policy of the Trust. The independent investigation panel were also asked to review the appropriate implementation of these policies in relation to the circumstances surrounding the death of Mr E.
- 8.36 On examination of the evidence the independent investigation panel have found that poor adherence to the observation policy and procedures were a key factor

- in this incident. The Trust policy (2008) on observation was well documented, being due for review in September 2010, a few months after the death of Mr E in April 2010.
- 8.37 From the start of his stay on ward A on 7th April 2010, it is clear that the 15 minute observations which had been recommended for Mr C upon his arrival at ward B on 6th April 2010 were not taking place. These fifteen minute observations were not properly handed over to the ward nurses on ward A when he was taken there by ward B nurses.
- 8.38 This was due to poor communication between the nurses involved in the transfer. The nurses behaved in an unprofessional manner making it clear that they did not want to have Mr C on the ward, thus making the handover of information about Mr C very difficult. Consequently, vital information about Mr C and his care needs was lost to the staff.
- 8.39 The Trust policy on record keeping is very clear. It states that “A high standard of record keeping provides security to the service users and staff”. On the occasion of Mr C’s transfer to ward A the standard of record keeping was very poor.
- 8.40 Evidence was provided to the independent investigation panel that medical staff on ward A were under the impression that Mr C was on 15 minute observations. It appears that observations on Mr C at 15 minute intervals only commenced on 9th April 2010 after the PICU’s staff assessment visit to the ward, and the suggestion that he be placed on that level of observation.
- 8.41 However, had the PICU staff read the notes on Mr C, prior to giving advice and leaving the ward, they would have seen that an entry prior to their entry on Mr C’s file clearly states that the plan for Mr C was for him to be continued on 15 minute observations, the same as was felt necessary on his admission to ward B.
- 8.42 It is evident from the documentation seen by the independent investigation panel that staff on ward A did not start to carry out any regular recorded observations on Mr C until the afternoon of 9th April 2010 when 15 minute observations were recommenced. In fact the observation sheet for the 9th April 2010 is the only one for ward A to feature Mr C’s name.
- 8.43 The internal review report into the death of Mr E points out that “The policy regarding observation was not followed by staff on ward A”. Indeed, this point is re-iterated in several places in the report. However, this view is contradicted by the internal review when they write that they believe, that “the observations were being carried out correctly but were not documented properly”.

- 8.44 The internal review report further contradicts its own finding by saying that it was clear to them that the same nurse was conducting one to one observations as well as 15 minute observations, which surely could not be the case given the fluidity of movement of patients around the ward. The independent investigation panel consider that it was not possible for one nurse to undertake both tasks.
- 8.45 The independent investigation panel does not believe that observations were being carried out correctly on ward A on 9th April 2010. It was clear that the same staff were recording observations on patients when they were actually elsewhere on the ward and not involved in the observation process at that time. This may have developed as poor practice because of the busy atmosphere around the ward but both observation in practice, and recording these observations were poor on the day of Mr E's death. The independent investigation panel heard evidence that the observation policy was not followed generally or regularly reviewed.
- 8.46 This independent investigation panel believes that the actual documentation around observations on all wards did not easily lend itself to a good system of observations. The forms being used at the time were clearly delineated for observations at intervals, but they did not contain a useful section explaining what type of observations each patient was on. Furthermore, the document did not require a supervisor to check and sign that this important role was being undertaken in the proper manner and in accordance with the plan set out upon admission in accordance with good nursing practice.
- 8.47 The independent investigation panel found that a date had been changed after the original documents had been photocopied, to make the observations look as though they had been carried out on that date. This leads us to believe that the staff on ward A that day, were aware of the fact that observations had not been done as they should have been. The alteration of the form by person or persons unknown should be seen as a very serious breach of policy and procedure on behalf of at least one member of ward A staff on 9th April 2010. This was a clear attempt to give a different picture to anyone investigating the incidents on 9th April 2010 to that which was actually happening regarding observations:
- In that people signed other nurse's observation sheets as having been completed.
 - A number of patients being signed as having been seen at the same time.
- 8.48 It is regrettable that the police investigating officer examining the events surrounding Mr E's death did not delve into this aspect of the incident more at the time. Clearly this was a serious attempt to mislead anyone charged with looking into the circumstances that pertained on the day of Mr E's death. It

should have formed part of the police investigation to probe the facts around why this form had been altered, as, if taken on face value this could have given a totally different view of what was happening on the ward that day and thus impeded the investigation.

- 8.49 The investigating officer (IO), told the panel that “we didn’t ask any of the witnesses in respect of that” [the false date on the observation forms]. It is unfortunate that the IO did not see this aspect of the observation routine as part of his investigation into the circumstances surrounding the death. It may well be that had this been asked of the nurses and staff on ward A at the time, some light may have been shed on the matter. However, the independent investigation panel found that no nurse had ever been asked about the observation forms and their alteration during the course of the police investigation which was a lost opportunity.
- 8.50 This is regrettable as some investigation into it at the time may well have revealed more to us about the poor observation culture that pertained on the ward.
- 8.51 The wilful alteration of documentation can be considered as an intention to pervert the course of justice. The IO made the point that this aspect of the case was put to the Crown Prosecution Service (CPS), who were considering a charge of corporate manslaughter³ but did not consider the altering of the forms as an issue within this. However, it is difficult to see upon what basis the CPS made that decision if, as the IO himself pointed out, there was no actual investigation at the time into this aspect of the incident.

Clinical Staff - Nursing

- 8.52 At the time of the incident there were two qualified nurses and two health care assistants (HCA) on duty on ward A. One of the HCAs was a bank nurse who was familiar with the ward. The most senior nurse was away from the ward for long periods as she was also the unit’s duty senior nurse (a role requiring her to support all the wards on the site) and was, in addition, allocated the care of four patients. She had also been on a training day from 09.00 – 17.00 hours and on return to the ward was not proactive in ensuring receipt of a robust handover. She stated that she did not seek a handover as she was aware that being the senior nurse would inevitably mean that she would be away from the clinical area (ward A) for some of the time. The remaining staff nurse was taking part in a consultant ward round from 14.40 – 17.10 hours approximately. It appeared to the independent investigation panel that having two unqualified staff to care for

³ Corporate Manslaughter - a routine consideration by the CPS when an individual has died under suspicious circumstances whilst on business premises (in this case the Trust).

very unwell patients, a third of who were on enhanced levels of observation could be considered unsafe.

- 8.53 It is unclear what mechanism, if any, was in place at the time for escalating concerns about staffing levels and or asking for help. There appeared to be a culture within the ward of “getting on with it” which may have led to a lack of awareness of potential risks and thus a reduction in quality of care of patients on the unit.
- 8.54 The staffing issues did not appear to have been escalated to the modern matron at the time, who was managing three acute admission wards within the mental health unit. The expectation was that a modern matron would manage a maximum of two units, so this was an unusual situation. The supervision arrangements appeared to be inadequate, and the modern matron at the time was reported to be overwhelmed with the degree of responsibility and workload. This led to a lack of structure around supervision and resulted in staff neither asking for nor receiving supervision on a regular basis.
- 8.55 During the period under consideration it was apparent from evidence provided to the independent investigation panel that nursing staff working in both wards did not feel empowered to highlight issues of concern. Medical staff appeared to be dominant with several nursing staff stating that during the ward rounds their opinions were canvassed rather than them being encouraged to give views freely. It is of note that none of the ward staff used the first names of the consultants, and there was clearly an outdated deference to medical staff on the part of a significant number of the nurses. The independent investigation panel saw no evidence that this has changed and consider that it may be hard for staff to raise issues if they feel that they will be humiliated or spoken to without courtesy. The independent investigation panel would encourage the Trust with their programme to hold multi professional training days to encourage mutual understanding and respect amongst the professional groups.
- 8.56 The Trust informed the independent investigation panel that they had had difficulties in recruitment with respect to the quality of staff. This did appear to be a particular problem within the Mile End Centre for Mental Health and specifically ward A which had been short of a manager for a protracted period of time. It appears that a new senior member of staff (PIN) had been appointed for ward A’s empty post, but had withdrawn at short notice prior to commencing employment. The independent investigation panel was concerned that more proactive steps were not taken by the Trust to appoint to this post after this withdrawal although they were informed that interim staff did cover the vacant post during this period.

- 8.57 The interviews with the qualified staff involved on the day of the incident left the independent investigation panel with concerns regarding their level of capability. This had been highlighted in the internal review and indeed disciplinary proceedings were instigated by the Trust which have now been concluded and the staff redeployed within the service. The independent investigation panel were not completely satisfied that a rigorous reinstatement process was put in place when these staff were redeployed to other areas of the Trust although have now been assured that a rigorous redeployment process is in place. Interviews with the independent investigation panel did take place with each of the staff members who had undergone the disciplinary process and without exception all expressed the view that they had been, and to a degree, were still confused about the process that they had been subject to.
- 8.58 It appeared to the independent investigation panel that some nursing staff on ward A were undertaking tasks that were above their individual level of competence, and it is still unclear how the Trust's Board assure themselves that staff are able to function safely within their respective roles. Regular supervision, appraisal and reflection are now in place which is reassuring. However, it may be of use for the Trust to consider using an Objective Structured Clinical Examination (OSCE) framework for the assessment of particular competencies – observations, medical devices, physical health and medication administration.
- 8.59 There remain issues of clarity regarding the new structure of practice innovation nurse (PIN) Band 7 and modern matron (MM) Band 8A. The Trust expressed a view that the name "ward manager" did not identify them as a practising clinician and led to confusion for patients and carers. The change of role from managing ward resources in their entirety to spending shifts on the ward role modelling for junior staff and having meaningful interface with patients is laudable. It was clear however from all the interviews that the blurring of roles between the MM and PIN essentially managing the ward "most of the time" creates ongoing confusion.
- 8.60 Neither the PIN or MM, were clear of their roles, responsibilities and accountability. In no small measure it also creates a contradiction of responsibilities and accountabilities between the staff in those posts. The independent investigation panel were also unable to find a senior manager who fully understood those roles.
- 8.61 Staffing levels were increased after the incident in response to the internal review recommendations and instead of a MM being responsible for three wards, ward A now has a dedicated MM plus a PIN. In addition, the Trust has increased the staffing establishment in all of their inpatient services by increasing the numbers of staff by one full time (09.00 – 17.00 hours) healthcare

assistant in each ward. The independent investigation panel saw evidence that was presented to the Trust Board of a process to identify the skill mix required on the wards that led to the decision to increase the establishment of one healthcare assistant.

Clinical Staff – Medical

- 8.62 Both prior to the incident and subsequently, the wards at the Mile End Centre for Mental Health have been staffed with consultant psychiatrists, junior and senior trainees and staff grade doctors. The independent investigation panel has no concern about the level of medical staffing provided by the Trust to its inpatient facilities. It is evident that the Trust has worked energetically to implement new leadership structures in the aftermath of this event which have impacted on nursing and medical working structures in particular; nevertheless, the independent investigation panel has identified some significant issues of concern which may be best addressed through a thematic analysis.

Medical Leadership

- 8.63 Prior to the incident the independent investigation panel consider that each psychiatric consultant worked autonomously with his/her medical team. Concerns which had relevance to other consultants were dealt with in periodic ad hoc consultants' meetings, and, where considered to be significant enough, issues were escalated to the clinical director. There was no consultant lead identified for each ward.
- 8.64 The independent investigation panel heard that before the incident specific issues which were of common concern to the consultant body had indeed been escalated by email to the clinical director. This does not appear to have resulted in remedial action being implemented. The independent investigation panel were informed that the Trust had more of a reactive approach to managing its concerns and its focus was upon implementing change in response to Serious Incidents, rather than towards preventing them.
- 8.65 Throughout, consultant psychiatrists have continued to work both in community settings as well as on the wards. In most cases consultant staff are based alongside their community teams. Consultants are expected to attend their weekly ward review meetings, but a regular presence on the wards at other times by the consultant, does not seem to have been expected prior to the incident, or indeed subsequently. Consultants, it is recognised, have different practices in this regard. The independent investigation panel was satisfied that there was a medical presence on most of the wards most of the time, usually provided by trainee doctors or middle grade staff.

- 8.66 Although each ward consultant considered himself/herself to be responsible for the management of their patients, there was no clear evidence that they were actively and directly involved in day to day management decisions for their patients. Indeed, several senior nursing staff interviewed did not feel that they could approach a consultant directly to discuss a concern. Some consultants when challenged on this point indicated that, although willing to be contacted, they would expect that most issues would be addressed by the trainee doctors who would then escalate the issue to them if this were necessary.
- 8.67 The Trust has implemented various changes to remedy clinical leadership deficits. A new structure for ward nurse management has been established and a new post of “Consultant Lead” has been created for each ward. The independent investigation panel welcomes the initiative but does have some questions concerning its chosen solutions.
- 8.68 The independent investigation panel heard that a “functional team model” whereby inpatient wards were managed by a single consultant had been considered by the Trust and found lacking. Evidence heard by the independent investigation panel suggested that the main opposition to this model came from the consultant body who favoured the existing model where each ward had inpatient beds managed by several consultants with roles in both the community and the inpatient unit. Such a model is seen to provide greater continuity of care. However this has an impact on nursing time within the inpatient service. For example there were four ward rounds a week held on ward A by four different consultants which involved a great deal of preparation and took at least one qualified nurse away from direct care for up to three-four hours on each of these days.
- 8.69 The Trust are in the process of establishing a functional team pilot in Hackney which will be evaluated with a view to extending the model across other services.
- 8.70 Although the new consultant lead post has boosted medical leadership to the ward as a whole, and has facilitated greater multidisciplinary management discussion, the independent investigation panel consider that the role remained somewhat nebulous, did not appear to be supported by a robust meeting structure where decisions were shared amongst consultant peers, and had not resulted in a significant change in either culture, or engagement of senior medical staff with the ward team.

Multidisciplinary Working

- 8.71 Effective multidisciplinary working requires an understanding of each other's roles and responsibilities and mutual respect. Although within each professional group some staff will be senior and others quite junior, true multidisciplinary teams do not accept a hierarchy of professions. Although the independent investigation panel identified pockets of good multidisciplinary working, especially within the Trust's CAMHS services, it had significant concerns around multidisciplinary working in the wards at the Mile End Centre for Mental Health.
- 8.72 The independent investigation panel interviewed staff from most professional groups. Each acknowledged that there had been improvement in multidisciplinary working in the last two years within inpatient services. Nevertheless it remained clear from evidence provided to the independent investigation panel that the work of nursing staff especially, is not always respected by the medical staff, and that some doctors are regarded by the nurses with a mixture of fear and awe.
- 8.73 Although attempts have been made by senior management to facilitate more meaningful multidisciplinary working, and the independent investigation panel were pleased to hear of team building events, and away days for example. The independent investigation panel was not satisfied that key players had always attended these events, or that their efficacy could be evidenced.
- 8.74 The independent investigation panel therefore remains unconvinced that attempts to date to achieve meaningful and significant change in multidisciplinary working have been adequately effective. An unhelpful hierarchical culture persists within the inpatient services in the Mile End Centre for Mental Health which will require further work by all professionals.

Accessibility and Availability

- 8.75 At the time of the incident a consultant psychiatrist presence on the acute wards at the Mile End Centre for Mental Health was generally infrequent. Consultants attended the ward for their weekly review meeting and for other exceptional duties. Senior nursing staff considered this to be "the norm". For a nurse to contact a consultant directly by telephone was considered to be unusual. Trainee doctors and duty doctor systems were expected to manage day to day patient management issues.
- 8.76 In the majority of cases consultants were based at a geographically distanced site, often alongside their CMHT, to whom, it is presumed they were more accessible and available. At the time of the incident the ward staff were found to

have been unaware of the location of particular consultants when not present for ward rounds.

- 8.77 Since the incident, some consultants have implemented a system whereby they make telephone contact daily with their inpatient ward to discuss concerns. However this is not universal and the independent investigation panel has concerns that consultants continue to remain physically distant and not as accessible as they should be to a group of seriously unwell service users.

Care Programme Approach (CPA)

- 8.78 At the time of the incident, wards at the Mile End Centre for Mental Health were still using paper notes. Since that time RiO - an electronic case record solution has been implemented, however the independent investigation panel remain unclear concerning the Trust's expectations concerning CPA documentation.
- 8.79 Independent investigation panel members who are acquainted with RiO recognise that its Care Programme Approach functionality is far from ideal. The independent investigation panel heard that it was not being used on ward B and that a Microsoft Word-based solution was being implemented.
- 8.80 The independent investigation panel was concerned that there did not appear to be a clear Trust directive concerning how CPA plans should be documented within its inpatient environments. The care plan remains a pivotal document in documenting service user care, and an aid to meaningful communication between teams. It is vital therefore that an agreed solution is implemented.

Transition between Services

- 8.81 The independent investigation panel was impressed with the quality of care provided by the CAMHS team to Mr C. Significant thought appears to have gone into his transition needs, and the allocation of a worker to span his care within CAMHS and the adult CMHT is an example of best practice. The process appears to have been completed within the time frame outlined in the Trust policy. The independent investigation panel were concerned however that the CMHT consultant indicated that it was not his usual practice to attend the CPA meeting where care was transferred to adult services, but then to arrange a further CPA meeting solely for adult services which he would attend. This seems to be a missed opportunity to hear directly from the patient's consultant prior to transfer and consequently requires two CPA meetings rather than one.

Ward A - Environment

- 8.82 Ward A is an acute admission ward of 19 beds located on the first floor of the mental health unit within the Mile End Centre for Mental Health in Tower Hamlets, East London. It is a mixed sex ward with a flexible lockable division between the male and female bedrooms. The corridors to the bedrooms are accessed via doors in the day area.
- 8.83 There is a small day room which could be used by either males or females and is considered as the only female lounge in the day area. The main communal area is unisex and quite small.
- 8.84 At the time of the incident the ward was reported as being dark and claustrophobic with poor access to natural light. There was no access for detained patients to the outside other than by staff escort to an enclosed garden accessed from the ground floor.
- 8.85 Observation of patients in their bedrooms would have been poor except where they were under one to one observations or having individual care plan sessions. At the time there were no mirrors or CCTV systems in place.
- 8.86 The male corridor where the incident happened is narrow and the doors were open outwards from the bedrooms restricting the space in the corridor further at the time of the incident. All bedroom doors in the Tower Hamlets Centre for Mental Health have anti-barricade devices installed in the door frames. These are large metal buttons that are depressed to enable the door to swing outwards. There is a reset button which, when pressed, extends the button out and acts as a stop meaning the door can only swing open into the bedroom. If these are not reset as they should be, then the doors will be able to swing in both directions, creating a potential hazard in the corridor and a fire risk.
- 8.87 Since the incident there have been structural changes made to the ward. The layout on the ward was changed with a new nursing station relocated to improve observation and accessibility. CCTV cameras have been installed to aid observation. An enclosed smoking balcony has been erected with access from the communal day room. There were plans for the relocation of the nursing stations to take place on each mental health ward in the Mile End Centre for Mental Health. The Trust's intentions were not carried out on two wards as these wards had reviewed the plans and proposed a different structure that better met their patient needs.
- 8.88 The independent investigation panel whilst acknowledging the changes made to the ward, consider that it still remains a small unit that restricts the activities

available to patients that have the complex needs of those admitted to an acute admission ward such as ward A.

- 8.89 Although the Trust has attempted to provide single sex facilities within what is clearly a mixed ward the independent investigation panel are not convinced that the facility afforded the level of privacy and dignity required, particularly for female patients and consider that there remains a potential serious risk to those patients. The independent investigation panel were not satisfied that options for single sex wards had been adequately considered, although whilst in the process of writing this report were informed that the Trust is considering plans for a female only service.
- 8.90 It is acknowledged that there are limitations within the footprint of any building and without major structural work it is not possible to radically change the ward environment.
- 8.91 Furthermore, although the new staff group have initiated changes to the patient day and brightened the ward by the addition of artwork, there are still additional changes that could be made. This applies particularly to the daily programme of activities that are being extended. The ward was clean, tidy and appeared well organised.

Psychiatric Intensive Care Unit (PICU)

- 8.92 The lack of an available bed for Mr C in the Psychiatric Intensive Care Ward on 7th April 2010 is of concern. In the event that a bed had been available then it seems likely that Mr C would not have been transferred to ward A and may not therefore have come into contact with Mr E. The independent investigation panel heard that there had been an inadequate number of PICU beds commissioned by Tower Hamlet's Primary Care Trust, a situation which has since been remedied.

Contact with the Police

- 8.93 In the first days of April 2010 there were two incidents where police came into contact with Mr C at the family home. On 1st April 2010 police were called after Mr C became violent and his family were in fear of what he would do. No evidence was given to the independent investigation panel as to who attended the address at this time.
- 8.94 Calls of this nature are defined by the Standard Operating Procedure (SOP) issued by the Metropolitan Police for such incidents. (This is the "Standard Operating Procedure for Police Responding to Incidents Involving Someone with

a Mental Illness”). The action of the police response to “spontaneous” incidents is covered by this procedure.

- 8.95 The SOP outlines that in such cases where a person is suspected of being mentally ill on private premises a police supervisor must be called to the scene to take the lead in the incident. No evidence was put forward to the independent investigation panel that a supervisor was in fact called to the scene on 1st April 2010. Given the nature of the circumstances outlined by the family of Mr C it is somewhat surprising that Mr C was not taken into police custody on that evening for a Mental Health Act assessment.
- 8.96 It appears evident that Mr C’s father was in great fear of being assaulted by his son. Mr C’s father told the internal review panel that he feared that his son would ‘...kill a family member’ on that night if the police and ambulance service attending the address did not take him. However, both the police and ambulance service declined to take Mr C either into custody or to a hospital Accident and Emergency department. This was despite Mr C’s father following the officers out on to the street and telling them that his son was likely to harm someone.
- 8.97 It is unclear whether in fact a police supervisor was called to the scene. It is also unclear what liaison took place between the police and the local Community Mental Health Team. The latter had already been called earlier that evening by the family, but because of a break down in communication the action recommended by the consultant in the case was not carried out.

Actions taken following the Attack on Mr E

- 8.98 Mr C was immediately taken to his bedroom and kept under constant observations by a male member of staff whilst the emergency team were with Mr E. The independent investigation panel heard that during this time Mr C was calm and not aggressive. The on-call staff responded quickly to the emergency and ensured that the other patients were safe within the communal area on the ward.
- 8.99 Arrangements were made for Mr C to be transferred to the Trust’s medium secure unit and he was initially taken to a seclusion room on another ward. When the police arrived at the hospital they arranged for him to be transferred to the police station where he was charged with assault and subsequently murder after the police were informed of Mr E’s death. Whilst at the police station arrangements were confirmed for Mr C’s transfer to the Trust’s medium secure unit. On 14th April 2010 Mr C was admitted to a High Secure Hospital within another NHS Trust where he remained for several months before being transferred back to the medium secure unit within the Trust’s services on 6th June 2011.

Section Two

Care and Treatment

Received by

Mr E

9. Outline of Events – Mr E

- 9.1 The following chronology of events has been compiled from case notes, oral evidence and documentary information made available to the independent investigation panel in regard to Mr E.

Mr E - Background

- 9.2 Mr E was born in January 1979 in Bangladesh and was of Muslim religion and moved to the UK at the age of ten years. He attended school in the UK but left with no qualifications and has since worked in a factory. His mother remained in Bangladesh and his father has remarried in the UK. Mr E had three sisters and one brother. As far as Mr E was aware there is no family history of mental illness.
- 9.3 Mr E got married in 1997 in Bangladesh but was unable to obtain a visa for his wife to live in the UK. He did not have any children and stated that his wife and himself had a very good relationship talking often on the telephone.

Contact with Psychiatric Services

- 9.4 Mr E was involved with a Community Drug Team prior to his first contact with Psychiatric services that were provided by East London NHS Foundation Trust. He was known to have used heroin, crack cocaine and cannabis on a regular basis.
- 9.5 On the 22nd January 2003, Mr E, accompanied by his brother-in-law, attended the Accident and Emergency department at St Bartholomew's Hospital. The Community Drug Team had advised him to go there as he had been reported to have tried to jump out of a first floor window. It was noted that he was scared to be alone at home as "there were too many noises". It was also reported that he was using threatening behaviour towards his sister and brother-in-law and had smashed a door and damaged furniture with a knife.
- 9.6 The family informed staff that he had appeared unwell for approximately six months with his behaviour becoming increasingly erratic and unpredictable. His father had "thrown him out" of the family home three weeks earlier and he had been living with his sister and brother-in-law since.
- 9.7 On assessment Mr E was found to have grandiose ideas, some paranoia but denied hearing voices. It was agreed that he was a risk to others and had little insight into his illness. He agreed to an informal admission to hospital and was admitted to St Clements Hospital, Tower Hamlets, where he remained extremely disturbed and unpredictable in his behaviour. It was necessary to detain him

- under the Mental Health Act and he was treated with significant doses of anti-psychotic medication. He was diagnosed as having had a psychotic episode secondary to drug use after using cannabis that day. Despite having attempted to jump out of a first floor window it was recorded that there was no current suicidal or homicidal ideation but he was known to have had several months of poly substance misuse.
- 9.8 A clinical assessment undertaken on 23rd January 2003 found him still quite elevated in mood and fairly restless. He was expressing some delusional ideas, and visual hallucinations but denied being unwell. He had reported that he saw three big men standing in front of him when he switched off the light in his room but denied having hallucinations.
- 9.9 The following day, 24th January 2003, Mr E was seen in the ward round by Dr W, his consultant psychiatrist, where Sections 5.2 and 2 of the Mental Health Act documentation were completed as Mr E was stating that he was not going to stay in hospital "I am not sick, I will go home soon". Section 2 of the MHA was later converted to Section 3 of the MHA.
- 9.10 It was reported that on 5th February 2003 Mr E still remained agitated and disinhibited on the ward. He was requesting to go home but was not physically aggressive and the plan was for him to continue on his medication of Haloperidol 10mg and Procyclidine 5mg three times a day, and Zuclopenthixol Acetate injection.
- 9.11 Two days later on 7th February 2003, Mr E was seen in the ward round by Dr W. It was noted that he still remained very agitated and disinhibited. He was reported to have absconded from the ward and was stopped at the hospital entrance before being brought back to the ward. On being returned to the ward Mr E stated that he was "not ill, I am not mental".
- 9.12 Mr E remained very agitated and restless over the following week and was seen in the ward round by Dr W again on 12th February 2003 where it was noted that he had had a difficult night having been awake until 01.30 hours in the morning. There was no improvement noted in his mental state. Seven days later after a further review, Mr E's medication of Sodium Valproate was increased to 750mgs twice daily.
- 9.13 Five days later, on 24th February 2003, Mr E was seen in the ward round where it was noted that there was no improvement in his mental state, he remained very "chaotic", with slurred speech and was very difficult to understand. He was observed by the nurses to be picking at invisible objects before taking his clothes off.

- 9.14 When seen in the ward round on 19th March 2003 Mr E was reported as feeling “good and happy”. His speech was difficult to follow and he was tremulous. He was talking about dancing, taking drugs and feeling that he could fly. Mr E denied experiencing auditory and visual hallucinations but gave clear descriptions of such experiences. The plan was to continue with his medication and to review him in one week.
- 9.15 One week later when reviewed, Mr E was more settled and not irritable but still asking to go home. It was agreed that he could have short escorted leave with a nurse and that occupational therapy was to be arranged. Mr E pleaded to be discharged home but it was agreed that he was not well enough yet.
- 9.16 During April 2003 Mr E was more responsive and receptive, he had had leave with his brother-in-law which went well. He was noted as feeling much stronger, not hearing voices or receiving messages from the television. The plan was to stop his Haloperidol, arrange a CPA review on 30th April 2003, and for him to have an overnight leave with his brother-in-law. His Chlorpromazine medication was reduced to 100mgs four times daily.
- 9.17 A CPA review took place on 30th April 2003. Mr E had attended NAFAS⁴ with an occupational therapist (OT) where he admitted to having taken cannabis, crack and ecstasy. He was also seen by a psychologist, who planned to hold a further session with Mr E and his family. He was to continue to have day leave, going home to his sister and his father and to attend NAFAS.
- 9.18 On 14th May 2003 Mr E was again seen in the ward round, it was reported that he was continuing to go to NAFAS. His latest home visits had not gone too well as there was a new baby in the house and he had not now got his own room to stay in. He requested to go to a homeless persons’ unit and also expressed concerns about his wife who remained in Bangladesh. He stated that “life isn’t worth living”.
- 9.19 On 27th May 2003 the duty doctor was called to a violent incident where another patient thought that Mr E had taken his radio and he punched him on the nose. Mr E reported feeling very angry and stated that he wanted to “beat up the other patient” but knew that this would prolong his treatment and impede his progress.
- 9.20 A CPA review meeting took place on 18th June 2003 where it was noted that Mr E’s Section 3 of the Mental Health Act was due to expire on 17th August 2003. It was noted that he was doing well, he was spending time at NAFAS and visiting

⁴ NAFAS – Bangladeshi Drug project, a culturally sensitive drug treatment service.

his family at their home although he did not want overnight leave. His family were reported to be upset that the ward staff were asking that Mr E had overnight leave at their home and wanted him to have independent accommodation.

- 9.21 On 25th June 2003 Mr E was seen in the ward round by Dr W and discharged from Section 3 of the MHA to his sister and brother-in-law's home. The plan was for him to continue to be seen by the clinical psychologist. A diagnosis of a schizoaffective disorder was made. He was referred to the community services and the Early Intervention in Psychosis Service (EIS).
- 9.22 In relation to his anticipated accommodation needs, on 11th August 2003, an OT "activities of daily living assessment" was undertaken. It was found that Mr E required minimal encouragement to cook, was familiar with the local shops and was independent with most aspects of daily living. It was decided that based on the assessment Mr E would need a supportive environment where he could be monitored on a regular basis.
- 9.23 Eight days later on 19th August 2003, a CPA review took place with Mr E who stated that he continued to take his medication and denied any depressive or psychotic symptoms when asked directly. He was to continue to be seen on a monthly basis.
- 9.24 In September 2003 a psychiatric report was completed by Dr W in regard to an application from Mr E's wife to move to the UK. Mr E at this time was living independently in hostel accommodation and had applied for a flat. The report stated that Mr E's mental state would be affected by the quality of the support that he would get from his wife and it was unclear as to whether she was aware of his mental health difficulties or his illicit drug taking.
- 9.25 The EIS continued to work with Mr E and on 21st October 2003 a CPA review was undertaken. Mr E reported that he had applied for a job making clothes and was waiting to hear about this. He had been allocated a flat and his brother was helping him apply for a grant in regard to buying furniture. He had begun to have contact with his father again and seemed to be more positive about their relationship. The plan was for his medication to remain unchanged and for him to continue on:
- Risperidone 6mg nocte (at night).
 - Sodium Valproate 1.2g nocte (at night).
 - Procyclidine 5mg bd (twice daily).
 - To attend NAFAS two days a week until they decided to discharge him.

- 9.26 The next CPA review was undertaken on 17th March 2004 where it was noted that Mr E continued taking his prescribed medication and remained abstinent from illicit substances. He had recently recovered from chickenpox. No evidence of recent psychotic symptomatology was found. Mr E planned to visit Bangladesh for a three month period.
- 9.27 A clinical psychologist reviewed Mr E on 27th October 2004 and stated that the primary input from psychology had been to support Mr E's attempts to move his wife to the UK. During this time he also had had an extended trip to Bangladesh but did appear to cope while there. It was agreed that the future focus of the psychology team would be to ensure Mr E had access to employment and educational resources as far as his interest and commitment went.
- 9.28 A further clinical psychology review took place on 27th February 2005 where it was stated that Mr E had been compliant with taking his medication and managed well through a time of conflict with his brother-in-law and gradually had started to see his friends again. Discussions had taken place in regard to the risks in terms of his substance misuse and he expressed the fear that if he continued to take drugs he might end up in hospital again, which he did not want to do. It was agreed that he would continue to be seen by the clinical psychologist.
- 9.29 Mr E and his sister were seen by the clinical psychologist on 10th August 2005 when Mr E expressed concerns about his medication and was worried about ongoing side-effects. He also discussed his concerns about his current housing where he found it difficult to stay due to being exposed to noise, fighting and people selling drugs on the premises. An application to be re-housed had been completed. He was to be seen again in one month. A letter was sent to the Housing Link team requesting assistance in re-housing. Mr E and Dr W were informed of the situation.
- 9.30 The EIS wrote to Mr E on 16th June 2006 stating that as he had had no contact with them since the previous September (2005), he would be discharged from their caseload.
- 9.31 On 12th September 2006 Mr E was seen in the outpatient clinic by Dr W. Mr E reported that he was trying to cope and also applying to get his wife over to this country. He did not like his flat, he thought it was too cold. It was noted that his mental state was stable and he was to continue on his medication. He had previously not attended appointments for many months and during the session it had transpired that the main reason why he had attended this appointment was to request a letter from Dr W so that he could support bringing Mr E's wife over from Bangladesh. A previous request had been turned down because he was unable to support her.

- 9.32 In terms of his mental state he presented with very good self-care, very good eye contact and rapport. There were no abnormalities of speech and he denied any auditory hallucinations. Mr E was informed that his care would be transferring to another consultant psychiatrist as since being re-housed he did not now live in Dr W's catchment area. His medication regime was to continue. A referral was sent to Dr Z to transfer Mr E's care to her and the transfer was agreed in writing on 13th October 2006.
- 9.33 Mr E was seen once more by Dr W on 7th November 2006 in outpatients. He was accompanied by his sister and reported that he was keen to stop taking his medication and that he had a job stacking shelves in an off-licence. His mental state was assessed as stable.
- 9.34 A transfer of care CPA took place on 18th December 2006 and Mr E was allocated a care coordinator from the Isle of Dogs Community Mental Health Team (CMHT). On 7th March 2007 having not attended two appointments he was discharged from the CMHT caseload. He did however continue to be seen by Dr Z in outpatients where he reported that he had full time employment in a restaurant.
- 9.35 On 20th August 2007 Mr E was seen in the local Accident and Emergency department St Bartholomew's Hospital by the Psychiatric Liaison Team having been talking and shouting over the past week. He was having dreams about his mother who lived in Bangladesh and gave a knife to his stepmother the previous day requesting that she "slash his throat". He denied taking any drugs or alcohol. A referral from the Psychiatric Liaison Team was made to the Home Treatment Team who attempted to monitor his care but Mr E refused to work with them.
- 9.36 Four days later, at the request of his GP, on 24th August 2007, a Mental Health Act Assessment was undertaken at Mr E's home in the presence of that GP and an approved social worker (ASW). Mr E looked withdrawn and downcast but denied suicidal thoughts, he was evading questions and stating that he wanted to jump off a bridge. He was thought disordered and "appeared psychotic". Mr E was admitted to ward A, at the Mile End Centre for Mental Health, under Section 2 of the Mental Health Act, accompanied by the ASW and two police officers. On admission he was placed on 15 minute nursing observations. When seen by the Doctor on-call he was calm and settled.
- 9.37 Two days after admission, on 26th August 2007, Mr E appeared anxious and mentally distressed although compliant with medication. He was paranoid and suspicious. Over the next few days he became more settled on the ward and had been watching television. No aggression or violent behaviour was observed by the nursing staff.

- 9.38 On 8th September 2007 Mr E sustained a head injury after being hit with a cup by another patient. He was seen and assessed by the on-call doctor who referred him to St Bartholomew's Hospital's Accident and Emergency department where he was taken by ambulance with a nursing escort. His head injury was treated and Mr E brought back to the ward. Two days later he appeared to be very distressed displaying confusion and forgetfulness and was occasionally verbally aggressive.
- 9.39 After this he became more settled and spent some time watching the television during the day. He asked staff if he could go home and was reassured that he needed to stay on the ward but was able to go home on overnight leave with his stepmother for the night two days later. It was reported that this went well.
- 9.40 On 17th September 2007 Mr E was reported as being unsettled in mental state, restless and agitated refusing his afternoon medication, and three days later in the evening was reported missing from the ward. The ward staff contacted his family and were informed that he had returned home and that the family had advised him to return to the ward. The police were informed of his whereabouts and as Mr E refused to return to the ward the police did not bring him back to the ward, although his family reported that he was causing a disturbance. It is unclear as to whether the police knew that Mr E was under the MHA.
- 9.41 On 21st September 2007 Mr E's brother-in-law brought him back to the ward in the morning. He appeared calm in mood and all parties were informed of his return at 11:10 hours. At 15:15 hours the Mental Health Act administrator informed the medical staff that Mr E's Section 2 of the MHA had elapsed the previous day. Section 5 (2) of the MHA was put in place, and a recommendation for detention under Section 3 of the MHA documentation completed.
- 9.42 Over the next few days Mr E appeared very agitated, was loud and noted to be entering other patients' bedrooms as well as pacing up and down the ward. PRN Haloperidol 10mg was given with Lorezapam which calmed him down.
- 9.43 Mr E was assessed under the Mental Health Act on 24th September 2007 when he expressed delusional thoughts and was assessed as being thought disordered. He was detained under Section 3 of the Mental Health Act.
- 9.44 Over the next week or so Mr E was very restless and destructive in behaviour, dressing and undressing, using his shirts to clean up spillages of tea and was confrontational with his approach to others. He continued to be elated and paranoid during the night. He stated that there was a ghost in his room and refused to sleep there and when reviewed by a doctor, it was noted that Mr E continued to remain agitated, sometimes shouting, dancing, banging on doors

- and windows. He had exposed himself in the communal area and did not appear to have been affected by the increase in his Lorazepam. His consultant advised that he should have a trial of Haloperidol 10mg orally and continue with his other medication.
- 9.45 On 12th October 2007, Mr E was very agitated, threatening members of staff and requiring restraint. He stated that “somebody's going to kill me” and he said that “I have begun a full bullet thing that I can kill anybody with”. He was seen to be agitated and stormed out of the room. His brother-in-law was seen by the staff and it was explained that there were two options in regard to Mr E’s future care, “a weekly injection and to have ECT treatment”, which his brother-in-law rejected.
- 9.46 The plan was to have a change of medication, to possibly transfer him to the PICU and a referral was made to the PICU for an assessment. During the late evening his behaviour became more inappropriate, he was aggressive and agitated and threatened to throw a table at a member of staff. During the night he needed to be restrained by the rapid response team and the following day was transferred to the PICU after becoming very violent.
- 9.47 He settled and was transferred back to ward A on 11th December 2007 but seven days later was transferred back to the PICU as his behaviour had become threatening and he was difficult to manage on the ward. He also tested positive for cocaine on a routine drug screen. He remained in the PICU for a few days and then transferred back to ward A.
- 9.48 On 1st January 2008 Mr E became extremely hostile and aggressive and needed to be placed in seclusion on the ward. This behaviour continued throughout the month and it was decided to try a different medication, Risperidone and reduce the Haloperidol and Zuclopenthixol.
- 9.49 In February 2008 Mr E began to make frequent abusive telephone calls to his family mainly in regard to a dispute about money. He continued to be challenging and grandiose with obvious thought disorder. He tried to strangle himself with a pair of socks when told he could not go home. Medication options were further discussed. He also drank a small amount of medicated shampoo on another occasion.
- 9.50 Mr E activated the call button in his room on 3rd March 2008 and was found with shoelaces tied around his neck. The emergency team were called and he was taken to the Royal London Hospital by ambulance for assessment. No cause for concern was found and he was returned to the PICU. He was placed on close observations, (within eyesight of a member of staff).

- 9.51 The following day he was reviewed on the PICU and plans to commence Mr E on Clozapine medication were made. He remained insightless, demanding discharge. During the rest of March 2008 he remained psychotic and on one occasion had become sexually inappropriate with a female patient. On 19th March 2008 Mr E's father became gravely ill and Mr E was escorted to the hospital to visit him. His father died later that day.
- 9.52 During April 2008 some improvement was seen in his mental state. He remained on close observations and started on Clozapine titration. He had 15 minute escorted leave with two members of staff which went well.
- 9.53 In May 2008 two drug screenings showed positive for benzodiazepines and the latter one for opiates as well. His leave was suspended.
- 9.54 During the early part of June he became calmer and was transferred to ward A on 27th June 2008. He deteriorated quickly and required rapid tranquilisation and was transferred back to the PICU the same day.
- 9.55 Mr E was transferred back to ward A on 4th July 2008. He required rapid tranquilisation twice during the month and was very challenging in his behaviour towards both staff and patients. He made threats to kill staff and was verbally and physically aggressive.
- 9.56 During August 2008 there was no real change in Mr E's mental state. He remained a challenge, making threats to shoot staff. His family reported that he was using his credit card to order expensive take away food and that they had cancelled the card. As he had calmed down it was agreed that he could have one hours accompanied leave with his sister. Whilst at her home he refused to return to the ward, ran away from the house and was brought back to the ward by the police. He remained calmer over the next few days.
- 9.57 Throughout the next two months there was little change in his mental state. He did have escorted leave and eventually, unescorted leave which went well. Over the month he did appear to be improving and appeared well-kempt and maintaining his personal care. It was agreed that he would require minimal support in the community on discharge.
- 9.58 On 20th November 2008 Mr E's care was reviewed in the ward round and it was agreed that he would be discharged to his home under the care of the Home Treatment Team and would continue to be monitored under a Community Treatment Order, (CTO).
- 9.59 A post discharge CPA meeting was held on 6th January 2009 where Mr E reported no auditory hallucinations, no paranoia was noted and that he was not suicidal

or homicidal. The plan was to continue to have weekly contact with his care coordinator, to investigate employment opportunities and for his medication to remain the same.

- 9.60 On 25th February 2009 Mr E informed staff that he intended to go to Bangladesh until May 2009. His consultant recalled him to hospital as he was in breach of his Community Treatment Order which included engagement with the Clozapine clinic two weekly. It was reiterated that Clozapine monitoring was not available in Bangladesh and that he could be endangering his health. Mr E agreed to go to Bangladesh for three weeks only from 2nd April 2009.
- 9.61 On 2nd March 2009 Mr E was recalled under his CTO and admitted to ward A at the Tower Hamlets Centre for Mental Health under Section 3 of the Mental Health Act as he was planning to go to Bangladesh in a few days time instead of at the beginning of April as previously agreed with Dr Z. He was discharged under a CTO on 5th March 2009 after agreeing to change his flight details to Bangladesh.
- 9.62 On failing to return to the UK by 6th May 2009, Dr Z wrote advising Mr E that he should return from Bangladesh to London as planned. It was pointed out that Clozapine was not available in Bangladesh and the Trust was not allowed to post it to him. He needed blood tests regularly and that he was still legally subject to Section 17A of the Mental Health Act (Community Treatment Order). By remaining in Bangladesh he would be in breach of the conditions of that order which could lead to him being recalled to hospital. Mr E was reported Absent Without Leave (AWOL) as he was still in Bangladesh. It is unclear as to whether in the circumstances this action applied as Mr E was not in the UK.
- 9.63 On 19th May 2009 Mr E's CTO expired and on 9th June 2009 he returned to the UK where he was recalled to hospital and seen on 16th June by his care coordinator and a locum consultant psychiatrist. He appeared settled in his mental state, he said he had seen a doctor whilst in Bangladesh and obtained his medication but had not had any blood tests for his Clozapine medication. This was arranged and he attended the clinic. His CTO was extended from 16th June 2009 until 19th November 2009. It is unclear as to under what grounds he was recalled to hospital as his CTO had expired.
- 9.64 An urgent CPA was arranged on 7th August 2009 as Mr E did not want to attend appointments and reported having a headache. Although his care coordinator insisted that he attend, he did not attend and it was decided to undertake a home visit. When seen, Mr E reported having headaches for the past two weeks that had now improved. It was unclear as to whether he was compliant with his medication. There was no evidence of psychotic symptoms.

- 9.65 On 25th August 2009 Mr E was admitted to ward A at the Mile End Centre for Mental Health and discharged two days later. There was then a period of non-engagement with appointments, not attending CPA reviews and he was recalled to hospital in November 2009. His Community Treatment Order was renewed. Mr E remained well until early in 2010.
- 9.66 On 16th February 2010 Mr E was referred to the Home Treatment Team to re-titrate Clozapine in the community. He was reported to have recently returned from Bangladesh, was complaining of difficulties in sleeping, poor appetite and seeing dead people. He was keen to gain access to the CMHT and to recommence Clozapine medication. An urgent assessment was requested by his GP and he was seen by his consultant and restarted on Clozapine. As the Clozapine dosage was increased Mr E became tachycardiac, (increased heart rate) with chest pain and there was a request to refer Mr E to a cardiologist.
- 9.67 On 30th March 2010 Mr E was taken to the Accident and Emergency department by his brother-in-law after an apparent deterioration in his mental state. He was recalled to hospital under the CTO process and admitted to ward A, Mile End Centre for Mental Health.
- 9.68 On 7th April 2010 Mr C, who later killed Mr E, was transferred from ward B to ward A at the Mile End Centre for Mental Health.
- 9.69 On 9th April 2010 Mr E was attacked in his bedroom by Mr C and later died of his injuries in Hospital.

10. Analysis of the Evidence – Mr E

- 10.1 Mr E's first contact with psychiatric services in January 2003 followed an attempt to jump from a first floor window. Mr E had previously been in receipt of services from the local Community Drug Team. He was admitted informally to St Clements Hospital, since closed and re-provided at the Mile End Centre for Mental Health in Tower Hamlets. Mr E remained as an inpatient until June 2003 having been admitted and treated under Sections 2 and 3 of the MHA.
- 10.2 During the first three months of his admission he remained very disturbed and agitated requiring high dosages of antipsychotic medication. He was diagnosed as having had a psychotic episode secondary to cannabis use. At the end of March 2003 he was considered well enough to have short escorted leave periods. This was extended to unescorted leave but his mental state fluctuated throughout the rest of April and May until he was discharged in June 2003 having finally responded to treatment.
- 10.3 The discharge plan was for Mr E to continue to attend clinical psychology appointments, to be referred to the Early Intervention in Psychosis Service (EIS) and for regular CPA reviews to take place. This was an appropriate discharge plan in accordance with the diagnosis of schizoaffective disorder.
- 10.4 His referral to NAFAS, the Bangladeshi drug treatment centre, in April 2003 was appropriate in regard to his known illicit substance misuse and he continued to attend the centre for several years following the initial referral.
- 10.5 Over the next two years Mr E appeared to have been well managed in the community by the EIS which included psychology sessions and regular CPA reviews. Mr E took extended trips to Bangladesh to see his wife and was compliant with his medication regime. There was no indication that he continued to abuse illicit drugs as his mental state remained relatively stable. His main concern during this time was the refusal to provide his wife with a visa to live with him in the UK.
- 10.6 During June 2006 it became apparent that he had not attended some of the appointments with the EIS and was therefore discharged from their service. He had also missed several outpatient appointments with his consultant psychiatrist, Dr W. The independent investigation panel wonder whether a more assertive approach might have been more appropriate.
- 10.7 His main concerns when seen by his care coordinator during this period were those in regard to bringing his wife to the UK and housing as he did not like his

present accommodation. He did attend an appointment with Dr W in September 2006 after not attending several previously arranged appointments. However Dr W was of the opinion that Mr E only attended this as he wanted Dr W to support his application for his wife to be allowed into the UK.

- 10.8 The independent investigation panel did not interview Dr W as it was considered the care provided to Mr E was appropriate and met his needs and did not have any implication on the death of Mr E in 2010.
- 10.9 Mr E's care was transferred to Dr Z on 18th December 2006 as he had moved out of the catchment area for Dr W when Mr C was re-housed. The transfer of care appeared to have been comprehensive and a care coordinator was allocated to Mr E from the local CMHT. However having not attended two appointments he was discharged from their service in March 2007 in accordance with the CMHT policy on non-engagement. The independent investigation panel saw no evidence that risk or the responsibilities under Section 117 of the MHA received appropriate consideration as part of the discharge process.
- 10.10 The services had no contact with Mr E until August 2007 when his mental state had apparently deteriorated and he was seen in the local Accident and Emergency department where a referral to the Home Treatment Team was made. Mr E refused to have contact with the team in keeping with what was to become a pattern of non-engagement with services. Four days later a MHA assessment was completed at his home and he was admitted to hospital under Section 2 of the MHA.
- 10.11 As seen in his previous admission in 2003 Mr E did not respond well to treatment and was placed on Section 3 of the MHA in September 2007. He remained in hospital for a period of fourteen months having been extremely disturbed at times during his admission and requiring long periods of time in the Mile End Centre for Mental Health's PICU.
- 10.12 During this admission Mr E was placed on Clozapine medication which is generally used for treatment resistant schizophrenia. Although it took several months to stabilise Mr E's mental state, by the time of his discharge in November 2008, he was calmer and had improved. He was discharged under a Community Treatment Order (CTO), which set out conditions regarding his compliance with his Clozapine medication and routine monitoring.
- 10.13 Over the next few months Mr E was recalled to hospital under the CTO four times. Three of these were in regard to his arranging to visit Bangladesh for long periods. There is concern in regard to the appropriateness of the recalls when Mr E was out of the country.

- 10.14 His final admission was as a result of him having been to Bangladesh and discontinuing his Clozapine. He had an adverse reaction following the recommencement of the medication, Clozapine, which required inpatient management and admission to ward A at the Mile End Centre for Mental Health.
- 10.15 The independent investigation panel on the whole were satisfied that Mr E had received appropriate care and treatment of his illness. The main concern was when he was discharged for non-engagement with the services without further investigation as to whether his non-engagement was caused by a deterioration of his mental state.

Clozapine Management

- 10.16 Mr E appears to have benefited significantly by treatment with Clozapine, and given his history of poor engagement with services, his care under a Community Treatment Order seems justified. The independent investigation panel heard that Mr E had been recalled to hospital on four separate occasions. On each of these occasions Mr E had booked tickets to travel to Bangladesh, and his recall was arranged specifically to thwart his wish to leave the country. The independent investigation panel accept that the lack of a robust Clozapine monitoring service in Bangladesh may well have meant that remaining in the UK was in Mr E's best interests, however, the independent investigation panel could find no clear evidence that Mr E's mental capacity in this matter was considered.

The availability of Clozapine in Bangladesh does not appear to have been an issue, but rather, the necessary blood test monitoring. In the event that Mr E were able to understand fully the risks associated with a lack of testing, accept them as true and retained the ability to weigh up the pros and cons of travel in such circumstances, then it is arguable that recall should not have taken place.

The Mental Health Act states that a Responsible Consultant may recall a patient under a Community Treatment Order for treatment if:

- a. The patient needs to receive treatment for a mental disorder in hospital.
- and
- b. There would be a risk of harm to the health and safety of the patient, or to other persons, if the patient was not recalled.

The independent investigation panel have included their comments on the inpatient service and other areas including ward A's environment in subdivision 8.

Section Three

General Issues

11. Internal Review

11.1 The following section sets out an analysis of the internal review completed by the Trust together with details of the review's recommendations and actions taken. The Terms of Reference for this independent investigation panel included a review of the Trust's internal review and set out two specific areas to examine:

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

Initial Actions

11.2 Immediately following the incident the Trust informed all of the agencies who they were required to do so, which included: -

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

11.3 An incident form was completed and followed by a 72 hour Initial Management Investigation report. A liaison meeting was held that included the police and which to a degree met the requirements of the National Memorandum of Understanding between health and the police (see subdivision 13 later in this section for further discussion on this).

11.4 The Trust's director of nursing was designated to be the contact person linking all agencies for the purpose of ensuring that communication was maintained.

11.6 The death of Mr E occurred on the 9th April 2010. The chief executive officer of the Trust commissioned an internal review which completed in September 2010. The internal review team was set up in accordance with the Department of Health Guidance "HSG (94) 27 as amended in June 2005".

The Internal Review Process

11.7 The Trust's internal review adhered to a clear set of Terms of Reference which had been determined by the Trust's chief executive and ratified by the Executive Board of Directors. These can be found at Appendix Five. NHS Tower Hamlets approved the Terms of Reference in line with NHS London's Serious Incident Management Policy.

- 11.8 The Terms of Reference, whilst covering all of the recognised areas to be examined in a serious incident, such as this one, were limited as to both individuals' care and treatment and did not extend to a detailed examination of the individuals' care and treatment throughout their contact with the Trust's services.
- 11.9 The individuals' care and treatment was only examined just prior to and during the incident itself. This is atypical of the normal process undertaken following a homicide that has occurred within an inpatient area. The process as set out in HSG (94) 27 includes the compilation of a detailed review of the individuals' care and treatment throughout their contact with psychiatric services.
- 11.10 The internal review team comprised of: -
- Chair**
 - An external Consultant Psychiatrist and Senior Clinical Advisor.
 - Team members**
 - Director of Nursing and Quality, Newham Primary Care Trust.
 - An Independent Advisor (former Deputy Chief Executive Officer/Director of Nursing, East London NHS Foundation Trust).
 - Consultant Forensic Psychiatrist and Deputy Medical Director, East London NHS Foundation Trust.
- 11.11 One review team member was from the Trust's senior management with the addition of a second member who had held a very senior post in the Trust until a few months prior to this incident. Two review team members were independent from the Trust which included the Chair who although was external had completed other work for the Trust.
- 11.12 The internal review team were supported by the Head of Corporate Administration and the Lead Nurse for Serious Incidents and Quality Assurance neither of whom were directly involved in the staff interviews, analysis or drafting of the report.
- 11.13 Not all members of the internal review team were available for each interview. In particular the Chair was unable to attend each meeting and or interview. Her place was then taken by the former senior Trust staff member who acted as the Chair. This was in part due to the timetable to complete the review and prior commitments of members of the internal review team. The staff interviews were recorded and a transcript of the interview made available to the staff for consideration. The internal review team did have access to all relevant policies of

the Trust and the clinical notes for both Mr C and Mr E from their first contact with psychiatric services.

- 11.14 The internal review undertook 28 interviews, all of which were recorded, transcribed and sent to those interviewed for comment. Statements were also provided by some staff.

Family Support

- 11.15 The internal review team met with Mr C's father and the family of Mr E. As English was not a first language for either family, interpreters were made available by the Trust.
- 11.16 Mr E's family presented a list of questions that they wished answered by the internal review team. The meetings were recorded and transcripts made available to both families for comment. The meeting with Mr E's family was also attended by family liaison police officers and for the initial part by the Trust's Chair of the Board and Medical Director.
- 11.17 The Trust's designated contact with both families was the Lead Nurse for Serious Incidents and Quality Assurance who maintained contact throughout the process. However with Mr E's family this proved difficult as they were often out of the country.

Staff Support

- 11.18 It is acknowledged that the Trust had provided support to staff and had made available a telephone helpline for staff immediately after the incident.
- 11.19 The independent investigation panel heard that staff's experience of support was variable, in particular as several members of staff were placed under disciplinary procedures with two staff members being suspended for long periods extending over several months.
- 11.20 Some staff seen by the independent investigation panel considered that the interviews conducted by the internal review team had not adhered to a "no blame" culture and consequently they had felt criticised. Some reported feeling uncomfortable with the process undertaken.

Methodology Undertaken

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

- Care delivery problems.
- Service delivery problems.
- Contributory factors.

11.22 The report makes recommendations in ten specific areas. Full details of these together with the independent investigation panel's comments can be found later in this section. The report was presented to and accepted by the Trust Board together with an action plan to implement the recommendations provided. NHS Tower Hamlets approved the final report and the action plan.

Conclusion

11.23 The internal review process was found to be robust although it was limited in its examination of the two cases, which only concentrated on the incident itself and not their prior contact with psychiatric services.

11.24 It was found that the internal review report's analysis of both patients' concordance with medication was limited as was their previous psychiatric histories and Mr E's misuse of drugs and or alcohol.

11.25 The independent investigation panel heard evidence that the internal review team's Chair was unable to attend many of the meetings held due to prior commitments. This was unfortunate and the independent investigation panel consider that the interviews should have been arranged around the Chair's availability.

11.26 In the absence of the Chair the former Deputy Chief Executive/ Director of Nursing acted in her place. It was considered that this had advantages and disadvantages to the internal review.

11.27 The advantages: -

- Familiarity with the Trust, its structure and service provision.
- Being known by staff members and perhaps still having the authority to access the information required.

11.28 The disadvantages included the following issues: -

- Some staff described feeling intimidated when interviewed by their former Director of Nursing.
- Concerns in relation to transparency in providing evidence as the former Director of Nursing had overseen and initiated nursing practice standards which were then under investigation.

11.29 The independent investigation panel are of the view that the presence of the former Director of Nursing on the internal review constituted a potential conflict of interest and could have led to thoughts of bias being aimed at the internal review team.

11.30 A tabular format setting out the internal review’s recommendations and actions together with the independent investigation panel’s view and, in some cases, additional recommendations, can be found below. The first four rows are taken directly from the internal review report’s section on recommendations.

Internal Review Recommendations

Recommendation One	The Trust must strengthen the nursing leadership resource available on a day to day basis in the Tower Hamlets Centre for Mental Health, until it can assure itself that all performance issues identified in this report are dealt with. The Trust is advised that it must deal with the individual performance issues identified in the report promptly.
Action taken by the Agencies	Improved nursing leadership at the Tower Hamlets Centre for Mental Health.
Timescale	April-October 2010.
Progress	Action identified by Trust/completed.
Independent Investigation Panel Comment:	
<p><i>The independent investigation panel supported the Trust’s plan to increase nursing leadership on the inpatient wards by reducing the number of areas that the modern matron had responsibility for. The Trust had previously changed the name and role of the ward manager to that of practice innovation nurse. This appears to have created a general confusion across the Trust as to the areas of responsibility and accountability for each role. The independent investigation panel remain confused as to who is responsible for managing the ward. For the independent investigation panel’s recommendation see the Section Four Findings and Recommendations.</i></p>	

Recommendation Two	Issues were raised about the performance of four members of trained nursing staff on ward A. For the purposes of maintaining staff confidentiality the details in regard to them have been
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	deleted.
Action taken by the Agencies	Performance reviews have been carried out in relation to ward A's nursing staff identified in the report. Changes to staffing arrangements have been made following the outcome of the performance reviews.
Timescale	30 th May 2010.
Progress	Performance issues referred to Human Resources process. Changes to staffing arrangements put in place.
Independent Investigation Panel Comment:	
<p><i>The independent investigation panel have concerns with regard to the length of time that the disciplinary process took and the variable support provided to the staff. The independent investigation panel were surprised that the process had not resulted in definitive action and mediation. In certain cases the independent investigation panel were unclear as to the Human Resources policies being implemented and some decisions appeared to be made without due process.</i></p>	

Recommendation Three	<p>The Trust should consider carefully their Human Resources and nursing performance management processes to ensure they are well linked with appropriate systems in place, to ensure that no ward or team in the Trust has a disproportionate number of staff whose performance issues are being investigated.</p> <p>The Human Resources department must continue to support the modern matron and other staff in resolving performance issues including what to do if a member of staff does not meet the required standards of passing their preceptorship. The Trust must ensure that the Human Resources department understands and links learning and performance issues arising from different incidents.</p> <p>The Trust should ensure that current nursing staff on ward A including the modern matron have sufficient support, capacity and resources to undertake all the current performance issues.</p>
Action taken by the Agencies	<p>a) Early warning of Human Resources issues that may affect clinical care.</p> <p>b) Human Resources reports to Directorate Management Teams include analysis of all capability and disciplinary issues within the directorate.</p> <p>c) National Patient Safety Agency Incident Decision Tree to be implemented.</p>

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	<p>d) Modern matron seconded to ward A following the incident to be based on the ward on a full-time basis until a permanent PIN is appointed.</p> <p>e) Improved monitoring of preceptorship programme.</p>
Timescale	<p>a) & b) In place 30th November 2010.</p> <p>d) 19th April 2010.</p> <p>c) & e) 30th November 2010.</p>
Progress	<p>Completed, Incident Decision Tree shared with Human Resources managers.</p> <p>Paper submitted to February 2011 Quality Committee. Training session to take place February 2011. Action identified by the Trust completed.</p>
<p>Independent Investigation Panel Comment:</p> <p><i>The independent investigation panel support the recommendation. They would have more confidence in the outcome if the Trust's disciplinary process was reviewed in relation to clarity of information to staff and a timely consistent approach.</i></p>	

Recommendation Four	<p>The Trust should consider the impact of the no smoking policy on the nursing numbers on wards that do not have direct access to a garden area. In addition, practices such as the "shop round" should be reviewed as these too take away staff from direct patient contact.</p>
Action taken by the Agencies	<p>a) The Trust has increased staffing on each adult acute ward (1 x HCA, Monday-Friday 09.00 hrs to 17.00 hrs) across the Trust as an interim measure until such time as a formal review of staffing resources takes place.</p> <p>b) Shop "round" to be discontinued by 31st August 2010.</p> <p>c) Proposals for use of smoking platforms to be developed.</p>
Timescale	<p>a) 31st May 2010.</p> <p>b) 31st August 2010.</p> <p>c) 31st October 2010.</p>
Progress	<p>Actions identified by the Trust completed.</p>

Independent Investigation Panel Comment:

The independent investigation panel endorse this recommendation and acknowledge that the Trust has had smoking balconies built on the rear of the wards situated on the first floor and accessed by the day room area at the Mile End Centre for Mental Health.

Recommendation Five	<p>A risk assessment of the ward A's environment should be undertaken immediately. This assessment should consider:</p> <ul style="list-style-type: none"> • The nature of the physical environment including the visibility in different areas. • The nature of the client group including fluctuations in risk of limited access at times to PICU beds. • The nursing numbers and skill mix. <p>The purpose of such a risk assessment is to ensure that the needs of the client can be met within that environment with the staffing levels and competencies.</p>
Action taken by the Agencies	Risk assessment completed and any actions addressed
Timescale	Report submitted to Inpatient Project Board: 31 st October 2010.
Progress	

Independent Investigation Panel Comment:

The independent investigation panel endorse this recommendation and furthermore request that the Trust considers implementing single sex wards. See recommendation twelve made by the independent investigation panel in Section Four.

Recommendation Six	<p>The Trust must urgently review the number of beds available for Tower Hamlets patients who may need intensive care or longer stay Low Secure care. The acute wards in Tower Hamlets are sometimes left managing patients who should have access to PICU beds, but their transfer is delayed and can often only happen by swapping with other patients who still are unsettled and unwell.</p>
Action taken by the Agencies	<p>PICU's to be viewed as a Trust wide resource accessible to all directorates.</p> <p>Review of PICU capacity to be undertaken.</p> <p>Resource requirements to fund additional capacity to be submitted to NHS Tower Hamlets.</p>

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Timescale	<ul style="list-style-type: none"> a) 16th April 2010. b) 30th June 2010. c) 31st July 2010.
Progress	<ul style="list-style-type: none"> a) Action identified by Trust/completed. b) Action identified by Trust/completed. b) The Trust has male PICU beds in all 3 localities (Tower Hamlets, Newham and City and Hackney) which are accessible to all directorates across the Trust. c) Action identified by Trust completed.
<p>Independent Investigation Panel Comment:</p> <p><i>The independent investigation panel support this recommendation.</i></p>	

Recommendation Seven	<p>The Home Treatment Team must review the operational policy and ensure that a system is developed that enables referrers to know if their referral is accepted, what action will be taken and what the outcome of the intervention will be. This should be documented in the Home Treatment Team records and a copy made available for the clinical records.</p> <p>The referral system should be monitored within the team on a regular and systematic basis, to ensure that referrals are being processed in accordance with the operational policy.</p>
Action taken by the Agencies	<ul style="list-style-type: none"> a) Alert sent to all Home Treatment Teams to ensure that referral procedures are robust and followed in practice. b) Details of all referrals to be reported to team meetings. c) Improved monitoring of referral processes. d) Overall functioning of the Home Treatment Teams to be reviewed. e) Trust Quality Committee to consider referral processes within all community services.
Timescale	<ul style="list-style-type: none"> a) 30th April 2010. b) 3rd July 2010. c), d) & e) 31st July 2010.
Progress	<ul style="list-style-type: none"> a) Action identified by Trust completed. b) Action identified by Trust completed. c), d) & e) Review completed 1st October 2010. Revised operational

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	<p>policy agreed 28th October 2010. Paper submitted to December Quality Committee. Proposal to develop electronic referral system agreed and implementation to be taken forward by Electronic Systems Project Board.</p>
<p>Independent Investigation Panel Comment:</p> <p><i>The independent investigation panel support this recommendation. A further recommendation can be found in Section Four, subdivision 15.</i></p>	

Recommendation Eight	The availability of interpreters for everyday management of service users should be reviewed by the Trust, as a high percentage of Tower Hamlet service users are Bengali speakers.
Action taken by the Agencies	Review of bi-lingual staff completed. Bi-lingual support workers to be recruited.
Timescale	31 st July 2010. Recruitment process commenced: 11 th October 2010. Completed: 1 st January 2011.
Progress	Action identified by Trust/completed Eight support workers recruited and in post
<p>Independent Investigation Panel Comment:</p> <p><i>The independent investigation panel support this recommendation. A further recommendation can be found in Section Four, Findings and Recommendations.</i></p>	

Recommendation Nine	The Trust should assure itself that all staff on ward A are up to date with their Equality and Diversity training, and the training reflects the specific diversity of the population that the Trust serves, as assumptions were made that Mr E and Mr C were quoting passages from the Koran. Mr C was a Muslim, Mr E a Hindu. Nursing and medical staff involved in this incident should receive vulnerable adult training.
Action taken by the Agencies	Training session for Ward A staff to be carried out. (NB Equality & Diversity training already a mandatory course for all staff). Training session for relevant the Mile End Centre for Mental Health

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	staff to be carried out Training session for ward A staff to be carried out. (NB Safeguarding adults training already a mandatory course for all staff).
Timescale	31 st October 2010.
Progress	Completed. Included in reflective practice sessions held on each ward by borough lead nurse.
Independent Investigation Panel Comment: <i>The independent investigation panel support this recommendation.</i>	

Recommendation Ten	The operational policy of the Home Treatment Team should be reviewed (see above). The Trust must clarify on every off duty rota who is in charge of each and every shift across the Trust and ensure that that person is competent.
Action taken by the Agencies	Not completed by the Trust.
Timescale	Not completed by the Trust.
Progress	Not completed by the Trust.
Independent Investigation Panel Comment: <i>The independent investigation panel support this recommendation.</i>	

12. National Patient Safety Agency Review

- 12.1 Following the incident on ward A the Trust commissioned in August 2010 a separate review of the internal inquiry reports completed over the previous few months at the request of the chief executive. This was initiated as a direct result of the homicide that took place on ward A.
- 12.2 There had also been a suicide on the same ward A and a serious incident which resulted in a member of staff being injured on another ward. The review was undertaken by the medical director of the National Patient Safety Agency (NPSA) and two senior managers, one internal to the Trust and one external.
- 12.3 The panel undertook a desktop review of the internal inquiry reports completed on the aforementioned three cases. The review also did a comparative review of similar Trusts and identified that in North London the Trust was the lowest incident reporting Mental Health Trust. It has been found nationally that there is a correlation between being a low incident reporting Trust and a negative safety culture.
- 12.4 In addition the review also took account of the staff survey undertaken by the Care Quality Commission (CQC) which found that the Trust was in the lowest 20% in regard to "Fairness and effectiveness of incident reporting procedures".
- 12.5 The panel examined a number of recent CQC reports on visits made to the Mile End Centre for Mental Health site and identified recurring themes which also formed part of the Trust's internal investigation into the death on ward A.
- 12.6 A comparison was also completed in regard to the progress made against the internal review recommendations within the action plan developed by the Trust.
- 12.7 The review concluded that the following areas needed additional consideration by the Trust to improve their service provision:-
- Organisational cultures, in particular related to patient safety and the low reporting of incidents across the Trust.
 - Clinical leadership and governance procedures.
 - Environment and ward design were identified as being of concern, Mile End Centre for Mental Health was of significant concern.
 - Nursing leadership - acknowledgement was made of the strengthening of nursing across the Trust since the incident on ward A.
 - Multidisciplinary responsibilities and accountability in regard to clinical decision-making.

- Engagement, cultural competence and the language/communication needs of service users.
- Use of the observation policy and adherence to it.

12.8 The independent investigation panel agree with these recommendations and understand that the Trust has put together an action plan in regard to these issues. It was agreed that the review was outside the Terms of Reference for the independent investigation so a detailed analysis of the outcome from the review has not been undertaken.

13. Police and NHS Trust Liaison

- 13.1 During the course of the Homicide Investigation into the death of Mr E the independent investigation panel heard evidence from both the Trust and the police that they were satisfied with the help and co-operation they had received from each other. However, there are some points to be made about the way that the two organisations co-operated and the lack of adherence to the agreed *ACPO/DofH/HSE 'Memorandum on Investigating Patient Safety Incidents'*, (Memorandum), which sets out a detailed procedure on how health and the police services should respond after a death such as Mr E's in an inpatient service.
- 13.2 It recommends that an Incident Co-ordinating Group (ICG) should be convened and attended by all parties concerned from the services involved in the incident. A strategy group was held on 12th April 2010 three days after the death of Mr E on 9th April 2010. The meeting, named the 'Police Liaison Meeting' in its minutes, was attended by senior members of the NHS Trust management and senior police officers assigned to investigate the murder of Mr E. The agenda for this meeting appears to have two items upon it. These were, 'Introductions and Apologies' and secondly 'Discussion'. This lack of a structured agenda, and the lack of use of the title 'ICG' indicated to the independent investigation panel that neither the police nor the NHS Trust actually followed the guidelines set out in the Memorandum of Understanding, if indeed they knew of their existence.
- 13.3 The independent investigation panel consider that due to the very unusual circumstances of the case, this meeting could have been held earlier. An emergency meeting of this kind, in order to plan strategy could well have been convened on Saturday 10th April 2010, although under the circumstances, and considering that the incident took place on a Friday evening, it is understandable as to why there was the delay. However had this happened more expeditiously, with a proper agenda worked to as recommended by the Memorandum, then some of the difficulties the Trust and the police faced later in terms of complaints from the two families, may well have been resolved at an early stage. The complaints mainly related to lack of information about their sons' whereabouts and condition.
- 13.4 The 'Police Liaison Meeting' took place at 15.00 hours on April 12th 2010 that followed a meeting of the 'Serious Incident Panel' of the Trust which had been held earlier that day at 10.00 hours. The agendas for the two meetings that day show a marked contrast, with the Trust's meeting following a 'Standing Orders' type agenda. This ensured that previous experience and advice in these cases was actually followed. Items such as the contact with the family were discussed as part of the agenda. The Police Liaison Minutes show clearly that the Trust

- themselves were keen to offer condolences to the family of Mr E. This was discussed as an item. However, the issue of keeping Mr C's family informed was not really discussed and should have been, arranging a strategy for information to be given to his family as well as that of Mr C.
- 13.5 There may well have been some information from the families that the NHS staff could have given regarding any community knowledge they had picked up. This would have been the forum to bring this up at. Such information could well have informed the police 'Community Impact Assessment' and helped to reduce potential tensions in the Bangladeshi community following the death of Mr E. The independent investigation panel are not sure that any real discussion on any potential community impact took place between the two bodies, both of which would have had a local workforce who may have contributed to information about the community.
- 13.6 The lack of meaningful discussion between the police and Trust at this stage led to the family of Mr C being left with little information about their son, and their subsequent anger at the lack of information they initially had. Section 8 of the Memorandum says that a 'Communications Strategy' should be agreed for dealing with "clients and relatives". This was not done to best effect by either organisation at this time.
- 13.7 Another suggested issue for the ICG in these cases is the agreement of a media strategy between the two organisations. The independent investigation panel saw no evidence that such a strategy was agreed upon at this time and were surprised to see that only one ICG type meeting seems to have been held throughout the police investigation.
- 13.8 At the very least, in accordance with the Memorandum, a meeting of the ICG should have taken place at the very end of the investigation. The independent investigation panel found no evidence that such a meeting of the ICG had taken place.
- 13.9 In terms of training for these types of investigation the independent investigation panel heard that the senior investigating officer had received no training in the investigation of cases in a mental health setting and had relied upon his standard knowledge of investigations. It is hardly surprising therefore that police involved in the investigation were themselves somewhat unaware of the provisions and help that could have been given by using the Memorandum.
- 13.10 The independent investigation panel heard that quarterly liaison meetings take place between the Trust and local police which has proved to be helpful in sharing information and improving relationships between the two organisations.

14. Police Involvement in the Notification of the Families

- 14.1 The Trust's internal review report into the death of Mr E highlights the confusing aftermath of the circumstances surrounding informing his family of his death. In terms of notifying the family of Mr E a member of his family told the internal review team that he had telephoned ward A late on 9th April 2010. This he says was after he was contacted by police to say that '...an incident had happened'.
- 14.2 The independent investigation panel heard about the notification of the death of Mr E to his family. A senior police officer in the case informed the independent investigation panel that a 'Death Message' had been delivered to the family of Mr E late on the night of 9th April 2010. This meant that an officer from Tower Hamlets borough police was sent to the address of Mr E's family at 23.15 hours that night. The officer delivered the information to the family that Mr E had in fact died in hospital earlier that night. Additionally, a family liaison officer (FLO) working with the Homicide Advisory Team deployed to ward A that night was sent to the family home of Mr E to liaise with and give information to the family. This was logged at 22.20 hours on the police records.
- 14.3 The independent investigation panel are satisfied that the family of Mr E were informed of his death on the night of 9th April 2010 by the police. However, it is understandable that the family were both shocked and confused about the information they had been given. It was reasonable therefore that they telephoned ward A for an explanation of what had happened to cause the death of Mr E.
- 14.4 With respect to Mr C his family were not told for some time that he had been arrested on suspicion of attempted murder and had been taken to the police station. A senior police officer informed the independent investigation panel that "the Metropolitan Police did not take immediate steps to notify the family of his arrest". The police officer thought that in hindsight this was "wrong".
- 14.5 The independent investigation panel heard that when suspects are arrested for offences, particularly serious ones such as attempted murder, there are often legitimate reasons for police to delay notification of a person's arrest. Vital evidence at crime scenes can be lost or tampered with if early notification of an arrest is given. However, in the circumstances of this case this factor was not an issue and the senior officer was open and forthright in his view that he felt that police could have notified the family of Mr C of his arrest at an earlier stage.
- 14.6 The independent investigation panel suggested to the police that in this case it may well have been expedient for the police to send a family liaison officer to

work with Mr C's family for an initial and short term period. This is of course not police policy, but due to the exceptional circumstances surrounding the case and the mental state of Mr C at the time this may have been useful on a very short term basis. This would have helped in passing on information to the family of Mr C and avoided any complaint that they had subsequently about the lack of information about the welfare and condition of their son. The family should have been able to receive information about their son that would have allowed them to make informed decisions about legal matters at an early stage.

- 14.7 The senior police officer in the case agreed with the panel that this type of deployment for a FLO, though unusual, may well have had some merit in this particular case, bearing in mind the mental health of the suspect.

Section Four

Findings and Recommendations

15. Findings and Recommendations

- 15.1 The following section sets out the independent investigation panel's findings and recommendations that have been identified in response to the evidence, both oral and written, that has been presented to them. The recommendations have been completed for the purpose of learning lessons and for the Trust to put into progress any actions required to prevent a similar occurrence happening again in their service. It also sets out areas where the independent investigation panel identified notable practice.
- 15.2 The independent investigation panel were impressed with the improvements that had been made by the Trust since the death of Mr E. It was clear that the shock following the incident reverberated throughout the Trust and extended to their commissioning organisations.
- 15.3 Service change can be quite a challenge and the Trust appears to have risen to this, assessed what needed to be done and responded in a timely manner. Reviewing the staff culture and supervision has become a priority and the independent investigation panel acknowledge the ongoing review that is taking place across all services. However as with all large organisations these changes do not happen overnight and it is acknowledged that there is still more to be done.
- 15.4 The independent investigation panel heard evidence from the Trust's commissioners that the quality of the services being provided in 2012 were improved compared with those in 2010. The independent investigation panel welcomed the commitment and determination by those responsible for implementing the service developments.

Notable Practice

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

Communication – Mr C

- 15.6 The independent investigation panel heard that a number of the patients accessing services at the Mile End Centre for Mental Health came from the Bengali community. Many did not have a clear understanding of the English

language which created difficulties in communicating with them, in particular regarding medication regimes.

- 15.7 It was noted that Dr M, (Mr C's consultant psychiatrist), had learnt key phrases in Sylheti, which assisted him in communicating with his Bengali patients, if an interpreter was not available. This was considered as responding to the need in Dr M's patient base and must have enabled better relationships between the consultant psychiatrist and patient.

Family Support – Mr C

- 15.8 There were some concerns raised in regard to the support that had been provided to the families of both Mr C and Mr E that are dealt with later in this section.
- 15.9 However the independent investigation panel were pleased to note the conscientiousness of Dr P, (Mr C's consultant adolescent psychiatrist), who made a determined effort to visit and provide support to Mr C's family after the death of Mr E. Her ability to communicate with the family was extremely helpful under the circumstances even though Mr C had been transferred to adult services in July 2008.

Transition between Services – Mr C

- 15.10 The independent investigation panel were impressed with the standard of the transition between the adolescent and adult psychiatric services once Mr C reached 18 years old. In particular this applies to the action taken by the family therapist who was covering for Mr C's care coordinator whilst they were on leave.
- 15.11 The transition followed good practice guidelines in that a nine month transfer period took place with the adult services slowly taking on responsibility for Mr C's care. In addition Mr C's family were involved in the process and Mr C's language needs were acknowledged. The member of staff was able to relate to the differences of patient experiences when transferring to adult services and how this affects not only the individual but also their family who may have been very involved in that person's care prior to transfer.

Management Ward Visits

- 15.12 The independent investigation panel were informed of an initiative that has been instigated by the medical director and director of nursing to undertake unplanned visits to individual inpatient services across the Trust. This has provided an opportunity for those areas that require additional attention to be

identified and dealt with. These visits are to be commended and the intention to extend these visits to other service areas is welcomed.

Findings and Recommendations

- 15.13 The following findings and recommendations are made to assist the Trust in furthering and improving the quality of their services. The recommendations have not been set out in priority order and relate to not only the Trust, and the service that they provide, but also to the local police service. Each recommendation has been set out in relation to the two individuals. They identify to which particular service or organisation the recommendation relates.

Communications

Communication – Mr C

- 15.14 The independent investigation panel heard a great deal of evidence in regard to Mr C's poor command of the English language. This would have created difficulties in ensuring that Mr C understood the treatment that he was being provided with. It is acknowledged that the lack of understanding and communicating in both individuals' native language might have contributed to the situation whereby Mr C was apparently deliberately intimidating Mr E. Staff were powerless to understand exactly what was occurring between the two men and therefore were unable to intervene meaningfully in the situation.
- 15.15 A full analysis of risk and management will necessarily include a comprehensive assessment of a patient's mental state and can not be completed without being able to communicate effectively with the patient. This in particular applies to someone who has limited command of the English language.
- 15.16 The independent investigation panel found that the Trust did fund and provide interpreting services particularly for ward rounds and patient CPA reviews. Staff indicated that they never had a problem with having agreement to gain access to interpreting services from their managers. However it was sometimes the case that staff omitted to request an interpreter or the interpreting services were unable to provide a service for the requested time or venue. The independent investigation panel do wonder whether the use of an interpreter was addressing staff needs rather than patient needs.
- 15.17 During Mr C's management in the community it appears that an interpreter was only used for CPA reviews.

- 15.18 The Trust has implemented a recruitment drive to employ more staff who are able to communicate with their culturally diverse patient population. In the case of Mr C, evidence was provided that on his admission to ward B in June 2010 staff had not arranged an interpreter for the consultant led ward round. As indicated earlier Dr M was able to communicate in a limited way with Mr C but this was not ideal.

Recommendation One

It is recommended that the Trust considers setting up their own interpreting services which could include those staff already employed to provide this additional expertise. It may be advantageous to involve other local Mental Health Trusts in this initiative.

Home Treatment Team

- 15.19 The independent investigation panel found that the Home Treatment Team did not respond adequately to the request for an assessment of Mr C's mental state in April 2010. Additionally Dr M, (Mr C's consultant psychiatrist), was not informed that the requested assessment had not taken place. We are of the opinion that communication was poor and that the Home Treatment Team failed in their responsibility to inform Mr C's consultant of the actions that had not been taken.

Recommendation Two

It is recommended that when a referral is made to the Home Treatment Team that the referrer is informed of the actions taken within 24 hours and that these are documented in the relevant patient records.

Recommendation Three

It is recommended that if a referral for an assessment is made to the Home Treatment Team then either a comprehensive assessment is undertaken or the reasons why not are communicated to the referrer and documented in the patient's record within 24 hours.

Nursing Handover of Mr C's Transfer to Ward A

- 15.20 The independent investigation panel heard evidence that the handover and communication in regard to Mr C's transfer from ward B to ward A was of poor quality. Information relating to Mr C's care was not communicated and adequate time and attention to the transfer of information regarding Mr C's care and treatment not given and neither was it conducted in a professional manner

by the nursing staff. The importance of a good handover in regard to a patient transfer was not recognised by the staff involved.

The independent investigation panel have been informed that a protocol is being developed in regard to the transfer of patients.

Recommendation Four

It is recommended that all transfers of patients should follow a comprehensive protocol that sets out a checklist that is audited on a regular basis to include:

- ***Risk analysis and management.***
- ***Level of Observations.***
- ***Management Plan.***
- ***Physical Health.***
- ***Medication Concordance History.***
- ***Allocation of Primary Nurse Role.***
- ***Diagnosis.***
- ***Health care needs.***

Nursing Staff Handover and Communication

- 15.21 The independent investigation panel heard that the nursing staff, particularly those working on ward A, were arriving on duty at different times. This appeared to be in relation to agency staff who would cover for the ward during busy periods. It is acknowledged that staff arriving at differing times on a ward present a challenge in relation to ensuring that a comprehensive handover takes place and that staff are aware of the risks associated with patients and any activities that would be taking place. Evidence was seen that this did not take place on ward A during the period of Mr C's admission to the ward.
- 15.22 It was also reported that routinely healthcare assistants did not participate in the handover process and this was of particular concern when considering that they undertook most of the patient observation processes. On the day of Mr E's death there was evidence to suggest that only one member of staff on the afternoon shift had been given a handover of the patients on the ward which was not then shared with the other staff on duty.

Recommendation Five

It is recommended that the Trust devises a system whereby key information about patients is communicated to all staff on duty at any given time and that this follows a standardised, structured and documented process.

Observation Levels

- 15.23 It was found that the observation policy was not followed in the case of Mr C on ward A following his transfer from ward B. The action plan produced by the Trust after the death of Mr E shows that the observation policy itself was to be reinforced and the system audited. Despite this fact the independent investigation panel were told that a 'drop in' audit of one ward after the death of Mr E revealed that observations were still not being carried out and a nurse was removed from their duties as a result of the audit.
- 15.24 There were several factors that impinged upon the fact that Mr C was not properly observed during the time he was on ward A. These were:
- The poor handover and communication of his observation status on transfer from ward B to ward A on 7th April 2010.
 - The lack of robust systems for the documentation and supervision of the observation procedure at that time.
 - The lax culture of undertaking patient observations and recording on the ward at the time.
 - The lack of clarity in terms of management of the ward on the 9th April 2010 and the absence of a senior nurse to ensure that the observation procedure was being completed correctly.

Recommendation Six

It is recommended that the Trust further review their observation policy to include supervision of the person conducting observations and changing the format of their observation form to ensure that:

- ***Clarity in regard to observation responsibility is added and staff responsible for the agreed tasks are identified and documented on the form.***
- ***A robust competency framework is implemented for measuring the ability of nursing staff to carry out this intervention safely.***

- *A senior member of staff agrees and approves that the observations have been completed and signs the form appropriately.*
 - *That qualified nursing staff undertake a minimum of one third of the observations within a shift.*
-

Roles and Responsibilities

- 15.25 The independent investigation panel found that there was a degree of confusion in regard to the roles and responsibilities of the modern matron and practice innovation nurse, both of whom have a senior management role to undertake on ward A. This was reiterated both by senior management of the Trust, nursing and medical staff and those employed in the actual posts.

Recommendation Seven

It is recommended that there is a review of the job descriptions of the modern matron and practice innovation nurse that clarifies the individual roles and allocates different responsibilities within each. In addition the Trust should consider reverting back to the title of ward manager for one of these roles.

Competency and Skill Mix

- 15.26 The independent investigation panel saw evidence that some nursing staff on ward A were undertaking tasks that were above their individual level of competence. It remained unclear as to how staff are able to function safely within their respective roles. Evidence was heard that regular supervision, appraisal and reflection are now in place which is reassuring.

Recommendation Eight

It is recommended that the Trust develops and implements an Objective Structured Clinical Examination (OSCE) framework for the assessment of particular competencies such as observations, medical devices, physical health and medication administration. The further development of Reflective Practice Groups should also be considered.

Medical Leadership

- 15.27 The independent investigation panel found that there was not a clear structure in regard to medical leadership. The Trust has since developed clinical leads on

each ward who take responsibility for reporting up through the Trust medical structure any concerns regarding the inpatient services. However it appears that these posts are not consistently filled and that many consultant psychiatrists are reluctant to undertake this additional work without remuneration.

- 15.28 Evidence was provided that prior to the death of Mr E a number of issues of concern in regard to nursing practice on ward A had been escalated by email to the clinical director. This did not appear to have resulted in any action being taken although it is acknowledged that the email was received and noted.

Recommendation Nine

It is recommended that the Trust reviews its clinical lead process on each ward and sets out a clear structure of responsibilities and the procedure to report concerns through the Trust's governance system. All concerns should be documented, with agreed outcomes and the process to achieve these monitored and reported back to the relevant professionals/service areas.

Medical Functional Team Model

- 15.29 The independent investigation panel were informed that a "functional team model" whereby inpatient wards were managed by a single consultant had been considered by the Trust and found lacking. Evidence heard by the independent investigation panel suggested that the main opposition to this model came from the consultant body who favoured the existing model which was seen to provide greater continuity of care. However this has an impact on nursing time within the inpatient service. For example there were four ward rounds a week held on ward A by four different consultants which involved a great deal of preparation and took at least one qualified nurse away from direct care for up to three-four hours on each of these days. The current model can often be seen as detrimental to multi-disciplinary working.
- 15.30 The independent investigation panel understand that the Trust have commenced a pilot functional team model in Hackney and welcome this initiative.

Recommendation Ten

It is recommended that the Trust gives serious consideration to the implementation of a Functional Team Model by discussing the process with their colleagues in neighbouring Trusts, medical professional bodies and their own consultant body. The opinion of other professionals such as nursing should also be sought and evaluation of the pilot model in Hackney undertaken.

Risk Management

- 15.31 The incident that took place on 9th April 2010 and the environment in which it happened has raised several concerns for the independent investigation panel. The nurse who found Mr E raised the alarm by activating their personal alarm after having encountered Mr C in the corridor who had just viciously attacked Mr E causing fatal injuries. Very little has been mentioned about the risk to this member of staff who was on her own in the male corridor undertaking close observations on another patient who was very disturbed.
- 15.32 The independent investigation panel did note that the Trust has installed alarms in patient bedrooms since the incident and welcome this action.

Single Sex Wards

- 15.33 Ward A is a mixed sex ward and the potential vulnerability of the female patients also raises concerns. The independent investigation panel were not satisfied that the present system provides single sex areas which are fit for purpose. The layout of the wards at the Mile End Centre for Mental Health dictates that both sexes will be in close proximity at all times.

Recommendation Eleven

It is recommended that serious consideration is given by the Trust to develop and implement single sex inpatient services.

Incident Reporting

- 15.34 Mr E sustained an injury to his face and mouth two days before his death when Mr C was observed kicking him in the face. No one contacted the police although a nurse did state that she had tried to telephone the police liaison officer to ask their advice as to what to do but could not get hold of them. So the attack was not reported either, via the Trust's serious incident process, or to the local police. The ward staff did not complete an incident form in regard to the injury to a patient.
- 15.35 Such a lack of communication was certainly unfortunate in light of future events. It appeared that a culture of acceptance of minor assaults was perceived to be in existence at this time on ward A. It was not surprising to learn therefore that this assault on Mr E was not followed up in terms of investigation and action.
- 15.36 The independent investigation panel were told by one nurse that a culture of asking "How serious does it have to be before we call the police about an incident", had grown up amongst staff on ward A. This referred to assaults on

staff as well as patient on patient assaults it seems. This may explain the reason why this particular assault was not investigated and followed up appropriately.

- 15.37 The independent Investigation panel firmly believes that the assault on Mr E should have been followed up and were pleased to hear evidence that the situation with regard to reporting incidents on ward A has improved since 2010. However, it seems that it was not only the staff on the ward who left incidents un-investigated. One nurse gave evidence that the attitude of some of the less experienced police officers in particular who attended the ward in response to reports of incidents, left a lot to be desired. It was reported that the perception was “this happens in mental health services”.

Recommendation Twelve

It is recommended that the Trust and their local police force should agree the criteria and level of service that can be provided to the Trust in terms of on-call and out of hours support to Trust members of staff when an assault on either another patient or member of staff has occurred. In addition the organisations should also ensure that proper training is given to those officers likely to be asked to attend incidents at the Trust.

Police Input to the Trust and Incident Investigation

- 15.38 The independent investigation panel have no doubts that the investigation of the death of Mr E was well carried out by the police. However, it is sad to see that the enormous amount of work that obviously went into the production of a protocol, or National Memorandum of Understanding for dealing with such cases more efficiently, was not used by either the Trust, or the police themselves. The National Memorandum of Understanding provides guidance on the process that needs to be taken following an incident such as that discussed in this report. This guidance includes:

- Advice on the process to be set up, such as an incident coordinating group.
- Example agendas for managing meetings.
- Liaison and support to families.
- Establishing communication strategies between statutory organisations and the media.

Recommendation Thirteen

It is recommended that any future incidents of this type and subsequent police investigation should be conducted under the auspices of the National Memorandum of Understanding and that the Trust ensures that the National Memorandum of Understanding is attached as a standard Appendix to their Serious Incident Policy and included in staff training into the use of the policy.

Ward Environment

- 15.39 The independent investigation panel had an opportunity to visit ward A and meet some of the patients and staff there. They were also able to see where the incident happened. Whilst it is acknowledged that the Trust has made essential alterations to the ward including relocating the nurses station there are still concerns in regard to the narrow corridors within the patient bedroom areas. All bedroom doors in the Tower Hamlets Centre for Mental Health have anti-barricade devices installed in the door frames. These are large metal buttons that are depressed to enable the door to swing outwards. There is a reset button which, when pressed, extends the button out and acts as a stop meaning the door can only swing open into the bedroom. If these are not reset as they should be, then the doors will be able to swing in both directions, creating a potential hazard in the corridor.

Recommendation Fourteen

It is recommended that the Trust liaise with their designated fire safety officers and estates department to undertake an environmental risk assessment in order to ascertain whether it would be feasible to alter the opening mechanisms of the bedroom doors on ward A, and to provide the Trust with an assurance that the exit routes from the bedroom area are adequate in the event of a fire.

In Conclusion

- 15.40 The independent investigation panel debated the issue of whether Mr E's death was predictable or preventable. We came to the conclusion that Mr E's death was not predictable and that no one action alone would have made the event preventable. However, it would have been preventable if all or several of the following measures had been taken:

- Mr C had been assessed under the Mental Health Act and admitted to hospital on 1st April 2010 before his mental state had deteriorated further.
- Mr C transferred to the PICU at the Mile End Centre for Mental Health on 7th April following the altercation with other patients on ward B instead of being transferred to ward A.
- Mr C being placed on 15 minute nursing observations on arrival on ward A.
- A comprehensive handover completed by ward B to ward A staff in regard to the risk posed to others.
- The use of the available interpreting services to understand what was going on between the two men, and the content of their conversation.
- The nurse undertaking close observations two doors away from Mr E's bedroom had actually heard the attack and was able to summon help to stop it continuing.

Timeline of Events – Mr C

Appendix One

Contact with Psychiatric Services

Mr C first presented to the local psychiatric services provided by East London NHS Foundation Trust in December 2006. Unconfirmed reports state that there may have been a hospitalisation for mental illness prior to the family moving to the UK.

Date	Relevant Chronology
09.12.2006	<p>Mr C was taken to the Accident and Emergency department at the Royal London Hospital by ambulance accompanied by the police. He was admitted as an inpatient under Section 3 of the MHA to the PICU at the Coborn Centre for Adolescent Mental Health. His family had noticed a change in his behaviour, he was aggressive, had an increase in religious beliefs and was having difficulty in sleeping. It was also reported that he thought he had special powers and that voices were telling him to pray and fast.</p> <p>On admission Mr C appeared over active and disinhibited, attempting to touch and kiss the female nurses' hands. He was rambling and thought disordered focusing on religious themes. Mr C was convinced he had special powers, was possessed by Djinn, but refused to discuss what they were. He also said that he was frightened of black people and claimed to be hearing voices. He was diagnosed as having a bipolar mood disorder and treated with Lithium which was increased up to 400mg daily during his admission. There continued to be evidence of sexual disinhibition and he is reported as asking female staff to come to his room for sex.</p>
18.01.2007	<p>Mr C was discharged from the Coborn Centre. The diagnosis of bipolar affective disorder had been made and his medication on discharge was Olanzapine 50mg nocte, and Sodium Valporate 600mg nocte. He was to be followed up as an outpatient by the adolescent mental health team.</p>
22.11.2007	<p>Mr C was admitted via Newham Children and Family Service after becoming aggressive towards his father and smashing all the light bulbs in his flat. His father called the police who took him to the Royal London Hospital's Accident and Emergency department. Mr C admitted to having been non-compliant with his medication. It appears that Mr C</p>

was discharged home that same evening and attended an outpatient appointment with Dr P his consultant adolescent psychiatrist where concerns were raised as Mr C appeared manic and irritable. He was reported as being elated in mood, singing and being over-familiar.

It was agreed to admit Mr C to the Cobourn Centre under Section 3 of the Mental Health Act.

- December 2007 A risk checklist was completed at the Centre where it was identified that when unwell Mr C was a risk to others. There was also a plan to assess whether the children in the family were at risk from him. It was reported that he was demanding, pushing boundaries and threatening towards staff, (to kill them and cut their throats).
- 18.12.2007 A nursing report dated 18th December 2007, states that there had been a significant reduction in violence and aggression. There was still some level of disinhibited behaviour and over-familiarity with staff.
- His behaviour continued to be sexually inappropriate and particularly targeted at female staff. He stated that when he felt angry he got sexually aroused.
- 19.12.2007 A CPA report was completed by Mr C's primary nurse. Mr C was escorted home to spend time with his family but on the way there became elated and irritable, wanting to stop off at a friend's house. When his father refused he became very angry and it was agreed to take him back to the ward.
- 10.04.2008 A part two discharge summary was completed in regard to Mr C's admission to the Coborn Centre. It stated that he was admitted under Section 3 of the MHA following a relapse in his mental state having being non-compliant with his prescribed medication. His mental state had improved during the admission.
- 23.04.2008 A referral letter from Dr P to Dr M, Consultant Adult Psychiatrist was sent requesting that he take over Mr C's care as Mr C would be 18 years old in July 2008. A summary of his psychiatric history was included.
- 24.04.2008 A CPA care plan was completed. Mr C reported being mentally stable and this was confirmed by his father who accompanied him to the review. Mr C's father continued to work away from home. It was noted that Mr C's mood was much improved and that he was sleeping better. To continue with his medication.

Independent Investigation into the Care and Treatment provided to Mr C and Mr E

- 08.07.2008 Confirmation was provided that Dr M would accept psychiatric responsibility for Mr C at the point of the proposed transfer CPA on 22nd July 2008.
- 22.08.2008 The transfer CPA was attended by Mr C's care coordinator and Dr P to complete Mr C's transfer to the adult mental health services. It was stated that Mr C reported that his mental state was stable and behaviour appropriate. His medication was to remain the same. Transfer to adult services confirmed.
- 28.08.2008 Reference was made to the CAMHS service CPA risk assessment and risk management plan completed by the care coordinator and countersigned by a consultant in child and adolescent psychiatry, Dr P. Mr C was on enhanced Level CPA. It was reported that Mr C was compliant with medication although there was some evidence that he had halved his Sodium Valpoate dosage.
- 06.10.2008 A CPA review was meeting held where Mr C reported that things were fine, there were no abnormal behaviours assessed or reported. He stated that he was no longer being possessed by Djinn and had no special powers.
- 12.01.2009 A CPA review was meeting held where Mr C reported being fine, no form of abnormal behaviours assessed or reported. Mental state stable.
- 27.01.2009 Disability living allowance form was completed with help from Mr C's care coordinator. No relapse was noted.
- 22.06.2009 A CPA review was completed, two weekly visits to be continued by his new care coordinator from the adult psychiatric services. It was reported that Mr C was mentally stable and this was confirmed by a personal adviser who had been working with him for some time. Mr C also reported that he was no longer responding to any form of external stimuli and that his family had no concerns about him. His father confirmed by telephone that his son was much better and had not displayed any form of aggression or abnormal behaviour.
- 22.03.2010 A risk assessment was completed by Mr C's care coordinator. It stated that Mr C had attempted to jump from the fourth floor of a building in 2006 and also had expressed suicidal ideations during a previous admission. It did not identify that he was a risk to others.
- 25.01.2010 The last meeting recorded in Mr C's notes. His care coordinator went on long term leave and left instructions for Mr C's family to contact the community duty team if there were any problems.
- 01.04.2010 Mr C's family became very concerned about his behaviour. A telephone

call was made by Mr C's father to the community duty team reporting that his son had been behaving oddly, not sleeping well, not eating and spitting food when he tried to eat. He had not been aggressive but was a nuisance in the house. Dr M was contacted by the Duty Team who had taken the call. It was suggested to refer Mr C to the Home Treatment Team and for a possible admission as Mr C becomes unwell very quickly. The Home Treatment Team were contacted who suggested referring Mr C to the Psychiatric Liaison Team and Mr C's father was informed that he could take him to the Psychiatric Liaison Team any time he was worried. The police were also contacted and visited the home. No action was taken.

05.04.2010 On the evening of Monday 5th April 2010 Mr C apparently hit his brother and the police were called to the house again. He agreed to attend the Accident and Emergency department for a psychiatric assessment. Following the assessment he was admitted to Ward B at the Mile End Centre for Mental Health.

06.04.2010 Mr C's father visited the duty team to inform them that he had called the police for help the previous Thursday. He informed them that Mr C had remained quite unpredictable following his previous contact to the team and in the early hours of the morning became violent, kicking his brother and breaking furniture. The police had been called again and after meeting Mr C called an ambulance which took him to the Accident and Emergency department prior to admitting him to Ward B at the Mile End Centre for Mental Health

Mr C was seen in the ward round by Dr M.

07.04.2010 Mr C was involved in two serious altercations with other patients on ward B and as a result of this and the plan to defuse the situation a bed was identified on ward A, at the Mile End Centre. Mr C was transferred to the ward in order to maintain his own safety.

After he arrived on Ward A he was seen bending another patient, Mr E's thumb back in the kitchen area, staff intervened but later Mr C was observed kicking Mr E in the face who was kneeling in front of Mr C at that time. Mr E sustained a cut lip. It was also at this time that the staff observed that Mr C was wearing Mr E's ring which was immediately returned to Mr E. The men were kept separated for the rest of the day.

08.04.2010 Throughout the day Mr C was seen to be intimidating Mr E, whose face was now red and swollen. Mr E's sister visited him in the afternoon and on leaving Mr C was rude and aggressive to her. Relatives of Mr E rang the ward and asked for the police to be informed of the assault. A referral for Mr C to be transferred to the PICU was to be made.

09.04.2010 On the morning of 9th April 2010, a nurse came on duty and discovered that the referral to be sent to PICU for Mr C's transfer on the previous day (8th April) had not been actioned and again requested that an assessment be made. An assessment was undertaken by the PICU staff who found that Mr C's mental state was not acute enough to meet their criteria for a transfer to the unit.

Mr C and Mr E were observed interacting during the day but as they were conversing in their native language it was not possible to assess what their conversations were about. At 18.00 hours Mr C was observed in the dining room waving his arms around, laughing to himself and appearing restless. The nurse in charge instructed the staff to give him medication to calm him down.

Just after 19.45 hours the ward panic alarm was rung and on investigation Mr E was found collapsed from multiple injuries in his room. The emergency team were called. Mr C had been observed leaving Mr E's room by a nurse who asked him what he had been doing in another patient's room. Mr C informed her that he was going to cut him and on being asked if he had done something to Mr E stated that the police were going to arrest him. She raised the alarm once entering Mr E's room to check if he was alright.

Mr C was kept under constant observations whilst the emergency team were with Mr E. Arrangements were made for Mr C to be transferred to the Trust's Medium Secure Unit and he was initially taken to a seclusion room on another ward.

14.04.2010 Mr C was transferred to the Trust's Medium Secure Unit and then to a High Secure Hospital where he remained for several months before being transferred back to the Trust's Medium Secure Unit.

Timeline of Events – Mr E

Appendix Two

Contact with Psychiatric Services

Date	Relevant Chronology
22.01.2003	<p>Mr E, accompanied by his brother-in-law, attended the Accident and Emergency department at St Bartholomew' Hospital. The Community Drug Team who had had contact with Mr E over a period of time in regard to his illicit drug use, had advised him to go there. He was reported to have been shaking and had tried to jump out of a first floor window. He was scared to be alone at home as there were too many noises. It was also reported that he was using threatening behaviour towards his sister and brother-in-law who he lived with and had smashed a door and damaged furniture with a knife.</p> <p>The family reported that he had appeared unwell for approximately six months with his behaviour becoming increasingly erratic and unpredictable. His father had "thrown" him out of the family home three weeks earlier and he had been living with his sister and brother-in-law in the period since.</p> <p>He was found to have grandiose ideas, some paranoia but denied hearing voices. It was agreed that he was a risk to others and had little insight into his illness. Mr E agreed to an informal admission to hospital.</p> <p>He was admitted to St Clements Hospital where he remained extremely disturbed and unpredictable in his behaviour requiring a lot of antipsychotic medication and also necessitating his detention under the Mental Health Act. He was diagnosed as having had a psychotic episode secondary to drug use after using cannabis that day. There was no current suicidal or homicidal ideation but he was known to have had several months of poly substance misuse.</p>
23.01.2003	<p>A clinical assessment was undertaken where he was found to remain quite high and elevated in mood and fairly restless. He was exhibiting some delusional ideas, claiming to touch a very hot object which automatically turned cold without him being hurt. He denied having hallucinations but did report that he saw three big men standing in front of him when he switched off the light in his room.</p>
24.01.2003	<p>Mr E seen in the ward round by the consultant psychiatrist, Dr W. Sections 5.2 and 2 of the Mental Health Act documentation were</p>

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completed as he was stating that he was not going to stay in hospital “I am not sick, I will go home soon”.

- 05.02.2003 Mr E still remained agitated and disinhibited on the ward. He wanted to go home but was not physically aggressive and the plan was for him to continue on Haloperidol 10mg tds. Procyclidine 5mg tds and Acuphase medication.
- 07.02.2003 Mr E was seen in the ward round by his consultant psychiatrist who noted that he still remained very agitated and disinhibited. He had run away from the ward and had to be stopped at the hospital entrance. Mr E stated that he is “not ill, I am not mental”.
- 12.02.2003 Mr E seen in the ward round where it was noted that he remained very agitated and restless, had had a difficult night being awake until 01.30 hours in the morning. There was no improvement noted in his mental state.
- 19.02.2003 Valproate medication increased to 750mgs twice daily.
- 24.02.2003 Mr E was seen in the ward round, no improvement, very chaotic, speech slurred and very difficult to understand. He was observed by the nurses to be picking at invisible objects before taking his clothes off.
- 19.03.2003 Mr E seen in the ward round by his consultant psychiatrist. He reported feeling “good and happy”, was wearing a funny hat and his speech was difficult to follow and he was shaking his wrists. He was talking about dancing, taking drugs and feeling that he could fly. Mr E denied hearing voices but had previously seen “big men and the toilet flushing for two hours”. The plan was to continue with his medication and to review him in one week.
- 26.03.2003 Mr E was reviewed in the ward round and found to be more settled and not irritable but still wanting to go home. It was agreed that he could have short escorted leave with a nurse and that occupational therapy was to be arranged. Mr E pleaded to go home but it was agreed that he was not well enough yet.
- 09.04.2003 Seen in the ward round, Mr E was responsive and receptive, had had leave with his brother-in-law which went well. The plan was to stop his Haloperidol, arrange a CPA review on 30th April 2003, and for him to have an overnight leave with his brother-in-law.
- 16.04.2003 Mr E much stronger, not hearing voices or messages from the television

and insisting on going home with his brother-in-law. To continue on his medication, Chlorpromazine was reduced to 100mgs four times daily.

- 30.04.2003 A CPA review took place. Mr E had attended NAFAS with the OT where he was inconsistent about his previous drug abuse but did admit to taking cannabis, crack and ecstasy. Seen by a psychologist, who would be seeing him again with his family. To continue to have day leave, going home to his sister and his father. Continued to attend NAFAS.
- 14.05.2003 Mr E seen in the ward round, was continuing to go to NAFAS. His latest home leaves had not gone too well as there was a new baby in the house and he had not got his own room to stay in. He was requesting to go to a homeless persons' unit and also expressed concerns about his wife who remained in Bangladesh. He stated that "life isn't worth living."
- 27.05.2003 The duty doctor was called to a violent incident where another patient thought that Mr E had taken his radio and he punched him on the nose. Mr E felt very angry and had stated that he wanted to beat up the other patient but knew that this would delay his treatment and the progress he was making.
- 18.06.2003 Seen in the ward round by his consultant psychiatrist and also had a CPA review meeting. His Section 3 of the Mental Health Act was due to expire on 17th August 2003. It was noted that he was doing well, he was spending time at NAFAS and visiting his family at their home although he did not want to be out on leave overnight. His family are upset that staff are asking that Mr E spends the night at the house and want him to have independent accommodation.
- 25.06.2003 Mr E was seen in the ward, for discharge and to continue to be seen by the clinical psychologist. Discharge summary completed that stated that Mr E suffers with a schizoaffective disorder. Referred to the Early Intervention in Psychosis Service (EIS).
- 02.08.2003 Letter from his consultant psychiatrist to Mr E's GP stating that the EIS have had no contact with him for over nine months and an appointment with him was made for 12th September 2006 with his consultant psychiatrist.
- 11.08.2003 An occupational therapy activities of daily living assessment was undertaken. It was found that Mr E required minimal encouragement to cook and was familiar with the local shops, he was independent with most aspects of cooking activity. It was decided that based on the

assessment Mr E had the capacity to carry out activities of daily living but would need a supportive environment where he could be monitored on a regular basis.

19.08.2003 A review/CPA took place with Mr E who stated that he continued to take his medication and denied any depressive or psychotic symptoms when asked directly. He was to continue to be seen monthly.

A psychiatric report was completed by his consultant psychiatrist in regard to an application from Mr E's wife to move to the UK. Mr E at this time was living independently in hostel accommodation and had applied for a flat. It was stated that Mr E's mental state would be highly dependent on the quality of the support that he would get from his wife and it was unclear as to whether she was aware of his mental health difficulties or whether she was aware of his drug taking.

08.10.2003 Note sent to Mr E's consultant psychiatrist from the EIS stating that they would continue to work with Mr E for the foreseeable future as he was now in contact again.

21.10.2003 A Care Programme Approach review was undertaken. Mr E reported that he had applied for a job making clothes and was waiting for them to get back to him about it. He had been allocated a flat and his brother was helping him apply for a grant in regard to buying furniture. He had begun to have contact with his father again and seemed to be more positive about their relationship. His medication remains unchanged:

- Risperidone 6mg at night.
- Sodium Valproate 1.2g at night.
- Procyclidine 5mg twice daily.

To continue to attend NAFAS two days a week until they decided to discharge him.

17.03.2004 CPA review undertaken, it was noted that Mr E continued taking his prescribed medication and remained abstinent from illicit substances. He had recently recovered from chickenpox. No evidence of recent psychotic symptomatology was found. Mr E planned to visit Bangladesh for a three-month period.

27.10.2004 A clinical psychologist's review took place of Mr E stating that the primary input from psychology had been a coordinating one in regard to Mr E's attempts to move his wife to the UK. During this time he also had had an extended trip to Bangladesh but did seem to manage his mental

state while there. The future focus of the psychology team would need to ensure Mr E had to access employment and educational resources as far as his interest and commitment went.

27.02.2005 A further review of Mr E was completed by the clinical psychologist and details sent to his consultant psychiatrist. It was stated that Mr E had been compliant with his medication and managed well through a time of conflict with his brother-in-law. He had gradually started to see his friends again. Discussions had taken place in regard to the risks in terms of his taking drugs and he had expressed the fear that if he continued to take drugs he might end up in hospital again which he did not want to do.

To continue to be seen by the clinical psychologist via individual appointments.

01.06.2005 Mr E did not attend his appointment with the clinical psychologist.

10.08.2005 Letter to Mr E's consultant psychiatrist from his clinical psychologist stating that he had seen Mr E and his sister that day. Mr E expressed concerns about his medication and was worried about ongoing side-effects, they also discussed his concerns about his current housing where he found it difficult to stay due to being exposed to noise, fighting and people selling drugs on the premises. An application to be re-housed had been completed. To be seen again in one month. A letter was sent to the Housing Link team requesting assistance in re-housing Mr E.

16.06.2006 Letter to Mr E from the Early Intervention in Psychosis Service stating that as he had had no contact since the previous September (2005), he would be discharged from their caseload.

12.09.2006 Mr E was seen in the outpatient clinic, by his consultant psychiatrist and reported that he was trying to cope and also applying to get his wife over to the UK. He did not like his flat, he thought it was cold. It was noted that his mental state was stable and he was to continue on his medication.

A letter was sent to Mr E's GP from his consultant psychiatrist regarding the outpatient appointment that Mr E had attended. The letter stated that Mr E had not attended appointments for many months and that he had been discharged from the Early Intervention in Psychosis Service for non-engagement and during the outpatient session it had transpired that the main reason why he had attended the appointment was to

request a letter asking his consultant to write in regard to his wife being brought over from Bangladesh. A previous request had been turned down because he was unable to support her.

In terms of his mental state: "he presented with very good self-care, very good eye contact and report. There were no abnormalities or speech and he denied any auditory hallucinations". Mr E was informed that his care would be transferring to another consultant psychiatrist as he did not now live in his consultant's catchment area. His medication regime to continue.

- 13.10.2006 Letter from Dr Z agreeing to take over Mr E's care from Dr W in response to a letter dated 26th September 2006 requesting that she took over his care.
- 07.11.2006 Mr E was seen in outpatients by Dr W accompanied by his sister. Mr E reported that he was keen to come off of his medication and that he had a job stacking shelves in an off-licence. His mental state was noted as stable.
- 18.12.2006 Transfer of care CPA arranged.
- 07.03.2007 Letter to Mr E from the Isle of Dogs CMHT informing him that as he had not attended the last two appointments his care coordinator was discharging him from her caseload.
- 11.05.2007 Seen in outpatients by Dr Z who noted that he was well and was to continue on his medication of Risperidone 5mgs with a decrease in his Sodium Valproate to 180mg at night. Mr E reported he had started working in a restaurant full time and was able to manage the work.
- 20.08.2007 Mr E seen in the local Accident and Emergency department having been talking and shouting over the past week. He was having dreams about his mother who lived in Bangladesh and took a knife to his stepmother the previous day. He told her to "slash his throat." He denied taking any drugs or alcohol. A referral was made to the Home Treatment Team who were monitoring his care but Mr E refused to work with them.
- 24.08.2007 A Mental Health Act Assessment was undertaken at Mr E's home in the presence of his GP and an approved social worker (ASW). Mr E looked withdrawn and downcast, denied suicidal thoughts, was evading questions and wanting to jump off a bridge, was thought disordered. Appeared psychotic and admitted to ward A at the Mile End Centre for Mental Health under Section 2 of the Mental Health Act, accompanied

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by the ASW and two police officers. To be on 15 minute observations. He reported hearing voices at night.

When seen by the Doctor on-call he was calm and settled.

- 26.08.2007 Mr E appeared anxious and mentally distressed although compliant with medication. He appeared paranoid and suspicious.
- 28.08.2007 Mr E appeared much more settled on the ward and had been watching television. No aggression or violent behaviour was observed.
- 08.09.2007 Mr E sustained a head injury after being hit with a cup by another patient. He was seen and assessed by the on-call doctor who referred him to the local Accident and Emergency department where he was taken by ambulance with an escort. His Head injury was treated and Mr E brought back to the ward.
- 10.09.2007 Mr E appeared to be very distressed mentally on the ward and was reported as easily getting confused and forgetful. He could sometimes be verbally aggressive.
- 12.09.2007 Mr E more settled and spent some time watching the television. He kept asking staff if he could go home and was reassured that he needed to stay on the ward.
- 14.09.2007 Mr E went home on leave with his stepmother for the night. It was reported that this went well.
- 17.09.2007 Mr E reported as being unsettled in mental state, restless and agitated refusing his afternoon medication.
- 20.09.2007 At 21:30 hours Mr E was reported missing from the ward and on contacting his family, staff were informed that he had returned home and that they had advised him to return to the ward. The police were informed of his whereabouts and as Mr E refused to return to the ward the police did not bring him back to the ward. His family reported that he was causing a disturbance.
- 21.09.2007 Mr E's brother-in-law brought him back to the ward in the morning. He appeared calm in mood and all parties were informed of his return at 11:10 hours. At 15:15 hours the Mental Health Act administrator informed the medical staff that Mr E's Section 2 of the Mental Health Act had elapsed the previous day. Section 5 (2) was put in place and the recommendation for detention under Section 3 of the Mental Health Act

documentation was completed.

- 22.09.2007 Mr E appeared very agitated, was loud and noted entering other patients' bedrooms. He was observed pacing up and down the ward. PRN haloperidol 10mg was given with Lorezapam and he calmed down.
- 24.09.2007 Mr E was assessed under the Mental Health Act. He expressed delusional thoughts and was found to be thought disordered. Section 3 of the Mental Health Act was completed.
- 30.09.2007 Mr E was very restless and destructive in his behaviour, dressing and undressing, using his shirts to clean up spillages of tea and was confrontational in his approach to others.
- 02.10.2007 Mr E was found to be elated and paranoid during the night. He stated that there was a ghost in his room and refused to sleep there.
- 03.10.2007 Mr E was reviewed by the Senior House Officer (SHO), who noted that Mr E continued to remain agitated sometimes shouting, dancing, banging on doors and windows. He had exposed himself in the communal area and did not appear to have been affected by the increase in his Lorazepam. Dr Z advised that he should have a trial of Haloperidol 10 mg orally and continue with his other medication.
- 12.10.2007 Mr E was very agitated, threatening members of staff and requiring restraint. He felt that somebody was going to kill him and he said that he has begun a "full bullet thing that he can kill anybody with." He was highly aroused and stormed out of the room. His brother-in-law was seen and it was explained that staff had two options of treatment. To put him on a very strong injection once a week and to have ECT treatment which his brother-in-law rejected.
- The plan was to have a change of medication, to possibly transfer him to the PICU and a referral was made to the PICU team for an assessment. During the late evening his behaviour became more inappropriate, he was aggressive and agitated and threatened to throw a table at a member of staff. During the night he needed to be restrained by the rapid response team and the following day was transferred to the PICU after becoming very violent.
- 11.12.2007 Mr E was transferred back to ward A from the PICU having improved whilst there.
- 18.12.2007 Mr E transferred back to the PICU as his behaviour had become

threatening and he was difficult to manage on the ward. He also tested positive for cocaine on a routine drug screen. He remained there for a few days and was then transferred back to ward A.

01.01.2008 Mr E became extremely hostile and aggressive and needed to be placed in seclusion. This behaviour continued throughout the month and it was decided to try a different medication, Risperidone and reduce the Haloperidol and Zuclopenthixol.

February 2008 Mr E began to make frequent abusive telephone calls to his family mainly in regard to a dispute about money. He continued to be challenging and grandiose with obvious thought disorder on the ward. He tried to strangle himself with a pair of socks when told he could not go home. Medication options were further discussed. He also reportedly had drunk a small amount of medicated shampoo on another occasion.

03.03.2008 Mr E activated the call button in his room and was found with shoelaces tied around his neck. The emergency team were called and he was taken to the Royal London Hospital by ambulance for assessment. No acute complications were found and he was returned to the PICU. He was to remain on "arms length observations".

04.03.2008 He was reviewed on the PICU and plans to commence Mr E on Clozapine medication were made. He remained insightful, demanding discharge or transfer back to ward A. During the rest of March he remained psychotic and on one occasion had become sexually inappropriate with a female patient. On 19th March 2008, Mr E's father became gravely ill and he was escorted to the hospital to visit him. His father died later that day.

April 2008 Some improvement in his mental state was observed during the month. He remained on 1:1 observations and started on Clozapine titration. He had 15 minute escorted leave with two members of staff which went well. His dosage of Clozapine was decreased from 400mgs to 375mgs.

May 2008 Two drug screenings showed positive for benzodiazepines and the later one for opiates as well. His leave was suspended.

June 2008 During the early part of June he became calmer and was transferred to ward A on 27th June 2008. He deteriorated again and on 27th June required rapid tranquilisation and was transferred back to the PICU.

July 2008 He was transferred back to ward A on 4th July 2008. He required rapid

tranquilisation twice during the month and was very challenging in his behaviour towards both staff and patients. He made threats to kill staff and was verbally and physically aggressive.

- August 2008 No real change in Mr E's mental state. He remained a challenge, making threats to shoot staff. His family reported that he was using his credit card to order expensive take away food and that they had cancelled this. As he had calmed down it was agreed that he could have a one hour accompanied leave with his sister. Whilst at her home he refused to return to the ward, ran away from the house and was brought back to the ward by the police. He remained calmer over the next few days.
- September 2008 Little change was observed in his mental state. He did have escorted leave and eventually, unescorted leave which went well. Over the month Mr E did appear to be improving.
- 16.10.2008 An occupational therapy assessment was taken, Mr E appeared well-kempt and it was reported that he was independent in maintaining his personal care. It was agreed that he would require minimal support in the community on discharge.
- 20.11.2008 Mr E was seen at the ward round by Dr Z and it was agreed that he would be discharged under the care of the Home Treatment Team and continue to be monitored under a Community Treatment Order (CTO).
- 06.01.2009 A post discharge CPA meeting was held, Mr E reported no auditory hallucinations, no paranoia was noted and he was not suicidal or homicidal. The plan was to continue to have a weekly contact with his care coordinator, to investigate employment opportunities and for his medication to remain the same.
- 25.02.2009 Mr E informed staff that he intended to go to Bangladesh until May 2009. His consultant recalled him to hospital as he was in breach of his CTO. Mr E agreed to go to Bangladesh for three weeks only from 2nd April 2009.
- 26.02.2009 Letter sent from Mr E's consultant psychiatrist to Mr E stating that if he goes to Bangladesh from 7th March to May 2009 he is breaching some of the CTO conditions which included engagement with the Clozapine clinic two weekly. It was reiterated that Clozapine monitoring was not available in Bangladesh and that he could be endangering his health.
- 02.03.2009 Mr E admitted to ward A at the Mile End Centre for Mental Health under Section 3 of the Mental Health Act as he was planning to go to

Bangladesh a few days later.

- 05.03.2009 Mr E discharged from hospital after agreeing to change his flight details to Bangladesh.
- 06.05.2009 Letter from Dr Z advising Mr E that he should return from Bangladesh to London as planned. It was pointed out that Clozapine was not available in Bangladesh and the Trust was not allowed to post it to him, that he needed blood tests regularly and that he was still legally subject to Section 17A of the Mental Health Act (Community Treatment Order) and that by remaining in Bangladesh he would be in breach of the conditions of that order which could lead to him being recalled to hospital. Mr E was reported Absent Without Leave (AWOL) as he was still in Bangladesh.
- 19.05.2009 Mr E's CTO expired.
- 09.06.2009 Mr E returned to the UK where he was recalled to hospital and seen on 16th June by his care coordinator and a locum consultant psychiatrist. He appeared settled in his mental state, he said he had seen a doctor whilst in Bangladesh and obtained his medication but had not had any blood tests for his Clozapine medication. This was arranged and he attended the clinic.
- 16.06.2009 Mr E's CTO was extended until 19th November 2009.
- 03.08.2009 A social circumstances report was completed by Mr E's care coordinator.
- 07.08.2009 An urgent CPA was arranged. Mr E did not want to attend appointments and reported having a headache. His care coordinator insisted that he attend the appointment that day, but he did not do so, and it was decided to undertake a home visit to his home. Mr E reported having headaches for the past two weeks that had now improved. It was unclear as to whether he was compliant with his medication. There was no evidence of psychotic symptoms.
- 25.08.2009 Mr E was admitted to hospital as he had breached his CTO conditions by not attending appointments.
- 27.08.2009 Mr E discharged from hospital.
- 06.10.2009 Mr E cancelled his CPA review, another one was arranged for the 28th October 2009.

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- 16.02.2010 Mr E was referred to the home treatment team to re-titrate Clozapine in the community.
- 19.02.2010 Letter to the Isle of Dogs CMHT from Mr E's GP stating that he had recently returned from Bangladesh, was complaining of difficulties in sleeping, poor appetite and seeing dead people. He was keen to gain access to the CMHT and to recommence Clozapine medication. An urgent assessment was requested.
- 05.03.2010 Letter to the GP regarding Mr E from Dr Z in regarding to him becoming tachycardiac with chest pain and palpitations as the Clozapine dosage was increased. There was a request to refer Mr E to a cardiologist.
- 30.03.2010 Mr E was taken to the Accident and Emergency department by his brother-in-law after an apparent deterioration in his mental state. He was recalled to hospital under the CTO process.
- 07.04.2010 Mr C, who later killed Mr E arrived on ward A where he was seen bending Mr E's thumb back in the kitchen area, staff intervened but later Mr C was observed kicking Mr E in the face who was kneeling in front of Mr C at that time. Mr E sustained a cut lip. It was also at this time that the staff observed that Mr C was wearing Mr E's ring which was immediately returned to Mr E. The men were kept separated for the rest of the day.
- 08.04.2010 Throughout the day Mr C was seen to be intimidating Mr E, whose face was now red and swollen. Mr E's sister visited him in the afternoon and on leaving Mr C was rude and aggressive to her. Relatives of Mr E rang the ward and asked for the police to be informed of the assault.
- 09.04.2010 Mr C and Mr E were observed interacting during the day but as they were conversing in their native language it was not possible to assess what their conversations were about.

At 18.00 hours Mr C was observed in the dining room waving his arms around, laughing to himself and appearing restless. The nurse in charge instructed the staff to give him medication to calm him down.

Just after 19.45 hours the ward panic alarm was rung and on investigation Mr E was found collapsed from multiple injuries in his room. The emergency team were called. Mr C had been observed leaving Mr E's room by a nurse who asked him what he had been doing in another patient's room. Mr C informed her that he was going to cut him and on asked if he had done something to Mr E stated that the

police were going to arrest him.

Mr C was kept under constant observations whilst the emergency team were with Mr E. Arrangements for made for Mr C to be transferred to the Trust's Medium Secure Unit and he was initially taken to a seclusion room on another ward.

Mr E later died of his injuries in Hospital.

Documentation Received

Appendix Three

1. Internal Review
2. Press Cuttings
3. CMHT Notes
4. Clinical Notes 22-11-07 – 01-01-08
5. Clinical Notes 01-01-08 – 04-04-08
6. Clinical Notes 2010
7. Action Plans 1 – 53
Ward A Improvement, Plan 54- 65
8. CQC Visit Summary
9. Internal Review Interviews
10. Patient Safety Report
11. Incident Reports
12. Referral to a special hospital Mr C
13. Police Liaison Notes plus others
14. Observation Sheets (altered)
15. Staff Rotas
16. Incident Report
17. Daily Duty Nurse Report
18. Witness Statement following incident
19. Court Print Index
20. Issues with care delivery and recommendations. HR report following recommendations
21. Service Directory
22. Organisational Chart
23. Action Plan D – 25.03.2011
24. Incident Policy
25. Patient Safety – Review of Internal Inquiry and Action Plan – August 2010
26. Ward A, Position Statement
27. Transfer Summary
28. Care Programme Approach Template
29. Confidential Forensic Psychiatric Report
30. Coroner Report from Police
31. Additional CAMHS documents
32. Tower Hamlets Violence and Aggression Data
33. CQC Summary and Responses
34. Post mortem results
35. Questions from Mr E's family

Investigation Procedure

Appendix Four

1. All meetings of the investigation will be held in private. The press and other media will not be invited to attend.
2. Staff to be interviewed will receive a letter in advance of appearing to give evidence informing them:
 - of the Terms of Reference and the procedure adopted by the investigator;
 - of the areas and matters to be covered with them;
 - that when they give oral evidence they may raise any matter they wish which they feel might be relevant to the investigator;
 - that they may bring a member of a defence organisation, a friend, relative, colleague or member of a trade union, provided no such person is also a witness to the investigation;
 - that it is the witness who will be asked questions and who will be expected to answer;
 - that their evidence will be recorded and a copy sent to them.
3. The findings of the Investigation and any recommendations will be presented to the Trust.
4. The evidence which is submitted to the investigator either orally or in writing will not be made public by the investigator, except within the body of the final report.
5. Findings of fact will be made on the basis of the evidence received by the investigator. Comments that appear within the narrative of the report and any recommendations will be based on these findings.

The Terms of Reference for the Internal Review

Appendix Five

The care that both patients were receiving in the run up to and at the time of the incident.

- The suitability of that care in view of the patients' history and assessed health and social care needs.
- The extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
- The delivery of the care plan and its monitoring by the care coordinator and multidisciplinary teams.
- To assess the adequacy of the risk assessments and actions consequent upon those assessments, including assessments and actions by staff from all wards associated with the care of the patients, i.e. ward B, ward A, PICU.
- To examine the adequacy of the observations policy, and its appropriate implementation in relation to this incident.
- To examine the clinical leadership and management issues associated with care and treatment.
- To examine the extent to which the concerns raised by relatives and close friends were taken into account in the management of the patients care and treatment.
- To make recommendations so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is minimised.
- To examine the clinical effectiveness of treatments and intervention.
- To assess the quality of care received within the framework of the Care Programme Approach.
- The extent to which the care and treatment provided was culturally appropriate.
- The extent to which safeguarding processes and guidance was followed.
- To assess the ward culture and leadership.
- To assess the ward environment, the design of the ward and physical location/placement of patients assessed as requiring close monitoring.
- The adequacy of staffing levels (including leave/cover arrangements).
 - To review the adequacy of support provided to staff and service users.
 - To review the immediate management of the incident.

Glossary

AMHP:	Approved Mental Health Practitioner
Care coordinator:	A mental health professional specifically identified to coordinate and manage the package of care for a service user under the auspices of the CPA
CMHT:	Community Mental Health Team
CPA:	Care Programme Approach
CPN:	Community Psychiatric Nurse
GP:	General Practitioner
HR:	Human Resources
HSG:	Health Service Guidance
HTT:	Home Treatment Team
MHA:	Mental Health Act
MDT:	Multidisciplinary team
Responsible Authority:	In relation to a patient detained in a hospital under the Mental Health Act 1983 this usually means the responsible Primary Care Trust, Strategic Health Authority, Local Health Board, Special Health Authority, NHS Trust or Foundation Trust
PIN	Practice Innovation Nurse
PRN	Medication prescribed and given as necessary
RiO:	Mental health electronic records system