Report of the independent investigation into the care and treatment of Mr MH

A report for NHS London

February 2010

NHS
London

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1. Investigation Team Preface

1.1 The Independent Investigation into the care and treatment of Mr MH was commissioned by the Waltham Forest Primary Care Trust in accordance with *HSG (95)27*[1] as amended in June 2005. This Independent Investigation Panel was asked to examine a set of circumstances associated with the death of Mr AD. Mr MH was subsequently arrested and convicted as the perpetrator of this offence.

1.2 Mr MH received care and treatment for his mental health and substance misuse problems from the North East London Mental Health NHS Trust (NELMHT). His accommodation at the time of the homicide was a bed and breakfast hotel was funded by the London Borough of Waltham Forest, and the victim worked at this establishment.

1.3 It has been necessary to examine the treatment and care Mr MH received since April 1995 up to June 2005 in order to fully understand all the circumstances surrounding the homicide. We would like to acknowledge the pain and distress this has caused the perpetrator's family in having to relive and re-examine their experiences. The Independent Investigation Panel is grateful to Mr MH's sister for providing information about her brother's early life.

1.4 The purpose of this Investigation is to learn any lessons that might help to prevent further incidents of this nature, and to help the North East London Mental Health NHS Trust and its partner agencies to improve their services and to share the lessons across the NHS.

1.5 Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They have all done so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. As a result the Independent Investigation Panel has been able to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

2. Condolences to the Family of Mr AD

2.1 At this point in an Investigation Report it would be usual for the Independent Investigation Panel to extend their condolences to the family and friends of Mr. AD who died on 25 June 2005. We understand that Mr AD came from Pakistan and was living at the hotel where he worked on his own. There is no further information about him, and it is thought he was an illegal immigrant.

3. Executive Summary

Incident Description and Consequences

On 25 June 2005 Mr MH went back to the Barking Park Hotel where he had been staying for a period of just less than eight weeks. Mr MH attacked an employee of the hotel who was lying on a settee with a hockey stick and then stabbed him with a knife in a frenzied assault from which he died.

Mr MH was found guilty of manslaughter with diminished responsibility and sentenced to prison where he currently remains.

Background to the Independent Investigation

The Health and Social Care Advisory Service was commissioned by Waltham Forest Primary Care Trust and NHS London to conduct this Independent Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

This guidance was slightly amended the following year and the particular paragraphs in the guidance relating to 'when things go wrong' further amended in 2005.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimize the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

Terms of Reference

"The Independent Investigation Panel should undertake all the tasks listed below in order to produce a detailed report on the care and treatment Mr MH received and make recommendations to help ensure that any mistakes made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Panel will:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan;
- review the progress that the Trust has made in implementing the action plan;
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration.

Stage 2

a) to examine the mental health care received by Mr MH in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr MH's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;
- the extent to which Mr MH's prescribed care plans were effectively drawn up, delivered and complied with by him;
- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:
    - medication;
    - staff responses to service user and carer concerns;
    - involvement of Mr MH and his family in the drawing up and appropriateness of his care plan;
    - range of treatments and interventions considered;

    - social care interventions;
    - reliability of case notes and other documentation.

- his assessed risk of potential harm to himself and others by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:
    - the risk of Mr MH harming himself or others;
    - the training of clinical staff in risk assessment;
    - systems and procedures in place during the period of Mr MH's contact with services.

b) consider the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular reference to the sharing of information for the purpose of risk assessment;

c) involve the perpetrator and his family as fully as is considered appropriate;

d) involve the victim's family as fully as is considered appropriate;

e) review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriate use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation;

f) consider any other matters arising during the course of the Independent Investigation which are relevant to the occurrence of the incident or might prevent a re-occurrence;

The Investigation Team

The Independent Investigation was undertaken by the following Panel of professionals who are independent of the healthcare services provided by the North East London Mental Health HNS Trust and the Waltham Forest Primary Care Trust:

Chair and Investigation Lead

Ian Allured	HASCAS Director of Adult Mental Health

Members of the Panel

Dr Simon Britten	Consultant Psychiatrist
Tina Coldham	HASCAS National User Development Consultant
Chris Hart	Nurse Consultant/Lecturer South West London and St George's Mental Health Trust
Charles Holloway	HASCAS Associate and Lay Member

Independent Advice

Paul Grey	Independent Management Consultant and service user adviser on cultural and diversity issues
Ashley Irons	Capsticks (Solicitors)

Findings and Conclusions

The Independent Investigation Panel found one key causal factor, six contributory factors and two service issues. These were in the order of importance agreed by the Panel:

Key Causal Factor - Non-Engagement with Services by Mr MH.

This meant that Mr MH never really entered into a therapeutic relationship with the Assertive Outreach Team (AOT) or Healthworks as he could not break away from his addiction to drugs, and frequently used the AOT for gaining practical help and food and financial assistance.

Contributory Factor 1 - Staffing Issues.

The limited access the AOT had to both psychiatric and psychology support in its early days reduced the team's capacity to identify alternative ways to work with Mr MH. This was a causal factor, but there was no evidence to suggest that other ways of helping to address Mr MH's addiction or his mental ill health would have succeeded due to the cycle of substance misuse he had adopted and appeared unable to alter.

Contributory Factor 2 - Housing and Accommodation Issues

The fact that Mr MH spent most of the 12 months prior to the homicide in bed and breakfast accommodation meant that he did not have a settled lifestyle. His drug taking and tendency to associate with other drug users caused him to be evicted from several establishments. The Independent Investigation Panel considered that the lack of appropriate accommodation, whilst not a root cause of the homicide, did contribute to the long term instability of Mr MH's life, and made it even less likely that he would be able to overcome his addiction.

Contributory Factor 3 - Resources

Mr MH was never given a conclusive diagnosis. There was continued uncertainty about whether the substance misuse and the subsequent addiction was the main

issue, or whether it was a mental illness, most likely schizophrenia. As a result Mr MH was not placed in a secure environment to try to determine whether the mental health or the substance misuse was the primary issue. The Independent Investigation Panel did not consider this a root cause, but another contributory factor which combined with the others was a factor in the build up to the incident.

Contributory Factor 4 - Risk Assessment

There was a lack of any robust risk assessment incorporating retrospective information about threats and actual violence. No one rated Mr MH as being at high risk of inflicting violence to others. In his history there were numerous instances of threats, challenging behaviour, damage to property and assaults. Staff also noted their concerns for their own safety and had taken pre-emptive measures to protect themselves, for example not visiting him alone, and only seeing him in an open part of the office but not in the area where staff worked. No detailed narrative history had been completed.

The Independent Investigation Panel felt that whilst the risk assessments were not as full as they could and perhaps should have been, there was no clear indication that an attack on a member of the public or an acquaintance was imminent and could have been foreseen.

Contributory Factor 5 - Management of Dual Diagnosis

In 2004/2005 there was no specific Dual Diagnosis service available within NELMHT. As in many other places there were specialist dual diagnosis trained staff. These workers were also available to provide advice on how best to manage a person with Dual Diagnosis.

The AOT was right to highlight the needs of those clients with Dual Diagnosis as they do pose an additional set of risks, and are ‘difficult’ to manage as they present challenging behaviours. This is a contributory factor, but is interrelated with Key Causal Factor 1 as Mr MH was not able or willing to fully engage with services. In this sense the Panel saw it as a causal factor but not a root cause.

Contributory Factor 6 - Relationship Issues both within the Management of NELMHT and between NELMHT and the other Organisations within Waltham Forest.

Managers above the level of the team manager appeared to have little ability to take decisions or to work with their counterparts in the London Borough of Waltham Forest to meet the needs of the complex and ‘difficult’ clients they were seeking to help. As a result accommodation was not available for Mr MH and the other service users in the group identified by the AOT. No formal escalation system was in place so that decisions could be raised to a more senior group of staff with easier access to the necessary resources and/or budgets. This again was not seen as a causal factor as Mr MH was not able to engage with services in a therapeutic sense, and having a precise diagnosis would not have affected this.

Service Issue 1: The lack of a full narrative history of Mr MH’s mental health, as well as his early life history.

This meant that that was no clear and easily accessible overall history of Mr MH immediately available in the case-notes, and the Independent Investigation Panel considered this an issue where practice should be improved.

Service Issue 2: The lack of a real Dual Diagnosis service prevented the AOT being able to fully address Mr MH’s substance misuse issues. The close working with Healthworks moved towards a joint approach but it was not sustained.

As Dual Diagnosis accounts for a very high percentage of the caseload of an AOT and that its prevalence on acute mental health admission wards is well in excess of 50 per cent, there is a strong and logical case for all trusts to have an effective dual diagnosis service.

Conclusion

The Investigation Panel, having examined all the available evidence, interviewed the staff and managers and undertaken the root cause analysis work, consider that there was no single root cause which was responsible for the death of Mr AD**.**

The one key causal factor and the six contributory factors combined contributed to the unfortunate outcome, but this could not have been predicted with any certainty to have led to this homicide.

Recommendations

The Independent Investigation Panel has made eight recommendations which are listed below.

Recommendation 1

The AOT should build into its working arrangements formal opportunities to review cases which are causing the Team concern, or where no progress is being made in meeting the clinical and social care objectives agreed.

(It is recognised that much has occurred since June 2005 to implement some of the points covered in this recommendation, especially the increase in psychiatric time.)

Recommendation 2

Where there is uncertainty about a service user's diagnosis the AOT, (or any mental health service) should take steps to pool their information and to agree on a diagnosis, or the steps needed to secure a definitive one, with a view to determining a coherent and consistent treatment plan that could then be negotiated with the patient.

Recommendation 3

The Trust should ensure that service users about whom clinical teams are concerned due to their potential for violence to themselves and/or others should

have access to a forensic assessment and, where necessary, a low secure placement so that additional and longer term assessment and consistent treatment can be provided.

It is recognised that considerable steps in this direction have been taken by the Trust since 2005.

Recommendation 4

Escalation processes must be established so that where decisions about housing or other fundamental issues cannot be agreed they can be moved up the management and decision-making hierarchy so the necessary resources can be identified and delivered.

Recommendation 5

The AOT (and all mental health services) should ensure that when they accept a service user to the service they compile a list of all the history relevant to a comprehensive risk assessment being made with the service user. This should include a detailed narrative history gathered from the patient. A risk management plan must then be made which recognises the patient's ability to comply with it. Both the risk assessment and the risk management plan should be regularly updated and kept in a prominent place within the case records so that it is available to all staff who may come into contact with the service user.

It is again recognised that the Trust has taken steps to improve the risk assessment process, but this should be regularly audited to ensure that the above recommendation has been implemented fully.

Recommendation 6

The Trust should give priority to the active treatment of patients with Dual Diagnosis. Many of the most severe patients are clients of the Assertive Outreach Team due to their inability to engage because of their chaotic lifestyles. The Trust should take the following steps:

a) appoint a "Product Champion" who should be either the team leader or consultant who is prepared to persevere and drive treatment on both the substance misuse and the mental illness;

b) provide tangible and public endorsement and support from the Trust Executive Team, particularly the Chief Executive and the Medical Director;

c) identify the local systemic factors which have undermined the successful development of Dual Diagnosis services and actively address them;

d) provide the AOT with the appropriate support in terms of resources, skills and leadership;

e) help to gain the support of the PCT and the SHA by highlighting the number of homicides committed by people while under the care and treatment of mental health services who are suffering from Dual Diagnosis;

f) the team should report directly to the CEO and Head of Operations on progress and their work should be considered as "core" to adult services development. Visits to nationally respected Dual Diagnosis services may be helpful (eg Haringey and Birmingham).

Recommendation 7

The Trust should support the new addiction consultant (who is the SHAs Dual Diagnosis lead) and the addiction service manager, in presenting the option for Dual Diagnosis services to the Board that best fits the Trust's population profile.

(It is understood that a Dual Diagnosis Strategy is currently being finalised and about to be implemented. It should take note of the recommendations of the Report)

Recommendation 8

The Trust should identify staff resources and supervision resources to ensure a comprehensive retraining of medical, nursing and other professions in Dual Diagnosis treatment.

4. Incident Description and Consequences

4.1 In the early evening of 25 June 2005, Mr MH returned to the Barking Park Hotel where he had been staying for just less than eight weeks, and noticed Mr AD lying on a settee in the hall. Mr MH hit Mr AD several times with a hockey stick and then stabbed him with a knife in a frenzied attack from which he died. The attack was captured on a CCTV camera and Mr MH was arrested that evening.

4.2 One of the witnesses in the subsequent Police Investigation stated that a few days earlier Mr MH had had a disagreement with Mr AD and had seemed upset and angry.

4.3 Mr MH was found guilty of manslaughter with diminished responsibility and sentenced to prison where he currently remains.

5. Background and Context to the Investigation (Purpose of Report)

5.1 The Health and Social Care Advisory Service was commissioned by Waltham Forest Primary Care Trust and NHS London to conduct this Independent Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved*".

5.2 This guidance was slightly amended the following year and the particular paragraphs in the guidance relating to 'when things go wrong' further amended in 2005. Now the criteria for conducting such an investigation include: -

i) When a person who has been under the care, i.e.; has committed a homicide subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

5.3 The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Mental Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

5.4 The role of the Independent Investigation Panel is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Independent Investigation Panel to form a view of what would have happened based on hindsight, and we have tried throughout this report to base our findings on the information available to relevant individuals and organisations at the time of the incident.

5.5 The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services and the interest of the wider public. It is important that this case has been fully investigated by a totally impartial and Independent Investigation Panel.

6. Terms of Reference

6.1 An Independent Investigation should demonstrate and promote good practice by being open and honest when addressing any shortfall in service provision to service users and carers. The national introduction of a Clinical Governance Framework (1999) of setting standards, sharing information and developing partnerships should already have encouraged a culture of openness. Services for patients and improved quality of care should flourish thus moving away from the 'blame culture' historically prevalent in many NHS Trusts. The main outcome must be to increase public confidence and to promote professional competence.

6.2 Such an investigation should therefore establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar event happening in the future. To enable this task to be carried out, the Investigation Panel used the following Terms of Reference:

Terms of Reference

"The Independent Investigation Panel should undertake all the tasks listed below in order to produce a detailed report on the care and treatment that Mr MH received and make recommendations to help ensure that any mistakes that were made will not be repeated in the future.

Stage 1

Following a review of clinical notes and other documentary evidence the Panel will:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan;
- review the progress that the Trust has made in implementing the action plan;
- agree with the Primary Care Trust any areas (beyond those listed below) that require further consideration.

Stage 2

g) to examine the mental health care received by Mr MH in the context of his life history, taking into account any issues raised by cultural diversity which appear to be relevant in order to obtain a better understanding of:

- the extent to which Mr MH's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90) 23 and local operational policies;
- the extent to which Mr MH's prescribed care plans were effectively drawn up, delivered and complied with by him;
- the appropriateness and quality of any assessment, care assessment plan and supervision having regard to his past history to include:
    - medication;
    - staff responses to service user and carer concerns;
    - involvement of Mr MH and his family in the drawing up and appropriateness of his care plan;
    - range of treatments and interventions considered;
    - social care interventions;
    - reliability of case notes and other documentation.
- his assessed risk of potential harm to himself and others by compiling a comprehensive chronology of the events leading up to the homicide. This should specifically include:
    - the risk of Mr MH harming himself or others;
    - the training of clinical staff in risk assessment;
    - systems and procedures in place during the period of Mr MH's contact with services.

h) consider the effectiveness of interagency working, including communication between the mental health services and other agencies, with particular reference to the sharing of information for the purpose of risk assessment;

i) involve the perpetrator and his family as fully as is considered appropriate;

j) involve the victim's family as fully as is considered appropriate;

k) review and assess compliance with local policies, national guidance and statutory obligations including (where relevant) the appropriate use of the Mental Health Act 1983 regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation;

l) consider any other matters arising during the course of the Independent Investigation which are relevant to the occurrence of the incident or might prevent a re-occurrence;

m) use root cause analysis as appropriate for the purpose of enabling lessons to be learned;

n) ensure that any action plan and recommendations take full account of the progress that health and social care services have made since the completion of the internal investigation report;

o) consider such other matters as the public interest may require;

p) prepare an Independent Investigation Report for the Primary Care Trust;

q) work with the Primary Care Trust in the period between the delivery of the Investigation Report and its formal publication."

7. The Independent Investigation Team

7.1 The Independent Investigation was undertaken by the following Panel of professionals who are independent of the healthcare services provided by the North East London Mental Health HNS Trust and the Waltham Forest Primary Care Trust:

Chair and Investigation Lead

Ian Allured	HASCAS Director of Adult Mental Health

Members of the Panel

Dr Simon Britten	Consultant Psychiatrist
Tina Coldham	HASCAS National User Development Consultant
Chris Hart	Nurse Consultant/Lecturer South West London and St George's Mental Health Trust
Charles Holloway	HASCAS Associate and Lay Member

Independent Advice

Paul Grey	Independent Management Consultant and service user adviser on cultural and diversity issues
Ashley Irons	Capsticks (Solicitors)

8. Investigation Methodology

8.1 Waltham Forest Primary Care Trust and NHS London commissioned this Independent Investigation under the Terms of Reference set out in Section 6 of this report. The Investigation was led by a project manager from the Health and Social Care Advisory Service (HASCAS). A meeting to discuss the procedure to be followed was held between Waltham Forest Primary Care Trust and HASCAS on 13 May 2008.

8.2 In September 2008 HASCAS received written consent from Mr. MH permitting the Independent Investigation Panel access to his clinical records. The Service Manager (Waltham Forest) of the North East London Mental Health NHS Trust met with the Investigation Lead on 15 October 2008 and the medical records were handed over, as was the archive of the Internal Investigation undertaken by the Trust. In addition an initial identification was made of the documentation required by the Independent Investigation Panel including the various relevant policies and procedures in force from 2002 to 2005. A careful analysis was made of these records to determine the skills and experience required of the Independent Investigation Panel. The Panel was then recruited, and at their first meeting a list of people to be interviewed was compiled.

8.3 All documentation received by the Independent Investigation Panel was indexed and paginated. A timeline of critical events was compiled and is contained within this report.

8.4 All witnesses were written to four weeks in advance of their interviews detailing the Terms of Reference of the Investigation, the areas that the Independent Investigation Panel would be questioning them about, and the operational process and timescale of the work. All witnesses to the Investigation were invited to attend an informal meeting on 20 November 2008 to meet the Chair/Investigation Project Lead and the HASCAS solicitor from Capsticks. During this meeting the process was explained and a question and answer session conducted.

8.5 Evidence was received from 14 individual witnesses orally over a period of five days during November and December 2008 and January 2009. Table 1 lists the witnesses interviewed during the Investigation.

Table 1 : Witnesses Interviewed by Investigation Team

Date	Witness	Interviewers
25 November 2008	CP - Manager AOT	Mr Ian Allured Mr Simon Britten Ms Tina Coldham Mr Chris Hart
	JM - CPN	
	Dr L - Consultant Psychiatrist	
26 November 2008	Dr W - RMO	Mr Ian Allured Dr Simon Britten Ms Tina Coldham Mr Chris Hart
	ZH - OT	
	DL - CPN	
	TL - Drug Worker	
	BMcA - LBWF	
	PS - CPN	
6 January 2009	JR - Service Manager/ Clinical Governance Lead	Mr Ian Allured Simon Britten Ms Tina Coldham Mr Chris Hart
	JW - Chief Executive	
	CW - CDAT	
11 December 2008	Mr MH	Mr Ian Allured Mr Christopher Welton
21 January 2009	Mrs UFH –Sister of Mr MH	Mr Ian Allured Mr Christopher Welton

8.6 All the interviews with the full Panel were recorded and a transcript prepared. The transcript was then forwarded to each individual in order for it to be checked for accuracy and also for any additional information to be added to it. It is the amended versions that have been used as evidence in this Independent Investigation. The interviews with Mr MH and his sister, were recorded manually by Mr Welton, the HASCAS Business Manager.

8.7 The Independent Investigation Panel was not able to interview all of the individuals involved in the care and treatment of Mr. MH as one was living abroad, another was not traceable and another was considered to be too vulnerable following a lengthy period of illness.

Root Cause Analysis

8.8 The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

8.9 The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of a contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents happening in the same way again. It must, however, be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

8.10 RCA is a four-stage process. This process is as follows:

1. **Data Collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.

2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this timeline causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Fish Bone Tool. This is a process where nine specific areas are examined and the findings written on the diagram shaped like the skeleton of a fish. (The nine areas are listed on Page 52)
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

8.11 When conducting the RCA the Independent Investigation Panel avoided generalisations and sought to use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

Salmon Compliant Procedures

8.12 The Investigation Team adopted Salmon compliant procedures during the course of their work. This process is set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's Final Report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

11. In addition witnesses to the Panel were offered the opportunity to read records relating to their involvement with Mr MH prior to their interview.

9. Information and Evidence Gathered (Documents)

9.1 The Independent Investigation Panel examined all the clinical files. These comprised the following files about the involvement of health and social care services with Mr MH from 1995 to 2005:

- Clinical Records 1
- Social Work A
- Social Work B
- Claybury Hospital Notes A
- Claybury Hospital Notes B
- CDAT I
- CDAT II
- Assertive Outreach A
- Assertive Outreach B
- Clinical Records 2A
- Clinical Records 2B
- Clinical Records 2C
- Clinical Records 2D
- SFC Access Notes & Social Work Notes

The following policies were examined:

- The Assertive Outreach Team Operational Policy (June 2004)
- Assertive Outreach Team (AOT) Information Pack (Undated)
- Procedure for Section 117 After-care under the Mental Health Act 1983 (Issued June 2003 and due for review in June 2005)
- Care Programme Approach (CPA) Policy and Guidance (Issued March 2005 and due for review in March 2007)

10. Profile of Mental Health Services (Past and Present)

Provided by the Trust Chief Executive

2004/5

10.1 At the time of the incident North East London Mental Health Trust was comparable to many other provider organisations across London. The organisation covered the London Boroughs of Barking and Dagenham, Redbridge, Waltham Forest and Havering serving a population of over 800,000.

10.2 There were a number of in-patient sites within the organisation with a traditional spread of community based services supporting the majority of the client group. The organisation was managed through two Directorates. They were not integrated with local authority services.

10.3 The professions with the organisations were not directly managed as part of the Directorate system but were independent within the organisational structure. There was comprehensive professional representation at Board level in the organisation but there was not an independent system of professional advice available to the Board. There were a number of governance structures dealing with different aspects of risk across the organisation each with its own route to the Board.

10.4 The organisation provided Mental Health and Learning Disability services only with some additional specialist services managed as an integral part of the system.

10.5 The organisation was relatively small with an annual turnover of less that £100m. It was meeting demands for cost efficiency savings. At the time the organisation was rated as one star.

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10.6 NELFT still covers the same geographical area as its predecessor organisation and serves a population of a little under one million. The organisation is now a Foundation Trust which runs its business through six local or speciality Directorates.

These directorates integrate health and social services with a number of joint appointments. In addition to Mental Health and Learning Disability services it provides a number of specialist services and all of the community health services for one borough.

10.7 The Trust has a significantly reduced bed base and Commissioners investment has increased to ensure that there are a wide range of new services as specified within the National Service Framework for Mental Health. The professions within the organisation are directly managed as an integral part of the directorates and there are integrated governance systems embedded within the organisation with a single route to the Board. There is a professional reference group providing clinical advice directly to the Board. The Board now reflects a typical FT Board with only the Medical Director and Chief Nurse representing the professions at Board level.

10.8 The organisation has grown in the intervening period and has a turnover in excess of £170m and generating a significant surplus. The care quality commission rated the organisation as double excellent in its recently published ratings.

11. Chronology of Events

Mr MH's Early Life

11.1 Mr MH was born on 6 June 1968 in Pakistan. Relatively little is known about his early life but his sister in interview explained that "until he was about six years old we had a most beautiful life in Pakistan. We had our own land in a special village and we were respected because we are a higher grade family descended from Mohammed. M was no problem, we all loved him, he was always polite and respectful."

11.2 The family came to England when Mr MH was about six years old, to join his father in Leyton. Mr MH was fairly quiet and did not make many friends, but is reported to have settled well at school. When he was about nine his mother died and his sister commented that "After mother died he became very withdrawn, he would stay in his room and say almost nothing......... he became a completely different person, something seemed to be missing and he became very withdrawn.......he went to school and did well, he was a bright child, brighter than all of us...he went to Pakistan just before he did his GCSE's. The teachers said that he shouldn't do the exams but he worked hard and we knew that he was the brightest of all of us. Then he went to Redhill College to do Aeronautical Engineering."

11.3 His teenage years do not appear to have been particularly happy as his father had remarried and as his sister explained "it was worse after father remarried. M said that he gave him leftovers and said that he was not welcome at home. I was married so I could go to my own home. Father then had a stroke and got worse, but M should have coped – he wasn't a baby."

11.4 It appears that at about this time his elder brother by three years died from a drug overdose and this further upset Mr MH who was already taking drugs himself by this time. He did not complete the course at Redhill, one reason being that he had a work placement at Biggin Hill but the bus service between there and Redhill was withdrawn so he could not continue.

11.5 Mr MH had been convicted of several offences between 1987 and 1991, these were:

- 1987 Convicted of False Imprisonment
- 1987 Imprisoned for two years for robbery and residential burglary
- 1988 Imprisoned for 21 months for robbery and burglary (Mr MH states that this was the first time he experienced mental health problems, which were described as a nervous breakdown)
- 1991 Mr MH imprisoned for 30 months for a further residential burglary.

11.6 On release from prison in 1992 Mr MH sought help for heroin and cocaine problems at Healthworks in Waltham Forest, and was given a prescription for Methadone.

11.7 Mr MH's sister reflected that he might have got in with the wrong crowd at Redhill and she realised that by the time he was 25 he was taking drugs. She had brought Mr MH up since the death of their mother. She commented that "When he was 25 he was still in my Dad's house. He wasn't speaking and spent two days asleep. I was called and he said 'You like talking too much' and that was the first time he had talked to me like that. I called an ambulance and they took him away to a Mental Health unit. He was very bitter and said that I had put him into the unit. I said that I just called for help. This was the first time that I recognised that he was not normal. I would go to the Borough Council and Social Services, then they realised that he was into drugs and they didn't help."

First Admission to Hospital (07 April 1995 to 23 June 1995)

11.8 Mr MH had been released from prison in November 1994 and was admitted into Claybury Hospital as an informal patient on 7 April 1995, the admission possibly the one referred to by his sister in the previous section. At admission the provisional diagnosis given was one of drug induced psychosis or schizophrenia. He had admitted taking heroin, crack cocaine, ecstasy and LSD and had been prescribed methadone.

11.9 **On 21 April 1995** there was an entry in the notes saying Mr MH was not to be allowed to leave the ward and suggesting that Clopixol should be tried.

11.10 A month later Mr MH was placed under Section 3 of the Mental Health Act 1983 when he stated that he wished to leave the ward. The assessment undertaken at this time states that he was considered to be a risk and presented “a danger of intimidation and violence to others.”

11.11 **On 23 June 1995** Mr MH was discharged with the following care plan:

- to continue depot and oral medication;
- Community Drug and Alcohol Team (CDAT) to be involved, with methadone to be given by the Hackney Drug team;
- Outpatient appointments at 608 High Street, Leyton.

11.12 Mr MH failed to attend an outpatient appointment on 18 September 1995 but on 3 December he attended and presented as feeling very depressed and wishing to kill himself.

Second Admission to Hospital (24 January 1996 to 05 August 1996)

11.13 **On 23 January 1996** Mr MH had an urgent outpatient appointment where he appeared to be depressed and had been neglecting his self care. He said he could hear voices and they were telling him to kill himself. It was agreed that he should go to the admission ward the next day and be assessed by Dr T.

11.14 At this meeting with Dr T Mr MH was admitted informally to the ward. The policy of not being allowed drugs on the ward was made clear to him, and also that he would be subject to urine testing. It was noted that he had been taking heroin for the past three years. He admitted owing over £200 to a drug dealer.

11.15 By mid-February an extended leave period was being discussed. **On 28 February 1996** there was a discharge meeting which Mr MH did not attend. The plan was for medication of lofepramine, droperidol, procyclidene and depot clopixol. There was continued support from a CPN and from TL (drug worker) from Healthworks plus access to a support worker.

11.16 After discharge Mr MH continued to take illicit drugs and was spending large sums on them. He claimed it was £40 a week but his brother said it was nearer to £50 to £100 a day. He was feeling unwell and his mental and physical health had deteriorated. It was alleged that Mr MH obtained the money to feed his habit by stealing from cars. He was showing signs of paranoia and said that some drug dealers were after him as he owed them money. They had bothered him at his father's home and as his father was frail following a stroke he was frightened of what they might do.

11.17 **On 5 July 1996** Mr MH contacted the mental health services requesting admission. In a letter to Dr T the CPN, PJ, wrote that he had spoken with Mr MH's brother who described the situation at home as "very tense" as Mr MH had "run up huge debts with local drug dealers who have now been harassing the family looking for Mr MH and have threatened physical injury if not paid." He mentioned that the voices had started again when his brother died in March aged 32. It was agreed that Mr MH should be admitted as an informal patient but that if he wanted to leave, a Section 5(2) should be considered. He was not to be allowed to leave the ward unaccompanied and his only visitors were to be members of his family. It was spelled out that he must not take any illicit drugs.

11.18 After four days the notes record that "MH has settled well on the ward with no violent or aggressive outbursts." A few days later Mr MH was allowed 15 minute unescorted leave in the hospital grounds but he had to tell staff where he was going. At the ward round on **16 July 1996** the nurses reported that he had brought some cannabis to the ward and refused to give a urine sample, but a few days had passed with no further incidents.

11.19 In general this spell in hospital appears to have gone well and Mr MH improved, although he still said he could hear voices but was able to ignore them. There were suspicions that he was still using drugs.

In the Community (05 August 1996 to 11 June 1998)

11.20 **He was discharged on 5 August 1996** and was planning to go to Pakistan although funding this was a problem. His care plan was similar to the previous one with depot injections monthly and support from TL for his drug problems. His depot was 400mg Zuclopenthixol every two weeks, plus Procyclidine 5mg tds, and he appeared to be reasonably settled back in the community. Mr MH was referred to the day service at Thornbury Day Hospital, received help from CDAT and received domiciliary support in his flat.

11.21 **At an outpatient appointment on 21 January 1997** Mr MH said he felt paranoid and that people were watching him. He did not attend the next appointment on 1 April 1997.

11.22 **On 11 July 1997** Mr MH went to Pakistan for an arranged marriage to a cousin he had known all his life. He returned to England in January 1998 but was unwell. He lived in his flat in Leyton and gradually deteriorated. In March 1998 he stopped claiming benefits and his sister was made his appointee. Mr MH was waiting in the flat for his wife, who was expecting twins, to join him from Pakistan, as there were immigration issues to be sorted out.

11.23 **On 29 April 1998** Mr MH was assessed under the Mental Health Act 1983 but a decision was taken not to admit him. He had been overtly psychotic when seen a week before by PJ but was more settled at the time of this assessment . The SHO gave a diagnosis of co-morbidity of drugs and schizophrenia. It was noted that Mr MH had at this time stopped taking his medication.

11.24 **A week later on 6 May 1998** Mr MH was reported to the Housing Department as he was repeatedly playing loud music late at night and was shouting obscenities until 04.00. **On 8 June 1998** PJ visited Mr MH who reported having kicked down the door of a female friend as she owed him £10 and was not in when he went to collect it. He had also had an argument with a shopkeeper who would not give him credit for cigarettes, and Mr MH stated that he had wanted to kill him. He had been walking around with a knife and hammer and said that he would have used them on anyone who got in his way.

Third Admission to Hospital (11 June 1998 to 19 June 1998)

11.25 **On 11 June 1998** Mr MH was admitted into hospital. He was assessed to be allowed only escorted leave but **on 18 June 1998** he went out unescorted for 30 minutes and returned 10 hours later with his eyes glazed and he was laughing inappropriately. Mr MH refused to provide a urine sample. The next day other patients on the ward alleged that Mr MH was selling drugs on and off the ward. When challenged he was angry and claimed to have only come to hospital to see a social worker. He insisted on discharging himself and was allowed to go.

In the Community (19 June 1998 to 14 December 1998)

11.26 **On 15 October 1998** Mr MH was arrested for a street robbery. The day before his arrest he had argued with his wife and said he felt like hitting someone. He was confused and could not remember the robbery. He was alleged to have grabbed a lady's handbag whilst on a central reservation crossing a road with little regard to her safety as she hung onto her bag. Mr MH was remanded to HMP Wormwood Scrubs whilst awaiting sentence for the robbery.

11.27 **On 26 November 1998** Dr T requested that Mr MH be transferred to the Pathways Unit, a Psychiatric Intensive Care Unit at Goodmayes Hospital on a Section 24. This was agreed and **on 14 December 1998** Mr MH was admitted to the Pathways Unit.

Fourth Admission to Hospital (14 December 1998 to 01 January 1999)

11.28 The main reason for this admission was described in his discharge summary as being because Mr MH had complained of hearing voices and expressing ideas of paranoia associated with psychotic symptoms, whilst being held on remand for the robbery. Mr MH was thought to be mildly depressed, although he denied any suicidal or homicidal ideation. There was no evidence of formal thought disorder. He did appear low in self esteem and had paranoid delusions of people trying to harm him, and he said he would get into some form of harm if he refused to obey the voices. In view of his past use of illicit drugs it is quite possible that he was being threatened by drug dealers to whom he owed money.

11.29 Mr MH settled fairly quickly on the ward and throughout his stay denied having any psychotic symptoms of note. It is reported in the clinical notes that his wife visited him on the ward, and that reconciliation between them appeared possible. When discharge was being arranged Mr MH said that he intended to stop using illicit drugs and would contact the substance misuse service for help. The Court Section was removed and Mr MH was transferred to the Stoneleigh Unit for discharge planning and he was discharged on **1 January 1999**, but did not keep his appointments with the CPN (DM).

In the Community (01 January 1999 to 13 April 1999)

11.30 When back in the community Mr MH made inconsistent contact with mental health and substance misuse services. **On 22 March 1999** Mr MH had kept an appointment with Dr C at Healthworks and was put on a maintenance methadone prescription. At this time his drug taking was financed through his Social Security Benefits, petty theft and begging, sometimes with menaces. Mr MH had reported that he was using £60 of heroin and £50 of cocaine per day.

11.31 There had been an incident at his home where he had dropped one of his young children due to the effect of illicit drugs, which prompted the departure of his wife with the two children. Mr MH came to the attention of the police due to the threatening and persistent begging to fund his habit, and was charged with demanding money with menaces, but this was dropped after his admission to hospital on **13 April 1999** as an informal patient.

Fifth Admission to Hospital (13 April 1999 to 11 May 1999)

11.32 Mr MH presented as rather dishevelled and was described as having a subjective feeling of depression for the past few weeks. He complained of auditory hallucinations telling him to kill himself but also of his father's voice saying he should not do so. Both voices were described as speaking directly to him. Mr MH also described ideas of reference thinking that his name was being called out on television, and that the programmes were made especially for him.

11.33 Mr MH described his relations with his family to have broken down, although he thought his relations with his wife were good, despite her having left him after he dropped one of the children. The social worker explained to a **CPA meeting on 27 April 1999** that Mr MH had at times spent all of the family budget on drugs, and that while his sister had been in Pakistan he had increased his drug taking considerably, this sister being the only family member he was in regular contact with.

11.34 Whilst on leave from hospital Mr MH was using drugs. He was not really engaging with services except on his own terms. **At the CPA meeting on 11 May 1999** Mr MH was discharged to 42b White House Estate in Leyton. His discharge plan was for:

- a weekly methadone prescription from Healthworks
- attending a day programme at St James Street five times each week
- seeing TL at Healthworks
- LA (social worker) to maintain contact and the CPN to monitor his mental state and administer the depot
- him to be placed on the Supervision Register
- referral for Occupational Therapy was made, although it is noted that this took at least 14 weeks to arrange due to staff leaving and subsequent shortages.

In the Community (11 May 1999 to 25 January 2002)

11.35 It appears from the records that Mr MH stayed in the community from **11 May 1999** and spasmodically attended his outpatients appointments. He displayed a similar pattern of engagement with the substance misuse service although he did collect his methadone prescriptions fairly regularly whilst still using illicit drugs.

11.36 Mr MH was still in the community on **12 February 2001** when he was convicted of a burglary. The sentence was for a period of two years, but as he had served all his period of remand in prison his release date was expected to be a year later in February 2002. He was sent to HMP Pentonville.

11.37 A locum doctor for Dr T wrote to Dr A at the Chase Farm Forensic Service requesting help with Mr MH. **On 12 June 2001** Dr C, a Forensic Psychiatrist, wrote to the doctor treating Mr MH in Pentonville stating that in his opinion he suffered from “a paranoid illness which is very likely paranoid schizophrenia and polysubstance misuse.” He confirmed the depot of Flupenthixol Decanoate 40mg two weekly and Procyclidine 5mg tds, though he considered that an increase may well be warranted, and also that Olanzapine at 10mg nocte be added. A referral to the prison CARATS team was also advised.

11.38 While Mr MH remained in HMP Pentonville Dr T sought both a secure admission and a PICU place for him. On 19 October 2001 Dr T complained that he felt trapped between two conflicting opinions as to where Mr MH should be treated.

Sixth Admission to Hospital (25 January 2002 to 21 March 2002)

11.39 **On 25 January 2002** Mr MH was admitted to Pathways PICU from HMP Pentonville. The Occupational Therapist at Pathways assessed Mr MH who was feeling positive and wanted to break his drug and crime lifestyle. In her assessment she suggested that Mr MH should be:

- assisted in making a housing transfer rather than returning to the estate where he would be a target for drug dealers
- given adult education centre and college course directories
- provided with employment agency information
- re-referred to Healthworks for drug counselling
- placed in a service user group where there might be legal advice

11.40 **On 25 February 2002** Mr MH was released from prison on licence (Section 48) and transferred from the Pathways PICU to the Stoneleigh Unit the next day. Mr MH appeared to settle quickly at the Stoneleigh Unit and was **discharged on 21 March 2002** when Dr W became his RMO. The CPA Discharge plan stated that Mr MH should:

- have regular outpatient appointments with Dr W
- work with J, a social worker who will assist with benefits, rent arrears and make a referral to a gym
- a referral will be made to Healthworks
- the Thornbury Day Unit would be approached about its 'back to work group'
- a CPN would be allocated from the Thames CMHT for the monthly depot injection.

In the Community (21 March 2002 to 07 October 2003)

11.41 The period from March 2002 until September 2003 appears from the medical perspective to have been relatively quiet with Mr MH engaging when he felt he needed to, and attending approximately half of his outpatient appointments.

11.42 **On 07 April 2002** Mr MH was reported to have debts of £5000 rent arrears, and he admitted that a hand injury had been caused by his attempting a burglary. The next month Mr MH reported at outpatients that he was trying to stave off the bailiffs. It appears that he was gradually starting to neglect himself and ultimately his wife left him for the last time.

11.43 JM, the CPN working with Mr MH commented during her interview with the Independent Investigation Panel that she had to chase him up and keep reminding him to come for his depot. Despite chasing him she felt she had developed a good working relationship with him. During the time JM was working with Mr MH she considered his mental state to have been good. She stopped working with Mr MH in June 2003 when it appears from the clinical notes that he was discharged from the mental health services.

11.44 **In August and September 2003** Mr MH was causing harassment and being a nuisance to his neighbours, and several of them complained to the Quadrant Housing Association. **On 25 September 2003** the Housing Association referred Mr MH back to the local mental health services and he was assessed by Dr W but found to be 'unsectionable' under the Mental Health Act 1983 as he was not displaying psychotic symptoms.

11.45 **On 07 October 2003** Mr MH was admitted to Nasebury Hospital under Section 136 as the Police had been summoned to his address where he had been banging on his neighbours wall, shouting and causing a disturbance. He was very aggressive to the police and had to be restrained. Mr MH also threatened to set fire to his house and there was a strong smell of gas.

11.46 Three sets of neighbours had contacted the police as Mr MH had knocked on their doors demanding to know where his wife and children were.

Seventh Admission to Hospital (07 October 2003 to 06 November 2003)

11.47 Mr MH presented as very aggressive and demanding to staff on his arrival at hospital. A drug screen was positive for cocaine. He was placed under Section 3 of the Mental Health Act 1983. He was reported to have settled fairly quickly but four days later **on 11 October 2003** he absconded from the ward and was brought back by the police a week later **on 17 October 2003**.

11.48 **On 28 October 2003** a CPA meeting was held. The staff agreed that Mr MH needed a home based occupational health assessment and the allocation of a new CPN. There was concern that he was not engaging fully with services and a **discharge CPA meeting was fixed for 11 November 2003.** In the event this did not take place as Mr MH was found smoking cannabis on the ward and his position was reviewed at the ward round by Dr F, SHO. He also rescinded the MHA Section and made Mr MH an informal patient. The Discharge CPA meeting was brought forward and held **on 05 November 2003** as part of the ward round. The decisions made were that Mr MH needed to:

- be referred to the AOT
- have a social worker and RS would also act up as Care Coordinator
- have a new male CPN
- attend drop in sessions at Healthworks.

11.49 A Crisis Plan was also prepared highlighting the early signs of relapse displayed by Mr MH which were identified as being:

- aggressive and violent behaviour
- increased use of illicit drugs
- neglect of self
- non-compliance with medication and the care plan.

11.50 The next day**, 06 November 2003** Mr MH was discharged due to his unacceptable behaviour on the ward. His medication was Piportil depot 100mg every 4 weeks. Dr H, a SHO to Dr W wrote to the manager of the Assertive Outreach Team (AOT) and cited the following reasons for the referral:

Mr MH was described as:

- having a diagnosis of schizophrenia, poly-substance misuse and personality disorder;
- being on enhanced CPA
- having a history of substance misuse which has included in the past: cocaine, heroin and cannabis. He currently denies any substance misuse, however upon admission his urine drug screen was positive for cocaine and cannabis;
- having a pattern of relapsing;
- being difficult to engage and despite the efforts of the CPN (JM) remains at a very high risk of disengagement;
- having aggressive behaviour at times;

- lacking insight into his condition and is sometimes non-compliant with medication.

In the Community (AOT) (06 November 2003 to 16 April 2004)

11.51 **On 14 April 2004** a locum social worker (JL) prepared a report on Mr MH for the AOT clinical meeting where a final decision on whether to accept him would be taken. It was stated that he fulfilled the criteria for the AOT as he:

- "was on enhanced CPA
- is willing, able and motivated to engage with services
- has a serious impairment in managing his day-to-day living
- has an inadequate range of social support
- has had time as an inpatient in hospital and extensive time as an inmate in various prisons
- is not at risk of harm to himself or others.

11.52 It is clear from the records that Mr MH fell back into his habitual lifestyle and was again being noted as a nuisance by his neighbours, and running up further rent arrears. It was also mentioned in the report above that Mr MH was spending between £50 and £100 a day to fund his drug taking and obtained the money by begging in the local area.

Eighth Admission to Hospital (16 April 2004 to 04 June 2004)

11.53 **On 16 April 2004** Mr MH was admitted to hospital at the Stoneleigh Unit after voluntarily attending the Access Clinic. He was hearing voices and was worried about doing something stupid. He was carrying knives for defence and thought he might attack someone. He had missed his last depot of Piportil. Mr MH was allowed an informal admission for withdrawal and the reestablishment of medication. Mr MH had reported that three weeks prior to this admission, he had experienced command hallucinations telling him to harm someone. Dr T of the AOT completed a risk assessment.

11.54 **On 22 April 2004** Mr MH was granted leave but did not return by the agreed time and was discharged in his absence. Later he returned to Stoneleigh and was readmitted because of increased hallucination and suicidal feelings after having taken heroin two days previously.

11.55 Mr MH was accepted as a client of the AOT with the transfer CPA meeting taking place on **29 April 2004** at the Stoneleigh Unit. Almost as soon as Mr MH was transferred to the AOT he was made homeless by the Quadrant Housing Association as he had turned his dwelling into a crack house which was frequented by drug addicts and prostitutes. He was made the subject of an Anti-Social Behaviour Order (ASBO) and was banned from returning to the property for three months.

11.56 Dr W allowed Mr MH to remain on the ward due to the problems with his housing. He was **discharged on 04 June 2004** because he had spent his benefit giro-cheque on alcohol and cannabis and returned to the ward having taken both. He was given a list of open access bed and breakfast accommodation.

In the Community (AOT)(04 June 2004 to 25 June 2005)

11.57 The London Borough of Waltham Forest considered that Mr MH had deliberately made himself homeless and therefore were not prepared to give him further housing. Responsibility then rested with the Social Services Department to find him accommodation, and a series of bed and breakfast establishments were arranged for him. **On 08 June 2004** Mr MH was living in a bed and breakfast hotel in Chingford.

11.58 Dr W wrote to the Borough's Vulnerability Panel explaining Mr MH's position and the effects of his mental illness. He explained to the occupational therapist in the AOT, who was cross with the apparent lack of whole-hearted support for Mr MH in his report, that he felt Mr MH's chances of getting accommodation were negligible as he would be deemed by housing agencies to be intentionally homeless. The AOT was advised to consider other options such as hostels.

11.59 Dr W had added that he felt the lack of accommodation would make Mr MH's prognosis even worse. He also explained that whilst the AOT considered that Mr MH required a high level of supported accommodation he doubted that this would make any appreciable change in his substance misuse habit as the level of support was unlikely to be as great as that provided by inpatient hospital care which had been shown not to be sufficient. He echoed the view of several of the staff interviewed by the Independent investigation Panel who thought Mr MH was capable of looking after himself and had proved himself remarkably adept at dealing with financial matters and other crises in the past.

11.60 **On 10 June 2004** the Social Worker went to the Homeless Persons Unit with Mr MH and he was given accommodation at the Ridgway Hotel for two nights so he was more local to Leyton. He was deemed intentionally homeless and therefore not eligible for housing other than bed and breakfast accommodation. This started a long period of staying in a range of accommodation, and he did not have a permanent home again.

11.61 **On 13 September 2004** Mr MH was seen by the SHO (Dr NR) and was given a monthly supply of medication but only issued with a week at a time with the balance stored at the Larkswood Centre, the AOT base. Mr MH admitted using £20-£30 on cannabis, £40 on crack cocaine and £30 on heroin plus consuming large amounts of high strength alcohol. He refused to take his depot but was eventually persuaded to accept Olanzapine but was warned that it needed the SHO to monitor it regularly. The prescribed dose was 5mg nocte for two days and then to increase to 10mg.

11.62 The majority of the time of the AOT was spent providing support to Mr MH and sorting out practical issues for him. He tended to keep appointments when he needed help, otherwise he was not really engaged with services. Examples of this are given below.

11.63 **On 19 November 2004** Mr MH had wanted food vouchers and to have access to his old property to collect some clothes and a prayer book. He was given £11 in food vouchers. It was subsequently discovered that his flat had been emptied and his property disposed of. The following week on **26 November 2004** Mr MH arrived at the Larkswood Centre seeking more vouchers, having spent his giro-

cheque on a new mobile phone. He was given £20 which he considered inadequate. Mr MH was furious and very aggressive and stormed out of the shop without any food. He later returned and saw CP and was angry and verbally threatening. (He apologised for this on 01 December)

11.64 Three days later Mr MH had an outpatient appointment with the SHO (NR). It was noted that he would be homeless again from The Ridgway in Chingford on 15/12/2004. He had not been referred to the Ferguson Centre (a Day Unit) as previously agreed and the issue of his property missing from the flat had not been dealt with. Mr MH had been attending Healthworks regularly and was on a daily dose of Subutex 16mg.

11.65 **On 13 December 2004** DL took Mr MH shopping to buy some new clothes which cost £100. He also took him to his new flat which the AOT had found and financed from their own funds. It was located in Leyton where Mr MH had his main contacts and which he considered to be his home area.

11.66 **On 18 December 2004** at an outpatient appointment Mr MH said that he had attended Stoneleigh one weekend in crisis with very powerful auditory hallucinations telling him to kill his brother. He admitted using £100/£200 on crack cocaine, and commented that he was living near two other AOT clients who also used crack.

11.67 It would appear that some of the AOT staff were getting exasperated by Mr MH and the lack of progress in addressing any of his key problems of housing, mental ill health and his substance misuse problems. In a heartfelt comment in her notes the SHO (NR) commented on **04 February 2005** that she could understand the team's view of Mr MH and that personality issues did play a strong part in the patient/staff relationship. She thought that Mr MH wanted to feel more human and that the AOT should try and do what they could for him to maximise his ability to overcome his addiction.

11.68 In her interview with the Independent Investigation Panel one member of the AOT explained that she thought the SHO was acknowledging and recognising that for anyone who works in mental illness and who works with people with symptoms or traits of personality disorders across the spectrum, the traditional and understandable reaction is to feel alienated.

11.69 Several staff commented that the AOT caseload with several young men with a dual diagnosis was one of the most difficult to work with and the most challenging. One team member considered that this was because they touched the staff members' own personal psyche. This person also thought that staff always had to hold on to their first and most persistent assumption that they are working with a fellow human being who requires help and support.

11.70 **On 11 February 2005** the occupational therapist (SG) left the AOT and in his handover report mentioned a methodology which went to the core of Mr MH's relapses, namely that he could have been trying to prevent a deterioration in his mental state by using illicit drugs, and therefore his treatment should concentrate on his co-morbidity in a dual approach.

11.71 Because of the concentration on practical things and the perceived need to provide strong boundaries for Mr MH the AOT decided when SG had left that ZH would be the care coordinator with LP being the second worker and DL having input as appropriate. **On 17 February 2005** Mr MH became angry when told he would have no more vouchers and that he must budget. He felt that his complaint about the loss of his property was not being dealt with. Mr MH was advised to put his complaint in writing and the AOT manager had seen the complaint and had faxed it to the NELMHT Complaints Department. It appeared to the Independent Investigation Panel that staff were making Mr MH take some responsibility for his life and his actions.

11.72 **On both 22 and 24 February 2005** Mr MH visited the AOT demanding vouchers and was refused. He had lost some which had been stolen. He still blamed SG for the belongings he had lost at the flat which he valued at £30,000. On 28 February 2005 ZH, K O'B (CPN) and DL went to visit Mr MH at his flat. He opened the door and said there were no other people there. When they went in they found five men who were obviously under the influence of drugs. ZH gave Mr MH an appointment for 02 March 2005. It was noted that another AOT client appeared to be sleeping in the flat.

11.73 Mr MH failed to attend the appointment ZH had made and his misuse of the flat was reported to the Social Services staff commissioning the flat which he was subsequently required to vacate. He was again reduced to having to stay at bed and breakfast establishments.

11.74 **On 09 March 2005** Mr MH visited the AOT asking for vouchers and these were refused. He became very aggressive and demanded to see a doctor but there was no one available. Mr MH claimed to be hearing voices and said he was going to kill himself. He went to reception and claimed ZH had called him a ‘Paki’ and he was racist and he was not going to leave until he had seen a doctor. KO’B assisted ZH.

11.75 The above incident started with a meeting with CP where it was pointed out to Mr MH that he had to take responsibility for better decision making about money and vouchers. CP used the phrase “concept of choice”. Mr MH eventually became aggressive and this continued into his meeting with ZH.

11.76 **On 14 March 2005** Mr MH visited the AOT requesting help in accessing his children. He felt he had not been treated fairly. There were concerns about the level of his medication which was currently Olanzepine 10 mgs Daily. Dr NR wanted to raise the dose to 15 mgs. However the next day Mr MH was again threatening to the AOT manager, and at a clinical meeting it was decided to raise the dose of Olanzepine to 20 mgs.

11.77 **On 16 March 2005** bed and breakfast accommodation at Elite Lodge was organised for Mr MH should it be necessary and this became his fourth move in three months. The AOT was very concerned that it was not fully fulfilling its responsibilities under the requirements of Section 117 of the Mental Health Act 1983. As a result an email was sent to JW (CEO) saying the AOT was not providing several clients with appropriate Section 117 support. (This is a joint responsibility with the Local Authority to provide aftercare and accommodation.) It was stated that there was a group of AOT clients who were very hard to manage as they were unable to access any planned care for their use of crack cocaine or engage with DDART, as they had no secure home because the London Borough of Waltham Forest deemed them to be intentionally homeless.

11.78 The email concluded by stating that in its opinion the team felt very strongly that it was failing its statutory S117 duty, and warned that a member of the public would sooner or later be hurt or robbed, or that one of these patients might on impulse, kill themselves.

11.79 JW responded by commenting that she did not understand why the email had been sent to her and passed it on to the Chief Operations Officer for her attention. In her interview JW did explain that NELMHT was characterised by decisions generally being pushed up the line so that a huge number of day-to-day issues were being made by the Executive Team. She likened it to there being almost a paralysis and an inability to make a decision. Even when the issues were discussed by the Executive Team decisions were not necessarily taken.

11.80 Meanwhile Mr MH was again being warned about his behaviour in Elite Lodge (31 March 2005) and when on 06 April 2005 ZH visited another client at the bed and breakfast accommodation he heard Mr MH in the corridor doing a drug deal and later saw him outside acting very suspiciously with another man.

11.81 **On 14 April 2004** Mr MH wanted a clothing grant and became angry when this was not provided. He denied the circumstances of the ASBO and the loss of his flat, and again blamed the AOT for the loss of his possessions.

11.82 **The next week on 21 April 2005** Mr MH attended the Larkswood Centre for his depot. He wanted financial help and was told he had to budget, whereupon he left abruptly. A few days later Elite Lodge reported that Mr MH was being disruptive and was hassling other residents for money (27 April 2005) and on 02 May 2005 he was reported to be verbally aggressive to staff and disruptive at night, and a request for him to leave was made, to which ZH, his care coordinator, agreed.

11.83 **On 03 May 2005** CP sought legal advice about whether the AOT were legally bound to find Mr MH accommodation to which the response was to suggest he could be placed out of Borough. Mr MH was placed at Barking Park Hotel which had a good ethnic mix including other people from an Asian background.

11.84 **On 24 May 2005** Mr MH attended his CPA meeting. The plan was for Mr MH to:

- have regular contact with AOT at least twice a week
- continue the ongoing monitoring of medication once a week
- continue the ongoing search for appropriate housing.

11.85 It was also noted that a “Mental Health Act assessment should be undertaken if it is felt that Mr MH is deteriorating.” The care coordinator was the named person responsible for all these tasks.

11.86 The CDAT worker found Mr MH extremely agitated at this meeting and making threats to kill someone. The consultant present did not feel he was psychotic, and it appeared to be a response to the news that his housing application had been turned down.

11.87 **On 29 May 2005** Mr MH attended CDAT and apologised for his behaviour at the CPA meeting. There was evidence of passivity feelings implying a schizophrenic form of psychosis. Mr MH stated that “ancestral spirits” were speaking “through him”. He was more settled in the accommodation in Barking but felt that he needed more support.

11.88 **On 02 June 2005** Mr MH attended the Larkswood Centre for his medication, which was a day later than it should have been. He reported that he was happy at the Barking Park Hotel, and had no problems. He had, however, had money stolen there so was given a £15 voucher for food.

11.89 **On 08 June 2005** ZH visited Mr MH and found him in low mood and to be paranoid about the public, but denied having any thoughts to harm them. The same day Boots Chemists phoned to report that due to Mr MH’s abusive attitude to the pharmacy staff they were no longer prepared to dispense methadone to him.

11.90 Following this ZH phoned CDAT advising them that Mr MH had not collected his prescription. CDAT were concerned about the Methadone prescription and ZH said that he would visit twice a week because he, too, was worried. ZH also mentioned that Mr MH had said he no longer wanted Subutex and insisted he was off illicit substances. Subutex/ Buprenorphene is a partial Agonist and also a blocker of opiate receptors. This means that when taken it does give a mild experience of taking opiates. This encourages the patient to keep on taking it but paradoxically it

blocks the effects of all other opiates taken such as street heroin. So if a patient takes it, but privately has no intention or cannot cope without experiencing the effects of "over the top" street heroin they may elect to stop the Subutex.

11.91 **On 13 June 2005** Mr MH attended CDAT and again said he wanted to come off Subutex as after three days he had back pain and had bought heroin. The CDAT team persuaded him to reconsider Subutex and offered higher doses provided he attended. Mr MH apologised for the problems with Boots but now had to find a new chemist. He said he was generally feeling more settled and wanting to see a solicitor about access to his children. He missed his next appointment on **17 June 2005** which meant he had no prescription for Methadone over the weekend.

11.92 **On 20 June 2005** Mr MH attended CDAT, apologised for not attending the last time and admitted having to use heroin. Dr A was involved and restarted Subutex at 4 mgs. Mr MH was told about the need to keep opiates in the system steady in order to stabilise. A big motivating factor for getting clean for Mr MH was his wish to get back with his wife and children.

11.93 **On the next day 21 June 2005** ZH visited Mr MH at his accommodation. The manager said there were no problems with his behaviour. Mr MH reported that all was well but he had lost some medication so a replacement was given. ZH noticed a hockey stick in the room, and Mr MH said that he might take up hockey again, but would probably take the stick back to the shop as it was bent.

11.94 **On 24 June 2005** Mr MH called the AOT office asking to speak to ZH but as he was unavailable other staff saw him at the Larkswood Centre and arranged emergency food. Mr MH complained that £90 had been stolen from him that morning, when he had put the money down whilst taking a wash and then discovered it had gone. MH had reported it to the police and showed TL the receipt. He was given food vouchers.

11.95 **The next day, 25 June 2005** Mr MH murdered a member of staff at the Barking Park Hotel with a hockey stick and a knife which he had taken from the kitchen at the hotel.

12. Timeline and identification of Critical Issues

Timeline

12.1 The Independent Investigation Panel produced a Timeline in tabular format in order to plot significant data and identify the critical issues and their relationships with each other. (The Timeline is attached as Appendix 1.) This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns of the Investigation Team.

12.2 The Timeline was examined by the Independent Investigation Panel and its contents considered alongside the Root Cause Analysis ‘Fishbone’. The topic areas for analysis using this methodology are:

a) Team and Social Factors

b) Communication Factors

c) Task Factors

d) Education and Training Factors

e) Patient Factors

f) Organisational and Strategic Factors

g) Working Conditions Factors

h) Equipment and Resources Factors

i) Individual Factors (which stand alone and are not embraced by the other categories).

12.3 The interviews with the members of staff and managers, and those with Mr MH and his sister were examined at length by the Independent Investigation Panel and are quoted throughout the next section where the Fishbone Analysis is described in detail.

12.4 These factors are examined in the order prescribed by the Fishbone Analysis. They can be collated under six main headings which group the findings from the overall analysis. These headings are:

- Staffing Issues
- Risk Assessment
- Relationship Issues both within the Management of NELMHT and between NELMHT and the other Organisations within Waltham Forest
- Housing and Accommodation Issues
- Non-Engagement with Services by Mr MH
- Management of Dual Diagnosis

13. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

RCA Third Stage

13.1 This Section of the Report will examine all of the evidence collected by the Independent Investigation Panel. This process will identify the following:

1. Areas of good practice
2. Areas of practice that fell short of both national and local policy expectation
3. Key casual factors

13.2 The headings in this Section of the Report are taken from the Fishbone Analysis. The Independent Investigation Panel examined all the evidence from the clinical records, the interviews it conducted and the appropriate National Guidance, Policies and Operational Policies in the North East London Mental Health NHS Trust in order to identify any causal factors relevant to the homicide.

13.3 There are three types of factors to be identified in Independent Investigations into the care and treatment of people who have committed a homicide whilst under the care of mental health services or having been under their care in the preceding six months of the homicide. These are:

Key Causal Factors:

13.4 This term is used in this Report to describe an issue or critical juncture that the Independent Investigation Panel has concluded ***had a direct causal bearing upon*** Mr MH and the homicide. When considering mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent suicide, or a homicide perpetrated by them.

Contributory Factors:

13.5 This term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the state of Mr MH's mental health and/or the failure to manage it effectively.

Service Issues:

13.6 The term 'Service Issues' is used in this Report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 25 June 2005, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

Team and Social Factors

Lack of Adequate Consultant Psychiatric Input to the AOT

13.7 It was evident from the interviews with Dr L and CP that the consultant psychiatric input to the AOT was relatively small at a 0.2 whole time equivalent (wte) post. In fact during the interviews staff were not agreed on the actual level of input. Dr L stated that he provided two sessions (1 day) a week whilst the team were clear that he was only available for one session (half a day) a week.

13.8 This discrepancy can probably be explained by the fact that Dr L was the only consultant psychiatrist for the Waltham Forest Rehabilitation Service covering a population of about 220,000. Dr L volunteered to take on the role of psychiatrist for the AOT as he thought the two teams did broadly similar work and therefore he was best placed amongst the then psychiatrist group. He was with the AOT on Tuesdays, but could easily have been called away to deal with rehabilitation work.

13.9 It appears that Dr L was struggling to provide a service and was not able to offer reflective advice on the management of cases. The service was in many ways forced to concentrate on the resolution of ongoing crises and meeting the practical needs of its clientele for food, employment, benefits and accommodation.

13.10 JR reported that prior to being the Associate Director for Child and Adolescent Mental Health Services for the Trust she was a commissioning manager for Waltham Forest PCT and remembered that the AOT had not been commissioned within the framework advocated in the Policy Implementation Guidance. It was never funded for medical input and the rest of the AOT comprised a number of agency staff, but the team had a very good reputation and had experienced staff within the team. It was not viewed by NELMHT or the PCT as being a cause for concern.

13.11 The medical position was improved when a Senior House Officer (SHO) was made available for 0.5 wte (5 sessions) a week. This was seen as a very positive move by the AOT staff. It is clear from the case files that the SHO wrote excellent reports and generally involved herself in the work of the team and apparently at the cost of her own health. She was described by one senior member of the AOT as “absolutely reliable, and she did all the work and more”.

13.12 Since the homicide in March 2005 the AOT has had its consultant psychiatric cover increased to a half time appointment (five sessions a week). As a member of the AOT commented during an interview with the Investigation Panel “everything changed after September 2006 as the AOT had an RMO for five sessions a week, but in practice the consultant was available for more sessions than this a week.”

13.13 The Independent Investigation Panel felt that the lack of sufficient consultant time resulted in a lack of capacity in terms of time and expertise to adequately reflect about their work; the actual nature of their relationships with their clients and how they could intervene proactively rather than being reactive. The Independent Investigation Panel observed the lack of any formal overview of treatment that defined Mr MH’s plan in a positive or goal orientated manner. Senior AOT members felt they had inadequate supervision and discussion time in which they could generate new ideas for engagement with Mr.MH. The Independent Investigation Panel felt there was little evidence of the use of models such as Motivational

Interviewing, Dialectical Behaviour Therapy and psycho-dynamics to elucidate how the key goals of real engagement, boundary setting and goals chosen by the client could be met. Clearly the AOT would be using these models, but when there were difficulties and these difficulties were of a degree and nature that stimulated the Team Leader to write to the Chief Executive, the Independent Investigation Panel could find no evidence that various treatment models had been discussed. Crucially there was no mention of the awareness that the more intense approach afforded by the high staffing and skills level of an AOT might be responsible for increasing transference difficulties and acting out behaviour. (The CMHT had engaged with Mr MH at a less intense level and there had been some co-operation and progress, yet they could see the great advantage of the more intensive input from an AOT when Mr MH was struggling hence the transfer to the AOT.)

13.14 The lack of adequate psychiatric cover also played a part in the difficulty in reaching a definitive diagnosis for Mr MH, as did the lack of any consistent psychology input to the AOT, as the psychologists would not agree to be care coordinators. The diagnosis of schizophrenia was initiated by the community mental health team and later revised to be dual diagnosis comprising schizophrenia and complex drug and alcohol misuse.

13.15 It was felt that an opportunity earlier in Mr MH's contact with the Trust had been missed (in being able to take him off medication and to observe his reaction when he was relatively drug free), when on **7 October 2003** Mr MH was admitted to Nasebury Hospital under Section 136 as the police had been summoned to his address where he had been banging on his neighbours wall, shouting and causing a disturbance. He was very aggressive to the police and had to be restrained. Mr MH also threatened to set fire to his house and there was a strong smell of gas. Three sets of neighbours had contacted the police as Mr MH had knocked on their doors demanding to know where his wife and children were.

13.16 On arrival at Nasebury Hospital Mr MH presented as very aggressive and demanding to staff on his arrival. A drug screen was positive for cocaine. He was placed under Section 3 of the Mental Health Act 1983. He was reported to have settled fairly quickly but four days later on **11 October 2003** he absconded from the ward and was brought back by the police a week later on **17 October 2003**.

13.17 **On 28 October 2003** a CPA meeting was held. The staff agreed that Mr MH needed a home based occupational health assessment and the allocation of a new CPN. There was concern that he was not engaging fully with services and a discharge CPA meeting was fixed for **11 November 2003.** This appears to have been due to the hospital team having no method to control Mr MH's use of illicit substances. There was little evidence to the Independent Investigation Panel that the team had considered the possible downsides of a "reactive decision" to discharge, and no evidence of a cooling off period before discharge to see if he could improve his behaviour given a bit of time and space. In the event this did not take place as Mr MH was found smoking cannabis on the ward and his position was reviewed at the ward round by Dr F, Consultant Psychiatrist. He also rescinded the MHA Section and made Mr MH an informal patient. The Discharge CPA meeting was brought forward and held on **05 November 2003** as part of the ward round, and he was discharged the next day.

13.18 Mr MH was not often under Section 3 of the Mental Health Act 1983, and this admission would have provided an opportunity to give him a medication holiday and to observe how his symptoms reacted. He could also then have been tried with antipsychotic medication to see whether this would positively assist his mental health. Such a course of action would require an inpatient admission under the MHA 1983.

13.19 The Independent Investigation Panel considered that the role of the RMO was absolutely crucial in this situation to "hold the team" in terms of providing the rationale for diagnosis and Mental Health Act status. The team has to gain an agreed and therapeutic consensus view on the patient in order to decide from which point they are starting to engage. In other words, is the patient suffering from a mental illness or is he bad or a mixture of the two? (to use an over-simplistic paradigm.) The consultant's job is to mould and expand this debate.

13.20 An important task in working with people with dual diagnosis is to try to determine how much of the problem is due to the individual, and how much due to their mental ill health. The RMO has the job of standing back and recommending that the mental health issues are dealt with first, using MHA Formal Status if appropriate. This may provide some control for the patient, helping him to deal with the psychosis and allowing the team to start work on the "illicit drugs". There is little evidence that such an approach was considered with Mr MH.

Recommendation 1

The AOT should build into its working arrangements formal opportunities to review cases which are causing the Team concern, or where no progress is being made in meeting the clinical and social care objectives agreed.

(It is recognised that much has occurred since June 2005 to implement some of the points covered in this recommendation, especially the increase in psychiatric time.)

Lack of Engagement

13.21 Throughout his time with the mental health services in Waltham Forest Mr MH engaged very much on his own terms. He was seen by staff as very able to look after himself and to be extremely resourceful.

13.22 Staff told the Independent Investigation Panel that in their non-clinical opinion Mr MH displayed the traits of a deeply disturbed individual, who was transferred to the AOT with a given diagnosis of schizophrenia which some doubted. This doubt was fuelled as staff seldom felt that any of the symptoms he spoke about really rang true. Mr MH was someone who became highly aggressive under the influence of certain substances on which he spent all his state benefits.

13.23 As staff frequently observed Mr MH, like many people who are dependent on drugs, would lie constantly. He was also very challenging to work with because he so often presented with an aggressive stance and used verbal aggression. This was occasionally palpable to some staff who could feel physical aggression coming and would therefore withdraw.

13.24 In the records Mr MH was described as highly intelligent, highly manipulative and needing instant gratification. Whatever his need was, it had to be done there and then and led to the AOT considering ways to set some boundaries for him. He was known to be an expert at splitting professionals, so it was decided that the care coordinator would be the main point of contact, and that the Occupational Therapy Trainee Instructor would work alongside the care coordinator. The Team Manager decided to be the other regular contact because so many of Mr MH's requests required a managerial decision over funding and the use of vouchers. Some staff thought that Mr MH was presenting time and time again with the main features of a personality disorder-type diagnosis, and was thought to be somewhere on that spectrum.

13.25 Staff commented that the features of his illness that Mr MH would describe were in stark contrast to how he spoke. Much of the time Mr MH was articulate and clearly intelligent. On good days he was described as coherent, interesting and able to talk a little about his childhood, his family and about what his religion meant to him. Once the real chaos of dual diagnosis and homelessness had started this more open side of him became more and more elusive.

13.26 Mr MH was seen as being very resourceful in the community, so staff said they knew he would never ever starve, whereas they had other patients who would be referred presenting exactly the same issues, but they would need to be admitted straight into hospital because they were considered vulnerable.

13.27 In contrast Mr MH was fairly consistent in his contact with the Drug and Alcohol services. He did appear for his prescriptions, as he did, if reminded, for his depot. He never managed to stop taking drugs, except for a period prior to his contact with the AOT when in the end the need to fund his habit took over. It was acknowledged that Mr MH had dual diagnosis but this proved difficult to treat. This was because Mr MH was difficult to engage with, particularly once the AOT Team started to impose boundaries around their provision of food and vouchers and other practical help.

13.28 The AOT was fortunate to have two dual diagnosis workers attached to it, although their remit was to train staff across the Borough in the techniques of dual diagnosis as well as have a caseload and to provide advice to colleagues. Healthworks was the substance misuse service and CW was the manager. She worked with ZH, MH's care coordinator and thus the drug and mental health issues were understood and, to an extent dealt with as well as they could be while Mr MH was homeless with no stable foundations for his life at the time other than his reliance on drugs.

13.29 One of these dual diagnosis workers commented that there was much better communication between the AOT and Healthworks, and in Mr MH's case there was excellent communication between CW and ZH on a weekly basis. Many of the dual diagnosis clients with the AOT were not linked in with Healthworks.

13.30 Mr MH was unable to fully engage with services as his addiction was too strong. He managed to give up cocaine for a brief period but soon went back to it. It is possible that his increased usage was due to the use of Subutex/Buprenorphine as Mr MH was too chaotic to stabilise on it, and this could have led to more chaotic heroin taking to gain the desired effect.

Recommendation 2

Where there is uncertainty about a service user's diagnosis the AOT, (or any mental health service) should take steps to pool their information and to agree on a diagnosis, or the steps needed to secure a definitive one, with a view to determining a coherent and consistent treatment plan that could then be negotiated with the patient.

Homelessness

13.31 The Timeline illustrates how Mr MH became homeless in **June 2004** after being evicted from his rented home owned by the Quadrant and London Housing Association due to his having turned it into a drug den frequented by drug addicts and prostitutes, and his disturbed and threatening behaviour to his neighbours. Mr MH was deemed 'intentionally homeless' by the London Borough of Waltham Forest and therefore responsibility for his accommodation transferred from the Housing Department to the Social Services Department.

13.32 Mr MH was discharged from the Stoneleigh Unit on **3 June 2004**, due to spending his giro-cheque on alcohol and cannabis whilst on unescorted Section 17 Leave from the ward. Mr MH was given a list of open access hostels and was living in a bed and breakfast establishment in Chingford. This occurred at the same time that Mr MH was being transferred from the CMHT to the AOT. Between June and December 2004 Mr MH had several different addresses due to being asked to leave premises because of his behaviour.

13.33 **On 13 December 2004** Mr MH was provided with a flat found for him by the AOT which also funded this. Mr MH stayed at this flat until early March 2005 when he was asked to leave following a visit by SH, DL and KO'B on **28 February 2005** when five people were seen in the flat who were all under the influence of drugs. Mr MH was found accommodation at Elite Lodge which was his fourth move in three months according to an email from CP to BM.

13.34 At this stage CP was very concerned that Mr MH and several other clients in similar circumstances were not being adequately helped as required by Section 117 of the MHA 1983. She considered them to be a real threat to either themselves or other people. Mr MH had only bed and breakfast accommodation, was constantly mixing with other drug users, and had a dual diagnosis of schizophrenia and substance misuse. It was felt that his condition and the lack of any settled accommodation was rendering him both vulnerable and a potential danger to the public.

13.35 CP had tried to obtain additional support but was unable to gain this from her immediate managers, so she emailed JW the Interim Chief Executive stating that she had been notifying strategic colleagues about this group of high risk patients for many months. These patients were not able to access any planned care regarding their use of crack cocaine, or engage with DDART because they had no secure home and the LBWF Housing Department would not re-house them due to their assessment that this group was intentionally homeless. She was very concerned that the AOT was failing its statutory duty under Section 117 of the MHA 1983 to provide community care. It was felt that this group of patients with complex problems were a potential danger to themselves and to other people.

13.36 The then Interim Chief Executive stated in her evidence to the Investigation Panel that the issue about CP not being able to gain a decision in response to her concern about this potentially dangerous group of patients was not unusual. She described the Trust as characterised by a sense of learned helplessness where people had reached the point of thinking that no matter what they did it would not make any real difference.

13.37 The situation where staff did not take decisions but everything was passed upwards was described. The concerns regarding Mr MH and the cohort of similar people were passed by the Chief Executive to the Borough Manager Waltham Forest and the Interim Chief Operating Officer for action. With no immediate resolution of the issue, the AOT was left with the crisis management, in the community, of a man of medium to high risk, who serially was evicted from temporary accommodation.

13.38 The AOT had made an application for appropriate housing for Mr MH which was considered by the Accommodation and Resource Panel for Mental Health Adults, up to age 75. This Panel dealt with referrals of people who had been assessed as needing supported accommodation or residential care. In the past specialist services would be referred to the Panel, because the Panel was often made up of a representative from the PCT, the Local Authority, NELMHT and Housing. The Chair of the Panel explained that Mr MH had applied for residential care, which the Panel had agreed, and two homes called Riverside and another called The Grove were identified as possibly being able to meet his needs. Following this decision it would have been the responsibility of the team manager or

the care co-ordinator to arrange for either of the homes to assess Mr MH and determine whether they would be able to meet his needs and offer him a place.

13.39 In the event Mr MH was very cross when he learned of the outcome of his application and was very aggressive at the CPA Meeting on 24 May 2005. He continued to live in bed and breakfast accommodation until the incident.

13.40 The Independent Investigation Panel considered that the care and treatment for Mr MH was appropriate given his dual diagnosis and his high dependence on drugs. There were doubts about whether Mr MH was psychotic, but as he was unable to fully engage the services did the best they could in the current circumstances. A low secure placement would have been useful for detoxification to have been achieved as well as investigating how his psychotic symptoms reacted to a period without medication.

13.41 It is understood that at the time there was no low secure facility within the Trust and that there was limited funding for people to be sent to other facilities in nearby mental health services. The housing application for residential care could have helped, provided there was a high level of supported care. It is assumed that the past history of Mr MH with his addiction and his selective engagement with the AOT and Healthworks played a significant part in the decision not to provide a placement.

13.42 AOT staff explained during their interviews with the Independent Investigation Panel that after accepting the referral of Mr MH in May 2004 they had felt quite clearly, once they had reviewed his history and had got to know him for a few months, that he needed to access low secure rehabilitation or another low secure setting. This was because he had never been given a chance due to his chaotic lifestyle in the community. Mr MH had been referred to the AOT because the CMHT were unable to work with him safely. The AOT felt that Mr MH merited a low secure placement in a hospital such as Clare House, in Essex, part of the St Andrews Group, or Kneesworth House run by Partnerships in Care where there would be a graduated programme and where he could not have the same access to drugs as he could in the local acute units. The crucial issue was whether Mr MH met the criteria for such a placement. Even if he did meet the criteria it was by no means certain that funding for it would have been available.

13.43 It is understood that the position has now improved as there is an internal Individual Service Agreement (ISA) Panel within Waltham Forest. This Panel coordinates the specialist resources people with complex needs may require and manages the access to these, which can be very useful in terms of getting access to forensic assessments, advice on the management of people with complex needs and access to low secure services or other specialised services.

13.44 The Chief Executive of the NELFT (North East London Foundation NHS Trust – as NELMHT is now called) explained that a low secure facility was being developed within the Trust and would be operational in about a year. Since the homicide the forensic service for Waltham Forest has been changed and is now provided from the John Howard Unit in Hackney and not from Camlet Lodge in Enfield. The service is therefore closer and better able to provide a more rapid response.

13.45 There is a wider concern about the lack of specialist treatment for people like Mr MH who have dual diagnosis and who due to the combination of their mental ill heath and their use of illicit drugs, become increasingly socially isolated and are deemed to have made themselves homeless due to their actions. The caseloads of many AOTs have a significant group of people like Mr MH and they do pose a dilemma for services. More will be discussed about this in the Section on Dual Diagnosis.

Recommendation 3

The Trust should ensure that service users about whom clinical teams are concerned due to their potential for violence to themselves and/or others should have access to a forensic assessment and, where necessary, a low secure placement so that additional and longer term assessment and consistent treatment can be provided.

It is recognised that considerable steps in this direction have been taken by the Trust since 2005.

Recommendation 4

Escalation processes must be established so that where decisions about housing or other fundamental issues cannot be agreed, they can be moved up the management and decision-making hierarchy so the necessary resources can be identified and delivered.

Risk Assessment

13.46 Risk Assessment is an important part of identifying what sort of treatment plan is required by a patient, and what needs to be done to minimise the risk to the patient and/or other people. The core ingredient of a good and comprehensive risk assessment is to have taken a full and comprehensive narrative history from the patient. It is essentially the Medical Director and the RMO's responsibility to insist on gathering a full narrative history in order to better facilitate the making of a reliable diagnosis.

13.47 The value of taking a full and detailed history of the patient cannot be overstated. It should have as much importance as the administrative process to ensure completion of the electronic CPA admission history in box format. Whilst this provides a potted history in note form, it is no substitute for a detailed history taking into account the real past experience of the patient being recorded accurately and in a manner that allows for accurate dynamic understanding. This can help the patient as they feel they have been listened to, and their experience has been taken into account which may lead to better engagement with mental health services. Clearly steps should be taken to corroborate the details given by the patient where possible, but when Mr MH was being treated in the community the staff were unaware of his sister living nearby.

13.48 The interim Chief Executive of NELMHT considered that the risk assessment arrangements within the Trust were not as strong as they should have been in 2004/5. The system and its coverage was described “as patchy.” The Trust used a tool called CRAMP: Clinical Risk Assessment and Management Plan. It was devised by Dr Stephen Pereira in conjunction with others within the organisation, but it was not used consistently. When the Trust implemented RiO (an electronic case record system) an executive decision was taken that the default position would be that everyone would use RiO. The reason for this decision was that although the RiO risk assessment tool was not as good and comprehensive as CRAMP, everybody would have had a risk assessment. As a manager stated, the decision meant that “because we knew we were not comprehensively delivering on the better tool, we said we would prefer to have consistent use of a basic tool.”

13.49 The Independent Investigation Panel thought that in the case of Mr MH there was a lack of any robust risk assessment incorporating retrospective information about threats and actual violence. Thus no one rated Mr MH as being a high risk of violence to others. Yet there were numerous instances of threats, challenging behaviour, damage to property and assaults. Staff also noted their concerns for their own safety and had taken pre-emptive measures to protect themselves.

13.50 Although not a formal risk assessment but more a cry of frustration from the AOT, their letter to the interim Chief Executive summed up their fears that their small but very risky cohort of about half a dozen clients like Mr MH posed a danger to themselves and potentially to other people because of their unpredictable behaviour following their high usage of cocaine, crack cocaine and cannabis plus alcohol.

13.51 The AOT had a 20 minute compulsory meeting every morning at 09.00 for all staff so that the work done the day before could be reviewed and the risky work for the day ahead could be identified and doubling up of staff visiting could be arranged. The team did not have the capacity to introduce any system such as ‘zoning’ to help them plan their work and formally identify those clients which presented the greatest risk.

13.52 It is quite clear that if the case record had been examined there were various episodes where Mr MH had displayed aggressive and dangerous behaviour. Examples include:

- Three residential burglaries between 1987 and 1991;
- On 08 June 1998 Mr MH reported kicking down the door of a female friend because she owed him £10. He also said that he had wanted to kill a shopkeeper as she had refused to give him credit for cigarettes;
- 25 November 1998 Mr MH committed a street robbery of a handbag in the middle of a busy road, with no regard for the safety of the lady who's handbag he grabbed;
- Further burglary in February 2002;
- 16 April 2004 Mr MH was admitted to Stoneleigh Unit as he was worried he could attack someone as he was carrying knives and reported that he had received command voices telling him to kill someone;
- The AOT staff felt uncomfortable in his company when he was aggressive, and on 27 April 2005 Elite Lodge report that Mr MH had been disruptive and was hassling other residents for money;
- On 02 May 2005 Elite Lodge again reported that Mr MH was being verbally aggressive to staff and was disruptive at night.
- On 24 May 2005 Mr MH was seen to be very aggressive at a CPA Meeting and made threats to kill which caused staff to feel uneasy;
- On 08 June Mr MH was abusive and threatening to staff at Boots and they stated they were no longer willing to dispense methadone for him due to his aggressive attitude.

13.53 This list should perhaps have triggered a more detailed risk assessment of Mr MH. There is no evidence that the AOT staff ever looked at how Mr MH presented and asked some "What if....?" questions to explore the likelihood of violence and a clear danger of risk to other people. This could have been crucial when on 21 June 2005 ZH noticed a hockey stick in Mr MH's room. There is no evidence to indicate that Mr MH had ever played hockey or had an interest in it, but his explanation that he was thinking of taking the sport up again was not questioned. A "What is this for?"

question could have produced a warning, but on this visit Mr MH was appropriate and the manager of the bed and breakfast establishment had reported to ZH that there were no problems with his behaviour.

Recommendation 5

The AOT (and all mental health services) should ensure that when they accept a service user to the service they compile a list of all the history relevant to a comprehensive risk assessment being made with the service user. This should include a detailed narrative history gathered from the patient. A risk management plan must then be made which recognises the patient's ability to comply with it. Both the risk assessment and the risk management plan should be regularly updated and kept in a prominent place within the case records so that it is available to all staff who may come into contact with the service user.

It is again recognised that the Trust has taken steps to improve the risk assessment process, but this should be regularly audited to ensure that the above recommendation has been implemented fully.

Communication Factors

Relationships between the Waltham Forest Primary Care Trust, the London Borough of Waltham Forest and the North East London Mental Health NHS Trust

13.54 Managers presenting evidence to the Independent Investigation Panel described the relationships between the three organisations, the Waltham Forest Primary Care Trust, the London Borough of Waltham Forest and the North East London Mental Health NHS Trust as poor. It appeared that the PCT had lost confidence in the Trust and was actively considering changing their contractual arrangements and seeking to commission some services from elsewhere.

13.55 The relationship between the PCT and the London Borough of Waltham Forest was portrayed as being somewhat fraught with difficulties and there was little

evidence of partnership as there were informal rather than formal arrangements in place. It appeared that there was a significant loss of confidence in the Trust's ability to deliver services effectively and within the resource envelope that was available. NELMHT was presented as a Trust in crisis and one in which commissioners and partners had lost confidence. The Panel was informed that there was not a strong history of engagement by NELMHT with service user groups.

13.56 In order to improve the situation the Trust fairly rapidly changed the whole of the operational infrastructure. In Waltham Forest the then entire management team of senior and middle managers was changed. This difficulty in the relationship between the various organisations in Waltham Forest may explain the lack of appropriate accommodation for Mr MH and the length of time he spent in bed and breakfast accommodation. It similarly explains why there was no clear understanding between the AOT and the London Borough of Waltham Forest over the exact housing needs for Mr MH and the small cohort of similar service users.

13.57 A positive relationship was that between the AOT and the substance misuse services within the Borough, and the close working relationship between the manager of the drug service and Mr MH's care coordinator, ZH. They worked well together and sought to complement each other's contributions. Similarly having TL as a member of the AOT with a focus on dual diagnosis was positive, and his longstanding 'on–and–off' relationship with Mr MH provided a history of the involvement of services with Mr MH and a reminder of the severity of his addiction to drugs. TL was able to offer substance misuse expertise and to help the AOT staff understand the complexities of working with people with dual diagnosis.

13.58 It is interesting that Mr MH had remained relatively cooperative with services when he was with the CMHT and had regular outpatient appointments with Dr W. Once he was accepted by the AOT he became more demanding as the team attempted to provide a structure to their involvement, and CP took steps to limit his reliance on food vouchers and other practical assistance. At the same time Mr MH was homeless during the time he was linked with the AOT.

13.59 Witnesses to the Independent Investigation Panel considered that Mr MH being rendered homeless was a turning point in his care. Homelessness certainly appeared to be the main motivation for Mr MH's complying once he went to the

Assertive Outreach Team. Prior to that he had had his flat to fall back on for accommodation.

Disabled Trust Hierarchy

13.60 The then interim Chief Executive of NELMHT, JW, described a situation where managers within the Trust did not take decisions, but tended to pass all questions about resources and other matters requiring a decision upwards. This has already been explored above in connection with the need for accommodation for Mr MH and the group of service users with dual diagnosis who were unable to organise their chaotic lifestyle.

13.61 Another example was when the acute ward was finding it difficult to assess and manage Mr MH. A low secure environment was thought to be appropriate so that he would have a trial off drugs and a view could be formed of whether he did have a psychotic illness or whether it was a reaction to his continued heavy substance misuse. At the time low security services were available but not within the Trust, which still does not provide its own. NELFT is currently building a unit which will be operational within the next year or so. Clinicians reported that the budget for low security had nearly always been substantially overspent so that obtaining placements for patients was not an easy process.

13.62 When asked whether the Trust tried to limit the use of low secure accommodation in the private sector clinicians stated that the managers had not normally interfered. The issue was more a question of finding a place suitable for Mr MH. This was difficult as the clinicians who treated him did not consider him to be significantly different to the small group of similar service users to warrant a low secure placement to determine an exact and definitive diagnosis.

13.63 Given the nature of the management within the Trust at that time as described above, it seems unlikely that such a course of action would have been actively endorsed or championed by any senior managers. In any event such an action could not be seen as a root cause of the homicide.

It is understood that the relations are now much improved and that the Trust and Borough Management has been reorganised with appropriate and effective processes in place.

Task factors

Section 117 Aftercare under the Mental Health Act 1983

13.64 When people who have been detained under Section 3 of the MHA 1983 are discharged the statutory services are required to provide them with the help and support they need in the community as described in Section 117 of the MHA 1983. The AOT manager was concerned that service users like Mr MH were not actually being covered by Section 117 because they were not able to access any planned care regarding their use of crack cocaine, or engage with DDART because they had no secure home. The London Borough of Waltham Forest would not re-house them due to their assessment that this group were intentionally homeless.

13.65 CP also asked the Trust Headquarters whether the AOT and the Local Authority were required to provide services under Section 117 to MH. The response was unequivocal and stated clearly that "as Mr MH had been subject to Section 3 of the MHA 1983 he was, despite his informal status at the time of discharge, fully covered by Section 117." The Section was then quoted in full:

13.66 'This section applies to persons who are detained under section 3...and then cease to be detained and....leave hospital.....It shall be the duty of the (Primary Care Trust) or (Health Authority) and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the (Primary Care Trust) or (Health Authority) and the local social services authority are satisfied that the person concerned is no longer in need of such services.'

13.67 As Mr MH was homeless the AOT sought to find accommodation for him and applied for accommodation from the Accommodation and Resource Panel. No immediate response was forthcoming and therefore temporary accommodation was provided. There is no doubt that the succession of bed and breakfast addresses did

not serve Mr MH well, and when the AOT found him a flat he was forced to leave as he was using it to entertain his friends and use illicit drugs.

13.68 It would appear that there was a vicious circle from which Mr MH and those seeking to help him could not escape, or a ‘Catch 22’ situation with no logical escape.

No Time for Reflection within the AOT

13.69 The Independent Investigation Panel considered that it would be difficult to convincingly argue that the only appropriate placement for Mr MH was an environment where his drug use could be therapeutically controlled (in a specialist drug hostel with 24 hour staff). Such placements are usually commissioned to take people just leaving prison or as an alternative to prison. Such accommodation can be successful when they care for people with Serious Mental Illness and substance misuse. It would take a very confident team, and especially the manager and the consultant, to really champion such an approach, especially four years ago.

13.70 The staff in the AOT described a working situation where there was little time for ‘reflection’ about their work or to discuss each situation in detail. The AOT had very limited psychiatric cover when they first accepted Mr MH as a client. There was also very limited input from a psychologist and as a direct result there was little opportunity to have a multidisciplinary reflective review of Mr MH and to ‘think outside the box’ about how he might be helped.

13.71 The difficulties of coping with a client who was difficult to manage understandably led the AOT to respond to the situations Mr MH presented them with, rather than to have adopted a more proactive approach in their dealings with him. As a result there was little if any time for robust thinking about how they might better manage Mr MH. CW and ZH worked well together and between them had a good appreciation of Mr MH and his needs, but they were unable to sufficiently contain his behaviour and to successfully combine the treatment approach for substance misuse with the AOT approach when the team had several such service users and a limited amount of clinical time.

13.72 The AOT, and in particular the manager, did try to provide boundaries for Mr MH but these were only partially successful and it was clear that Mr MH only really engaged on his own terms when he required specific assistance. Such assistance usually consisted in seeking accommodation, having food or clothing vouchers, and on limited occasions, help with benefits or seeking employment opportunities.

Education and Training Factors

Understanding Dual Diagnosis

13.73 In common with many mental health trusts in 2004/2005 NELMHT had appointed some dual diagnosis staff to work with community and inpatient teams to help staff understand the needs of people with both a mental health problem and a substance misuse problem.

13.74 The AOT was the first team to have an attached dual diagnosis worker. The team found the additional skills and knowledge useful and the Dual Diagnosis Worker attended the clinical meetings. A few months later a second Dual Diagnosis Worker was appointed and they took it in turns to attend the AOT clinical meeting and the clinical meeting of the Community Drug and Alcohol Team. Each team then got to know both workers, and they worked closely with the AOT.

13.75 The two Dual Diagnosis Workers also had a Trust-wide remit to train other staff having undertaken the 'Train the Trainers' course. They were also expected to give advice to staff about complex cases and to work with them on occasions. The Manager of the AOT thought the two workers were "very effective at teaching, they were very effective at enabling us to focus on aspects of our clinical work that weren't particularly drug-focused, by setting up groups within acute inpatient settings, both for patients, carers and staff in different groups."

13.76 As always happens the staff who were keen to learn and who wanted to help their service users address their addiction problems as well as their mental ill health issues were quick to seize the opportunity to increase their skills in trying to meet the complex needs of the AOT caseload. Other staff were less enthusiastic, particularly the inpatient staff, as they often considered that the patients had caused their own

problems, and did not regard the substance misuse as part of their overall treatment plan. It should be emphasised that this was common throughout the NHS and not specific to NELMHT. The introduction of the specialist Dual Diagnosis workers was a positive move, but the need to change the negative culture surrounding substance abuse was not really tackled as this would need full and committed senior clinical and management leadership.

13.77 Whilst there was evidence of a greater understanding of the relationship between serious mental illness and substance misuse, there was little evidence from the interviews with staff of the AOT of the need for emphasising perseverance with both the drug addiction and the mental ill health. The latter approach would require regular assessment of the patient's motivation (Prochaska and Di Climente 'Cycle of Change') and the need to press hard and use all appropriate means under the Mental Health Act 1983 to aggressively treat the Severe Mental Illness symptoms.

13.78 In Mr MH's situation there was unfortunately, due to his homelessness and the chronic state of his addiction, no settled area within his life on which to build. As a consequence neither staff nor Mr MH were able to take advantage of the dual diagnosis approach. The AOT did find a flat for him after the loss of his long-term substantive address. This had been an attempt to provide a more secure and potentially stable address rather than a stream of bed and breakfast establishments, but he was asked to leave after breaking the terms of the lease by using drugs with his friends there.

13.79 Dual Diagnosis is now recognised as an important part of the work of mental health services. There are insufficient resources available in the NHS to fully equip every team, but access to advice and assistance should be made available. The Independent Investigation Panel agrees with Manager of the AOT that there are small groups of service users like Mr MH and the cohort of others about whom the AOT were concerned. Due to this fact and the experience of the Independent Investigation Panel a full recommendation is made about how the Trust should tackle the issue of Dual Diagnosis.

13.80 Nationally the development of Dual Diagnosis Teams has been patchy and few have managed to make the same impact as the Early Intervention in Psychosis

Teams have on first onset of a psychotic illness. The following recommendation is based on the experience of the few Dual Diagnosis Teams which have been successful, and uses the key factors which have been cited as contributing to their success.

Recommendation 6

The Trust should give priority to the active treatment of patients with Dual Diagnosis. Many of the most severe patients are service users of the Assertive Outreach Team due to their inability to engage because of their chaotic lifestyles. The Trust should take the following steps:

- **a) appoint a "Product Champion" who should be either the team leader or consultant who is prepared to persevere and drive treatment on both the substance misuse and the mental illness;**
- **b) provide tangible and public endorsement and support from the Trust Executive Team, particularly the Chief Executive and the Medical Director;**
- **c) identify the local systemic factors which have undermined the successful development of Dual Diagnosis services and actively address them;**
- **d) provide the AOT with the appropriate support in terms of resources, skills and leadership;**
- **e) help to gain the support of the PCT and the SHA by highlighting the number of homicides committed by people while under the care and treatment of mental health services who are suffering from dual diagnosis;**
- **f) the team should report directly to the CEO and Head of Operations on progress and their work should be considered as "core" to adult services development. Visits to nationally**

respected Dual Diagnosis services may be helpful (eg Haringey and Birmingham).

13.81 Once the Trust has started to implement this recommendation the following steps should be taken to support the Dual Diagnosis service to increase and maximise its chances of success. The Independent Investigation Panel is convinced that the delivery of a modern dual diagnosis function will need to occur to lower the frequency of future drug related SUIs within the service user group presenting to the mental health services.

Recommendation 7

The Trust should support the new addiction consultant (who is the SHAs Dual Diagnosis lead) and the addiction service manager, in presenting the best option for Dual Diagnosis services to the Board that fits the Trust's population profile.

(It is understood that a dual diagnosis strategy is currently being finalised and about to be implemented. It should take note of the recommendations of the Report)

Recommendation 8

The Trust should identify staff resources and supervision resources to ensure a comprehensive retraining of medical, nursing and other professions in Dual Diagnosis treatment.

Clinical Leadership

13.82 Whilst Mr MH was being treated by the CMHT he had several inpatient episodes but there was no serious attempt to take a detailed history nor to undertake

a comprehensive assessment early on in his relationship with clinical services. Because there was never any apparent attempt to complete this during the rest of his time in the service, no clinician ever knew the full detail of Mr MH's life or could understand his behaviour and symptoms within the context of his personality, culture and life.

13.83 The AOT was only allocated one day a week from a consultant psychiatrist which was only two-fifths of the recommended time in the Policy Implementation Guidance for an Assertive Outreach Team (and as described above there was dispute within the team members interviewed as to whether this was actually only one session a week.) As there was also extremely limited psychology time the AOT lacked any real clinical leadership which could be called upon as needed rather than on the one day a week the psychiatrist was on site. This again inhibited the collection of a detailed chronology of Mr MH and the risk assessments did not list the occasions when he had been aggressive.

13.84 As mentioned above an opportunity was missed to test the diagnosis of drug induced psychosis during Mr MH's admission to Nasebury Hospital during October and November 2003 when he was subject to Section 3 of the MHA 1983. Plans for a discharge meeting were being made but as Mr MH broke the ward 'rules' regarding the use of drugs and alcohol he was taken off this Section 3 and discharged the next day by Dr F. It appears that Mr MH was regarded as a difficult and troublesome patient, so rather than use the MHA Section 3 as an opportunity to test his diagnosis by treating him in the PICU without medication to test whether he deteriorated, he was summarily discharged.

13.85 The same happened in April 2004 when Dr W discharged Mr MH when he again broke the ward rules and used illicit drugs. There did not appear to be a formal policy about how to manage vulnerable service users who used drugs on the ward. No emergency CPA meeting was called and Mr MH was discharged back to the flat from which eviction proceedings had started.

13.86 Had a clear lead on a dual diagnosis approach been adopted it is possible that Mr MH would not have been discharged when he had the day before been rendered homeless. Had a clinical dual diagnosis lead been available it is possible that:

- an urgent CPA meeting to see how Mr MH's needs could be met would have been called;
- a cooling off period would have been allowed for staff to dissipate their counter-transference and rejection feelings that dismissal from the ward would cause;
- a more positive view of Mr MH as a struggling patient in distress may have emerged;
- an ongoing discussion about Mr MH and the arguments for and against his being discharged would have taken place. A functional analysis session with Mr MH to demonstrate to him where his challenging behaviour of breaking the ward rules was likely to take him and what he could do to stop the almost inevitable 'out of the ward and onto the streets' outcome;
- an urgent request for CDAT to engage Mr MH and undertake a detailed review;
- the development of a positive plan rather than Mr MH being allowed to become homeless with no planned accommodation other than bed and breakfast.

13.87 The Independent Investigation Panel thought that if there had been more medical leadership allied with a greater understanding of the nature of dual diagnosis then additional support for Mr MH might have been possible. This could have helped to provide more emphasis on the positives of his position rather than a focus on the negatives throughout his time with NELMHT.

Patient Factors

Mr MH's Life

13.88 Mr MH appears to have been a private man throughout his time with the mental health services and he did not reveal very much about his past or his family. The known facts are assembled together with the key events in his early life to the time he was known to have started using heroin and are listed in the Table 2 below.

13.89 As can be seen from Table 2 Mr MH was a very private person and did not have many friends. He was a second generation immigrant from Pakistan. His family were initially very supportive of him and his father and his brother helped him a great deal until it became obvious that he was unable to break his addiction to drugs.

Table 2 - Brief Chronology of Mr MH's early life

Age	Event
6	Moved from Pakistan to London
8/9	His mother died. According to his sister Mr MH became more withdrawn
12/14	Father remarried – his stepmother appeared not to like him
14	Took overdose and said he wanted to die
18	Started to drink alcohol and to use cannabis
19	First known contact with the Criminal Justice System when he was fined £200 for false imprisonment.
19-23	Three terms of imprisonment for robbery and burglary
22	Started to use heroin
25	He was still living at his father's house. He was very much a loner.
25/26	First contact with substance misuse services
27	First admission to psychiatric hospital – start of mostly ongoing contact with mental health services
28	His brother died and this was a tremendous loss for him
29	Went back to Pakistan to get married – he was very upset when this broke down after a few years.

13.90 In his interview with HASCAS Mr MH stated that he had been alone for most of his life with very few friends. He had got on well with his mother and father but his

mother had died when he was 12. His father "was OK but later on we didn't talk. My elder brother died about 12 years ago and before he got married we were very close."

13.91 His sister is the only family member still in contact with him, and she stopped supporting him after he had been threatening to her when she was unable to provide money for him. Since the homicide she has visited him in prison and feels he needs some contact with his family.

Drug Misuse

13.92 As the clinical notes demonstrate Mr MH was addicted to drugs from the age of 18 (cannabis) and by 22 had started to regularly use heroin. It appears that his criminal behaviour was entirely a means to fund his drug and alcohol habit. The staff who knew Mr MH all felt he was street-wise and was well able to take care of himself, but perhaps overlooked the danger he posed when he was on drugs and became aggressive.

13.93 He had contact with Healthworks for many years (from 1992/1993) and similarly an ongoing contact with mental health services from 1995. Despite the long contact with the substance misuse and mental health services Mr MH never really engaged with them. His contacts were essentially when it was appropriate and useful to him in his search for accommodation or financial and material help with getting vouchers for food or assistance with other practical matters.

13.94 It is clear that his need for drugs became all consuming, and he was unable to see the consequences of his actions. Having been evicted from his relatively longstanding address in the London and Quadrant Housing Association property for using it as a crack house and causing a constant disturbance to neighbours, he did exactly the same in a flat found for him by the AOT. This had been an attempt to provide a more secure and potentially stable address rather than a stream of bed and breakfast establishments, but he was asked to leave for breaking the terms of the lease.

13.95 As discussed in the section on Dual Diagnosis it is clear that Mr MH was never able to really address his problems. He remained pre-contemplative (in Prochaska and Di Climentes 'Cycle of Change) and rarely gave any hint of being ready to address his problems. There were glimpses of this when he was working with TL and CW, but the mental health services were unable to build on this and responded to a series of crises. They were thus unable to concentrate on the positives in situations as they were essentially responding to constant crises and practical assistance which precluded any deeper work to tackle the causes of these.

Organisational and Strategic Factors

Lack of Effective Operational Management

13.96 As was made clear in the interim Chief Executive's interview with the Independent Investigation Panel the management of NELMHT was not fully effective in 2005/2006. The mental health services were struggling with some very complex and difficult cases where Dual Diagnosis was the main issue. The Trust did not have access to its own low secure services and it relied heavily on other trusts or the private sector, and placements were expensive.

13.97 The AOT was commissioned without the recommended establishment for psychiatric or psychological input. This directly affected the team's ability to reflect effectively on cases, and to seek ongoing and regular discussion with a full multidisciplinary team. Dr L took on the role as consultant of the AOT as he felt that someone had to do it and the work was probably more similar to his usual rehabilitation work than to the work of the other consultants. He was able to offer one day a week, although several members of the AOT stated that he was really only available on site for half a day a week, but in either case it was well below the recommended 0.5 whole time equivalent.

13.98 It appeared that the psychologist was not a member of the team because although there should have been one, according to the Policy Implementation Guidance, at the time there was a political problem in that psychologists in the Waltham Forest part of the Trust refused to act as care coordinators.

13.99 Despite repeated requests for more time, the Medical Director was unable to identify funding, and the various levels of management appeared unable to reach any decision and the post remained at its low level. The same was true when CP requested some action on the group of complex cases which included Mr MH. As a consequence she was frustrated because no one would take appropriate action or make a definite decision.

13.100 The same was true in the difficulties of gaining accommodation for people like Mr MH who had lost their council housing for breaches of the lease agreement (using drugs, causing disturbance, sub-letting) and although managers in NELMHT were aware of the problem they were unable to get the London Borough of Waltham Forest to take action. There was no process to 'escalate' the problem so that a higher tier of management took responsibility for it.

13.101 The Independent Investigation Panel asked whether the AOT had a formal method for identifying the risk levels of its service users. As mentioned above CRAMP was used at the time. Some services use a zoning system whereby service users would be graded green, amber or red depending on their level of risk to themselves or others, with red being the 'zone' for those most at risk. The AOT did not have the time to effectively administer such a system but it did hold a compulsory short team meeting each morning so that all staff could update the team on how their most 'risky' service users were coping. This early morning meeting acted as the way in which the most worrying situations were identified and when staff could ask for assistance.

13.102 As several people interviewed commented, the AOT was regarded as one of the better community teams, and it was the CMHTs which caused the management of the Trust the most concern. The AOT was therefore not given the assistance it required as it was seen to be functioning well.

Working Conditions Factors

13.13.8 There were no indications that the working conditions for the staff of any of the teams which worked with Mr MH from 1992 to 2005 were other than satisfactory as far as the overall environment was concerned. It was reported that the Community Drug and Alcohol Team was co-located in the same building as the AOT which greatly assisted the joint working between the teams.

Equipment and Resource Factors

Staffing

13.103 The position of the AOT in 2004/2005 has been referred to several times before in this Report. Suffice to mention here that the lack of a psychologist fully attached to the AOT did limit their opportunities to offer therapeutic interventions to Mr MH, and to have the opportunity for 'supervision' where alternative ways of working rather than just responding to crises could have been explored. The locum SHO Dr NR did work hard and provided a good service to the team. She also reminded the staff to treat Mr MH as someone who deserved to be helped and not to get frustrated by his non-engagement with the service (really an emergent dual diagnosis approach).

13.104 The half a day or one day a week that Dr L was with the team was insufficient to allow the team to function in a full multidisciplinary way and again reduced the opportunity to look at other ways of working and to really deal with the Dual Diagnosis issues Mr MH presented. The AOT really only worked with Mr MH on his terms when he needed something done, although they did, to their credit, try to impose some boundaries and structure to his care and treatment.

Lack of Appropriate Accommodation (Low Secure Facility)

13.105 The Community Mental Health Teams and the AOT did not have direct access to a low secure unit. This facility could have allowed the medical team to observe Mr MH in an environment free from drugs and to cease his medication in an attempt to determine a definitive diagnosis and thereby develop an appropriate treatment plan.

13.106 The Inpatient Service, the CMHT and the AOT all worked without a definite diagnosis. Indeed the diagnosis was changed on several occasions. The diagnosis of schizophrenia was initiated by the inpatient team and the AOT accepted this, but had some doubts about it as his behaviour was seldom if ever clearly psychotic. Over time the diagnosis was added to and became Dual Diagnosis, meaning schizophrenia and complex drug and alcohol misuse.

13.107 After the homicide the Forensic Psychiatric Team assessing Mr MH prior to his court appearance subjected him to a drug holiday and noted that his mental state improved when he was not taking prescribed or illicit drugs. They recommended a diagnosis of drug induced psychosis, dissocial personality disorder and poly-substance dependency.

Lack of Appropriate Accommodation (Residential)

13.108 When Mr MH was evicted from his flat in June 2004 there was no supportive accommodation available and he was deemed to have intentionally rendered himself homeless. The only accommodation available was bed and breakfast, in somewhat dubious premises, where Mr MH was inevitably mixing with other service users from the AOT, other mental health services and habitual illicit drug users with easy access to dealers.

13.109 An application for accommodation was made but there was little appropriate supported accommodation available and in the event his application was rejected. Mr MH had found it impossible to break his drug dependency over a number of years and the lifestyle he led from June 2004 to June 2005 was unlikely to alter this, as drugs were too easily available. In his interview with the Investigation Panel ZH

commented that he remembered a conversation he and CW had had about Mr MH regularly concerning the difficulty in really helping him. Despite his contact with the drug and alcohol service and the AOT, the potential for rehabilitation was greatly reduced due to his extremely unstable home lifestyle. The lack of appropriate support was one of the main arguments ZH had made when he attended the Accommodation Panel meeting.

13.110 It is understood that there is now a more robust system of allocating accommodation within Waltham Forest which is more in line with the type of support individual service users need to aid their treatment and care.

Individual Factors

13.111 There was only one individual factor identified. This was the Internal Investigation Report which in many ways appeared symptomatic of the confusion and poor middle management within NELMHT at the time of the homicide.

13.112 The Internal Investigation Report is examined in Section 15 "The Response to the Incident by the North East London Mental Health NHS Trust and the Internal Investigation."

14. Findings and Conclusions

14.1 The Independent Investigation Panel recognised that between 2000 and 2004 many national initiatives were in an embryonic stage of local implementation. This was particularly evident with the AOT which did not have the staffing levels recommended by the Policy Implementation Guide.

14.2 In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms ‘key causal factor’, ‘contributory factor’ and ‘service issue’ are used in this section of the report. They have been defined above on Page 54.

14.3 The Key Causal Factor and the Contributory Factors identified by the Internal Investigation Panel are now outlined in their order of importance as agreed by the Investigation Panel.

Key Causal Factor 1

Non-Engagement with Services by Mr MH

14.4 It is clear from all the clinical notes from the Community Drug and Alcohol Team, the In-Patient services, the Community Mental Health Team and the Assertive Outreach Team that Mr MH really only engaged when he needed assistance. He seldom sought help with his actual addiction to illicit drugs and mental ill health.

14.5 The NELMHT services did their best to engage him and remained in touch despite his frequent non-attendances for arranged appointments. The AOT did try to set some limits to his contact by making it clear that he could not expect to always get vouchers or food without first having done something to help himself.

14.6 Ultimately the only clear root cause was the fact that Mr MH had a substance misuse problem which he was unable to overcome and this, together with his mental ill health which was exacerbated by the frequent misuse of drugs and alcohol, appears to have been the main cause of the homicide.

Contributory Factor 1

Staffing Issues

14.7 The limited access the AOT had to both psychiatric and psychology support in its early days reduced the team's capacity to identify alternative ways to work with Mr MH. Due to the nature of his lifestyle he had many practical problems and frequently sought help from the team, and they felt unable to leave him due to his vulnerability and the need to offer care and support under Section 117 of the MCA 1983.

14.8 This was a causal factor, but there was no evidence to suggest that other ways of helping to address Mr MH's addiction or his mental ill health would have succeeded due to the cycle of substance misuse he had adopted and appeared unable to alter.

Contributory Factor 2

Housing and Accommodation Issues

14.9 The fact that Mr MH spent most of the 12 months prior to the homicide in bed and breakfast accommodation meant that he did not have a settled lifestyle. His drug taking and tendency to associate with other drug users caused him to be evicted from several establishments.

14.10 When Mr MH was made homeless in June 2004 the AOT sought help from the Local Authority for some supported accommodation. This was not provided prior to the homicide, so Mr MH had to remain in a series of temporary bed and breakfast establishments. CP was very concerned about MH and a small cohort of AOT clients who all needed accommodation as they were complex cases and presented a risk to

themselves and potentially others because of their dual diagnosis of psychosis and substance misuse. She tried to secure accommodation via the usual channels but to no avail, and Mr MH had to live in a succession of bed and breakfast establishments where he was mixing with other drug users and, on occasions, where he was relatively isolated being out of his own neighbourhood.

14.11 The AOT provided Mr MH with a flat to rent in an attempt to give him a permanent address. The tenancy had to be vacated when Mr MH used it as a drug den with his friends.

14.12 In some ways he was considered well equipped to manage as he had on several occasions shown that he was street-wise and could usually manage, unlike other service users in his situation. The Independent Investigation Panel considered that the lack of appropriate accommodate, whilst not a root cause of the homicide, did contribute to the long term instability of Mr MH's life, and made it even less likely that he would be able to overcome his addiction.

Contributory Factor 3

Resources

14.13 As has been made apparent in the previous section of the Report, Mr MH was never given a conclusive diagnosis. There was continued uncertainty about whether the substance misuse and the subsequent addiction was the main issue, or whether it was a mental illness, most likely schizophrenia.

14.14 The staff interviewed stated that they would have welcomed the availability of a low secure unit where Mr MH could have been given a 'holiday' from his medication for schizophrenia. This facility would have provided a safe environment for a formal admission under the MHA 1983 where the staffing levels would have been sufficient to cope with any deterioration in his behaviour due to the withdrawal of drugs. The possibility of obtaining illicit drugs and alcohol would also be lessened in such a unit.

14.15 Under these conditions it would have been possible to make a more fully informed diagnosis and to have treated Mr MH accordingly. Unfortunately NELMHT did not have its own low secure unit, and the clinicians treating Mr MH did not feel his need for such a facility was as great as some other patients placed in the private sector.

14.16 Again this is not considered a root cause, but another contributory factor which combined with the others was a factor in the build up to the incident.

Contributory Factor 4

Risk Assessment

14.17 The majority of the staff from the AOT who were interviewed felt that Mr MH posed a slight threat in that they felt uneasy in his presence on some occasions when he was not getting what he wanted from the team. Despite this the risk assessments made did not really reflect this.

14.18 There was a lack of any robust risk assessment incorporating retrospective information about threats and actual violence. No one rated Mr MH as being at high risk of inflicting violence to others. In his history there were numerous instances of threats, challenging behaviour, damage to property and assaults. Staff also noted their concerns for their own safety and had taken pre-emptive measures to protect themselves, for example not visiting him alone, and only seeing him in an open part of the office but not in the area where staff worked. No detailed narrative history had been completed.

14.19 The mixture of mental ill health and substance misuse can be a volatile cocktail, and there are several potential triggers, such as having command auditory hallucinations or being prevented from doing or getting what one wants. Mr MH had on occasions been open and staff had been able to have some good conversations with him. These more positive interactions were somewhat ephemeral, and the risk assessment did not really reflect this.

14.20 Although in the ‘plea’ to the Chief Executive for some help in securing resources for the small group of dual diagnosis clients who were homeless, the team had identified that their circumstances and their addiction were a risk factor. Indeed they had specifically said that they would either harm themselves or a member of the public. There was nothing to indicate that Mr MH would commit a murder.

14.21 The Independent Investigation Panel felt that whilst the risk assessments were not as full as they could and perhaps should have been, there was no clear indication that an attack on a member of the public or an acquaintance was imminent and could not have been foreseen. The Panel took this view because within the context of the heavy caseload of the AOT and the group of service users they were concerned about, Mr MH was one of several complex situations they were dealing with. The team was relatively small, had limited psychiatric and psychology support, with little support from more senior managers, and felt they had to manage as best they could. With hindsight it is easy to say the event was predictable, but at the time and in the prevailing set of circumstances affecting the team, the Panel concluded it could not have been predicted.

Service Issue 1: The lack of a full narrative history of Mr MH’s mental health, as well as his early life history. Recommendation 5 covers this issue.

Contributory Factor 5

Management of Dual Diagnosis

14.22 In 2004/2005 there was no specific Dual Diagnosis service available within NELMHT. As in many other places there were specialist dual diagnosis trained staff. Their remit was to train staff in the mental health services to be able to recognise people with dual diagnosis and to take into account both their mental ill health and their addiction. These workers were also available to provide advice on how best to manage a person with Dual Diagnosis.

14.23 Their role was extremely difficult as there were, and still are, many staff to train, and also there are an increasing number of service users with dual diagnosis within mental health services. They were unable to carry anything but a token caseload and due to their other commitments were unlikely to provide a comprehensive service to a specific client/patient.

14.24 The AOT was right to highlight the needs of those clients with Dual Diagnosis as they do pose an additional set of risks, and are 'difficult' to manage as they present challenging behaviours.

14.25 This is a contributory factor, but is interrelated with Key Causal Factor 1 as Mr MH was not able or willing to fully engage with services. In this sense the Panel saw it as a causal factor but not a root cause.

Service Issue 2: The lack of a real Dual Diagnosis service prevented the AOT being able to fully address Mr MH's substance misuse issues. The close working with Healthworks moved towards a joint approach but it was not sustained. Recommendations 6, 7 and 8 cover this issue.

Contributory Factor 6

Relationship Issues both within the Management of NELMHT and between NELMHT and the other Organisations within Waltham Forest.

14.26 The poor relationships with the Borough of Waltham Forest both within the NHS and between the NHS and the Local Authority were well described by the then interim Chief Executive of NELMHT.

14.27 Managers above the level of the team manager appeared to have little ability to take decisions or to work with their counterparts in the London Borough of Waltham Forest to meet the needs of the complex and 'difficult' clients they were seeking to help. As a result accommodation was not available for Mr MH and the other service users in the group identified by the AOT. No formal escalation system

was in place so that decisions could be raised to a more senior group of staff with easier access to the necessary resources and/or budgets.

14.28 Similarly there was no decision taken at a senior level to seek a low secure placement for Mr MH, which might have assisted in gaining a definitive diagnosis for his mental ill health. This again was not seen as a causal factor as Mr MH was not able to engage with services in a therapeutic sense, and having a precise diagnosis would not have affected this.

Conclusion

14.29 The Investigation Panel, having examined all the available evidence, interviewed the staff and managers and undertaken the root cause analysis work, considers that there was no single root cause which was responsible for the death of Mr AD**.**

14.30 The one key causal factor and the six contributory factors combined contributed to the unfortunate outcome, but this could not have been predicted with any certainty to have led to this homicide.

14.31 Recommendations have been made in the Report to address the two identified service issues.

15. North East London Mental Health NHS Trust Response to the Incident and the Internal Investigation

15.1 NELMHT set up an Internal Inquiry into the care and treatment of Mr MH once they had ascertained there were no immediate actions to be taken to safeguard other patients, members of the public or staff. The Internal Inquiry was conducted in accordance with the Department of Health Guidance EL (94)27, LASSL(94) 27.

15.2 Such Inquiries are supposed to be completed fairly quickly, but NELMHT had a backlog of such Inquiries and it did not publish its Report until 11 December 2006, nearly 18 months after the homicide. This Report was then amended in February 2007. The Inquiry Panel comprised:

- Mr R Jeffries - Non Executive Director of NELMHT and Chair of Inquiry
- Dr A Horne - Medical Director of NELMHT
- Ms M Togher - Interim Director of Nursing
- Mr M Roach - Lecturer/Practitioner, Oxfordshire Mental Health Care Trust
- Mr E Joseph - Associate Director of Governance and Assurance and Inquiry Manager

15.3 The Panel was expected to meet 10 times between 27 July 2005 and 08 February 2006, but it had not completed its work and some interviews were held later in February. Some of the delay was due to the Inquiry Manager being unwell, and also due to the original draft Inquiry Report being criticised by the staff who had been interviewed.

15.4 The staff of the AOT interviewed by the Independent Investigation Panel described that they were given no feedback about the Internal Inquiry, and that they were dissatisfied with the written records of their individual interviews with the Panel which had basic facts wrong and were not a true record of the interviews. Some staff said they had never seen the Internal Inquiry Report, with another insisting he only saw it in the morning before his interview with the Independent Investigation Panel in the afternoon.

15.5 Due to the illness of the Inquiry Manager the report was not written quickly after the interviews and all the information gathering, until Ms M Togher, the Interim Director of Nursing, who subsequently retired from the Trust, was asked to return to write the Report.

Terms of Reference

The Terms of Reference for the internal Inquiry Panel were:

To examine all the circumstances surrounding the care and treatment of Mr MH and in particular:

- the quality and scope of his health and social care and any assessment of risk;
- the appropriateness, quality and adequacy of any assessment, care plan, treatment or supervision provided, with regard to:
    - his past history
    - his psychiatric diagnosis
    - his assessed health and social care needs
    - his use of alcohol and other substances
    - his history of violence
    - his relationships with Mental Health Services
    - the effectiveness of liaison arrangements between the various specialty services with Mental Health care and the Local Housing Department
    - his ethnic origin, religion and culture
- the extent to which his care corresponded to statutory obligations and duties and relevant guidance from the Department of Health
- the extent to which his care and treatment plans:
    - were based on assessed and managed risk

    - were effectively drawn up, implemented, communicated, monitored and reviewed
    - were complied with by Mr MH

- to examine the adequacy of the coordination, collaboration, communication and organisational understanding among the various agencies involved in the care of Mr MH or in the provision of services to him. In particular whether all relevant agencies and whether such information as communicated was acted upon adequately.
- To prepare an Internal Report and make such recommendations as may be appropriate for the Trust
- The facts surrounding concerns expressed and issues raised by a member of Mr MH's family during a meeting with panel members in order to ensure that due consideration is given to those issues that the family wish the panel to address within the Inquiry. Specifically, the issues are:
    - Despite repeated requests by Mr MH to have access to his children, why was support to achieve this never progressed?
    - CPA meetings within inpatient settings had maintained contact and attendance with family members. Why did family involvement not continue to be maintained throughout CPA in the community?
    - How was the family notified following the arrest of Mr MH and what support has been provided for the family?

Conclusions and Recommendations

The Internal Inquiry grouped its conclusions and recommendations under nine main headings. These were:

1) Care Programme Approach

The Inquiry Panel identified that there were several different systems in place for the recording of CPA. Details of Mr MH's sister were not passed to the AOT, and a letter she had written to the service had not been responded to. The main recommendations made concerned:

- Standard documentation for CPA should be used and shared with all involved in the care of the patient/client
- The Family should be involved in CPA in inpatient and community settings. The Community Drug and Alcohol Team should also use CPA
- Correspondence from family members should be responded to quickly bearing in mind the client's wishes and confidentiality

2) Risk Assessments

The Inquiry Panel found that risk assessments were not always completed and that not all the risky behaviour exhibited by Mr MH had been recorded. The level of risk sometimes recorded did not appear to accord with the information available in the case records. The main recommendations made concerned:

- Risky behaviours should always be recorded and be assessed with a new risk management plan being generated as a result
- When clients are placed in accommodation outside the Borough any risks associated with such a move are clearly recorded as part of the risk assessment
- Where high risk issues are identified and letters are sent to senior personnel these should be discussed with the Clinical Director, the RMO

and the Care Coordinator. Where appropriate the Medical Director and the Director of Nursing should also be involved

3) Access to Children

The Inquiry Panel had heard conflicting information about Mr MH and the views of staff about whether or not he should have access to his children. It also heard of the distress Mr MH suffered through not being allowed access.

The main recommendations made concerned:

- The need for a full team discussion about access before a minuted decision is made with full reasons given
- Where there is family involvement the access decisions should be shared with them

4) Forensic Services/Assessment

The Inquiry Panel was concerned about the apparent complexity in making referrals to the forensic services provided by the North London Forensic Services. The main recommendations made concerned:

- The speeding up of a review of access to forensic services in Waltham Forest
- Any referral should be allowed and should not be prevented through cost or resource constraints.

5) Housing/Accommodation

The Inquiry Panel was concerned at the difficulty in accessing appropriate supported housing for Mr MH, and then placing him in bed and breakfast accommodation out of the Borough. It was also noted that confidentiality precluded AOT staff being able to provide details of the mental health of the people they placed in bed and breakfast establishments. The main recommendations made concerned:

- An escalation policy should ensure that decisions about accommodation are resolved at a senior level of management
- Commissioners should ensure that there is appropriate accommodation with support for clients like Mr MH
- Confidentiality issues should be resolved with the assistance of the Trust Caldecott Guardian

6) Staffing

The Inquiry Panel were concerned at the lack of adequate consultant time for the AOT and also about the heavy caseloads of the staff. It also mentioned the level of experience and skills of some of the team. The main recommendations made concerned:

- A review in the RMO cover within the AOT
- A review of supervision/mentoring and the size of caseloads being based on the level of client need
- Using Agenda for Change to review the skills required by staff in the AOT and then appointing staff with those skills

7) *Informing Relatives and Support for Staff*

The Inquiry Panel was concerned that Mr MH's sister was not informed about the homicide and the arrest of her brother until some weeks after the event. The staff interviewed had criticised the level of support they had received after the homicide. The main recommendations made concerned:

- The families of clients involved in serious untoward incidents should be seen by the care coordinator and senior members of the care team as soon as possible after the event
- The process for informing and supporting staff after an incident should be reviewed and strengthened

8) *Cultural Issues*

The Inquiry Panel had been aware of Mr MH's needs due to his culture, and his care coordinator had been selected for this reason. The main recommendations made concerned:

- The cultural and ethnic needs of clients are always given due consideration when allocating care coordinators

9) *Communication*

The Inquiry Panel was concerned about several areas where communication both within the recording and within the NHS had been poor, as had some communication between the NHS and other agencies. The main recommendations made concerned:

- The care coordinator should be responsible for the transfer of all relevant information between teams
- All relevant information and discussions about clients should be recorded in accordance with good clinical practice and record keeping.

Action Taken as a Result of the Internal Inquiry

The Interim (substantive when interviewed by the Investigation Panel) Chief Executive of NELMHT described the positive changes which had occurred since the Internal Inquiry.

The Internal Inquiry made 24 recommendations, but there is no suggested timescale for their implementation. There was however evidence of some positive action by the Trust as a direct result of its recommendations. The main changes have been:

Staffing

The AOT was funded for a part-time consultant psychiatrist for 18.5 hours per week (five half day sessions) which met the requirements of the Policy Implementation Guidance, and several of the staff interviewed confirmed that this allowed the team to be far more reflective about their work, and to have easy access to RMO and clinical advice when needed.

Since the homicide the contract for forensic psychiatry has been changed. The John Howard Unit in Homerton now provides this service and has arranged for a sector forensic psychiatrist to be responsible for Waltham Forest and a forensic community CPN who is based with the AOT.

More recently (2009) funding has been secured from the PCT to employ an outreach engagement worker to follow up clients who do not keep their appointments with the AOT or the Community Drug and Alcohol Team.

Knowledge and Skills

The Trust has invested in running an assessment centre for all its ward managers and community team managers. 58 out of 65 eligible managers took part and the feedback from them was positive. The aim was to ensure that the right staff were in the right posts, and to undertake some associated organisational development in areas which were considered to present a high risk.

A current project has been to agree the Service User Standards and make sure these are adhered to, with service users assisting with the development and implementation of the standards, and monitoring the results and helping to provide some of the training. Running alongside this improving standards work has been the Inpatient Ward Improvement Programme, which is a long term project to raise the overall standards of the ward areas and the level of care and treatment provided.

Management Systems

The Borough Director for Waltham Forest at the time of the Independent Investigation interviews explained that the management structure inherited in August 2005 did not include any clinicians. There was a very poor relationship between management and clinicians, so one of the first actions the new Borough Director was to establish a senior management group (SMG). This comprised:

- The Associate Medical Director
- The Community Services Manager
- The Acute Services Manager,
- The Head of Psychology
- The Head of Psychotherapy,
- The Head OT
- The Lead Nurse

As a result communication improved and all disciplines knew what was happening and were able to contribute to decision making through their senior manager on the SMG. These arrangements have also assisted in having a system whereby difficulty in reaching inter-agency decisions about resources for people with complex problems can be ‘escalated’ to managers with direct access to the resources required.

There is also a better relationship with the London Borough of Waltham Forest and a revamped Housing Panel. This is the internal ISA (Individual Service Agreement)

Panel within the Borough which assists finding appropriate resources for the management of people with complex needs requiring access to low secure services or other specialised services.

Governance Arrangements

The Chief Executive described the complete overhaul of the governance arrangements as having been “a real hearts and minds thing.” The meeting structures have been altered as have the reporting arrangements, and as staff have noticed that there is a cycle and results happen people have gained confidence in the process and are working to it.

The quality of the Trust’s Internal Investigation Reports has improved and they are now all quality assured. The Chief Executive sees all Serious Untoward Incident reports and they are now signed off at Board level by two out of the nominated three executive directors, the Medical Director, the Chief Operating Officer/Chief Nurse and the Chief Executive.

The current Borough Director of Waltham Forest also commented that following any untoward incident the alerts are done on the same day that the incident occurs. The policy now is that a 48 hour report is produced rather than a 72 hour one, and the Borough has achieved a complete success record in this area. The quality of the reports has improved as all middle line managers, senior managers and some senior lead clinicians have been trained in Root Cause Analysis and report writing.

The Trust has five Directorates, four for the Boroughs and one for Specialist Services. There are monthly performance meetings, and the quality and timeliness of the alerts, the 48 hour reports and the full reports where an incident warrants a full internal investigation. Each Directorate has an integrated governance meeting once a month, and a risk group where all of the action plans are monitored in terms of compliance against the action. The Borough Director has to sign off the action plans to confirm that all the actions have been completed.

In addition the Associate Medical Director and the Borough Director review all alerts and 48 hour reports, and agree the final report and the action plan before they are sent to the Trust Headquarters.

Service Developments

The Trust has started to build its own low secure unit and this will be operational in 2011. In addition it has approval to develop a Tier 4 Detoxification Unit to deal with complex substance misuse cases, including formal Dual Diagnosis. The aim is to recruit a core team of highly specialist staff. This development forms part of planned work to transform the assertive outreach and community infrastructure, so that it becomes much more rehabilitation and recovery centred.

Supporting Relatives and Staff

A new policy has been implemented whereby as soon as an incident is reported a senior manager is allocated to make contact and work with the family. The Trust aims to have made contact with the family within 24 hours of the incident.

The Chief Executive will visit the ward or unit where an incident has occurred within a week. The purpose of this visit is to provide support and to see what action needs to be taken to help the unit. The Internal Investigation process has been reviewed and is now using a less adversarial style than it did in the Mr MH Internal Inquiry.

Implementation of the Recommendations

Of the 24 recommendations 22 have been addressed. The inclusion of the CPA Policy to CDAT has not been implemented as the workers do not act as care coordinators as staff in other community teams do. The creation of the outreach engagement worker to follow up clients who do not keep their appointments with the AOT or the Community Drug and Alcohol Team was intended to meet the issue the recommendation was seeking to address.

The other recommendation which has not yet been implemented is the development of a Dual Diagnosis Strategy. The full time consultant psychiatrist in CDAT has taken the lead on this, and the strategy will be complete with the opening of the two addiction detoxification units in the near future.

Comment

The Internal Inquiry was badly managed from the outset and took 18 months or more to deliver what was a poor and rather limited report. Despite this most of the issues which have been identified in this report were covered, albeit without very much detail.

The medical staffing has been increased and the training and development of managers and clinicians has improved. Additional resources have been established although there is more to be done in relation to the care and treatment of those complex cases of Dual Diagnosis. A strategy for this is nearing implementation, but will still rely upon a hub of expertise which has to be spread across the whole Trust.

The Internal Inquiry found “no serious failings of care,.....and noted the difficulties in managing this very complex case and the efforts of staff to meet his needs....and noted a number of system failures which added to the difficulty in managing his care.”

This Independent Investigation did find some failings of care in allowing Mr MH to be discharged from hospital without any stable and permanent accommodation and in not being able to provide an appropriate staffed supportive housing placement for him. As described above (Page 93) the Independent Investigation Panel concluded that despite these failings there was no single root cause for the homicide which was due to the interplay of several diverse contributing factors.

16. Notable Practice

16.1 Whilst the emphasis of this Report is to examine the care and treatment provided to Mr MH and to highlight areas where processes could be improved, during the Independent Investigation the Panel noticed some good practice and would wish to mention examples of this.

The Work of the AOT

16.2 Despite its staffing limitations, particularly with regard to the level of medical and psychology input, the staff working with Mr MH provided a consistent service and always tried to respond appropriately to his needs, usually in providing practical help with form filling or making applications for services, or in actually providing food and equipment. It also found a flat for Mr MH but due to his drug taking and association with other addicted people this tenancy was lost.

16.3 It is evident that Mr MH was not an easy man to deal with, but the team stuck to its task and provided help and support. The level of therapeutic intervention was limited, but Mr MH was seldom ready to deal with these issues.

The Use of Dual Diagnosis Workers and the Positive Relationship between CDAT and the AOT

16.4 The NELMHT was taking a positive step when it decided to appoint two Dual Diagnosis workers to the AOT. This enabled close working between the AOT and CDAT which helped provide some measure of help and support for Mr MH. He was not ready to really actively address his addiction, but the services worked well together and continued a positive dialogue to ensure both were aware of how Mr MH was coping.

The Assertive Nature of the CMHT Support

16.5 Prior to the transfer of Mr MH to the AOT the Community Mental Health Team had worked closely with him. The Community Psychiatric Nurses followed him up regularly in the community and reminded him of his depot injections. Mr MH attended a reasonable proportion of his outpatient appointments, but never fully engaged. The CMHT managed to support him in the community until he lost his accommodation due to turning it into a 'crack house'.

17. Lessons Learned

17.1 A major lesson is that there is a need for a full history to be taken on all patients so that their mental health issues can be seen in a full and accurate context. Despite having been a patient of mental health services for many years there was no detailed history of Mr MH's early life in Pakistan and then after his move to England as a young boy. The family dynamics in his life in England are not known and his treatment is therefore rather in a vacuum.

17.2 It is possible that if more had been known about his early life and any pressures this may have had, Mr MH's drift into crime and drug taking could have been better understood. Such better understanding might have enabled a more proactive approach to have been taken.

17.3 The other crucial lesson is about the need to accept that a service user with a dual diagnosis of mental health issues and substance misuse needs to have both identified and dealt with. It is difficult to treat both issues at the same time, but if both are acknowledged and discussed the main one can be addressed without altogether forgetting about the other. The AOT and Healthworks worked well together but this did not lead to a full Dual Diagnosis treatment plan being attempted. Mr MH may have remained pre-contemplative and not ready to accept personally that he needed to address his substance misuse, but the staff working with him should have kept the issue alive.

17.4 In the end Mr MH was so dependent on drugs that he was unable to choose to give them up. The NHS now recognises that Dual Diagnosis needs to be seen as being in the mainstream of mental health services, as roughly 50% of people with a severe and enduring mental health problem do also have an addiction problem. The services in Waltham Forest and elsewhere in the North East London Foundation NHS Trust need to accept this, and to invest in training their staff to deal with the issue with more determination and conviction that they can make a difference.

18. List of Recommendations

Recommendation 1

18.1 The AOT should build into its working arrangements formal opportunities to review cases which are causing the Team concern, or where no progress is being made in meeting the clinical and social care objectives agreed.

18.2 (It is recognised that much has occurred since June 2005 to implement some of the points covered in this recommendation, especially the increase in psychiatric time.)

Recommendation 2

18.3 Where there is uncertainty about a service user's diagnosis the AOT, (or any mental health service) should take steps to pool their information and to agree on a diagnosis, or the steps needed to secure a definitive one, with a view to determining a coherent and consistent treatment plan that could then be negotiated with the patient.

Recommendation 3

18.4 The Trust should ensure that service users about whom clinical teams are concerned due to their potential for violence to themselves and/or others should have access to a forensic assessment and, where necessary, a low secure placement so that additional and longer term assessment and consistent treatment can be provided.

18.5 It is recognised that considerable steps in this direction have been taken by the Trust since 2005.

Recommendation 4

18.6 Escalation processes must be established so that where decisions about housing or other fundamental issues cannot be agreed they can be moved up the management and decision-making hierarchy so the necessary resources can be identified and delivered.

Recommendation 5

18.7 The AOT (and all mental health services) should ensure that when they accept a service user to the service they compile a list of all the history relevant to a comprehensive risk assessment being made with the service user. This should include a detailed narrative history gathered from the patient. A risk management plan must then be made which recognises the patient's ability to comply with it. Both the risk assessment and the risk management plan should be regularly updated and kept in a prominent place within the case records so that it is available to all staff who may come into contact with the service user.

18.8 It is again recognised that the Trust has taken steps to improve the risk assessment process, but this should be regularly audited to ensure that the above recommendation has been implemented fully.

Recommendation 6

18.9 The Trust should give priority to the active treatment of patients with Dual Diagnosis. Many of the most severe patients are clients of the Assertive Outreach Team due to their inability to engage because of their chaotic lifestyles. The Trust should take the following steps:

a) appoint a “Product Champion” who should be either the team leader or consultant who is prepared to persevere and drive treatment on both the substance misuse and the mental illness;
b) provide tangible and public endorsement and support from the Trust Executive Team, particularly the Chief Executive and the Medical Director;
c) identify the local systemic factors which have undermined the successful development of Dual Diagnosis services and actively address them;
d) provide the AOT with the appropriate support in terms of resources, skills and leadership;
e) help to gain the support of the PCT and the SHA by highlighting the number of homicides committed by people while under the care and

treatment of mental health services who are suffering from Dual Diagnosis;

f) the team should report directly to the CEO and Head of Operations on progress and their work should be considered as "core" to adult services development. Visits to nationally respected Dual Diagnosis services may be helpful (eg Haringey and Birmingham).

Recommendation 7

18.10 The Trust should support the new addiction consultant (who is the SHA's Dual Diagnosis lead) and the addiction service manager, in presenting the best option for Dual Diagnosis services to the Board that fits the Trust's population profile.

18.11 (It is understood that a Dual Diagnosis Strategy is currently being finalised and about to be implemented. It should take note of the recommendations of the Report)

Recommendation 8

18.12 The Trust should identify staff resources and supervision resources to ensure a comprehensive retraining of medical, nursing and other professions in Dual Diagnosis treatment.

19. Glossary

Anti-Social Behaviour Order (ASBO) : places limitations on people who repeatedly cause alarm or distress to others through their selfish and inconsiderate behaviour.

Assertive Outreach Team (AOT) : providing intensive support to people with mental health problems who find it difficult to engage with services and require considerable help to remain living independently in the community.

Cannabis : is the most widely used illegal drug in Britain. Made from parts of the cannabis plant, it's a naturally occurring drug. It is a mild sedative (often causing a chilled out feeling or actual sleepiness) and it's also a mild hallucinogen (meaning you may experience a state where you see objects and reality in a distorted way and may even hallucinate).

Care Programme Approach (CPA) : this is a national systematic process within mental health services to ensure that assessment and care planning occurs in a timely and user centred manner.

CDAT : the Community Drug and Alcohol Team providing a service for those with substance misuse issues.

Clopixol : Zuclopenthixol works by restoring the balance of chemical transmitters in the brain. It is used to treat symptoms of schizophrenia. Zuclopenthixol decanoate is a depot injection that is a longer-acting form of zuclopenthixol.

CMHT : Community Mental Health Team providing health and social care to people with mental health problems being treated in the community.

Cocaine : Cocaine powder, freebase and crack are all forms of cocaine. They are stimulants with powerful, but short-lived, effects. Stimulants temporarily speed up the processes of your mind and body. 'Freebase' cocaine and 'crack' cocaine, can be smoked, and so can reach the brain very rapidly in high dosage.

CRAMP (Clinical Risk Assessment and Management Plan) : a form of risk assessment and the development of plans to manage the risks identified.

DDART Team : provides a service in the London Borough of Waltham Forest for people with a personality disorder who experience problems with either drugs or alcohol.

Depot Injection : a specially prepared antipsychotic medication which is given by injection. The medication is slowly released into the body over a number of weeks.

Dialectical Behaviour Therapy : is an innovative method of treatment that has been developed specifically to treat those with Personality Disorder in a way which is optimistic and which preserves the morale of the therapist.

Droperidol Procyclidene : a drug sometimes used for the rapid sedation of people who are violent.

Early Intervention in Psychosis Teams : specialist teams for people aged 18-35 experiencing their first onset of psychosis.

eCPA : is an electronic computerised version of CPA (see above).

Flupenthixol Decanoate : an anti-psychotic drug used for the treatment of schizophrenia and similar psychotic disorders. Long-acting depot injections of drugs such as flupenthixol decanoate are extensively used as a means of long-term maintenance treatment.

Healthworks : A community substance misuse service trying to meet the needs of those with drug and/or alcohol addiction problems.

Lofepramine : a medication used to treat depression.

Methadone : a drug often used as a replacement for heroin as it can prevent or reduce the unpleasant withdrawal symptoms. Many people stay on methadone long-term, but some people gradually reduce the dose and come off drugs altogether.

Mental Health Act 1983: Section 48 – to allow someone to be transferred to a psychiatric hospital from prison or court from where they will not be allowed to leave without the agreement of the Secretary of State for Justice.

Section 136 - the police may 'hold' someone they suspect of having a mental health problem under this Section of the MHA until a

mental health professional has visited and assessed the person. It is also common for such people to be taken to a Section 136 assessment suite at the local psychiatric hospital.

Section 3 – part of the Act allowing people who are assessed as a danger to themselves or others to be taken into psychiatric hospital without their consent for treatment and care.

Section 117 – when patients who have been subject to Section 3 are discharged the statutory services are required to provide them with the help and support they need in the community as described in Section 117 of the MHA 1983.

Motivational Interviewing : a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

National Patient Safety Agency (NPSA) : An 'arm's length body of the Department of Health which seeks to lead and contribute to improved and safe patient care by informing, supporting and influencing organisations and people working in the health sector.

Nocte : at night. Usually referring to when prescribed medication should be taken.

Olanzapine : is a medication that is used to treat psychosis (particularly schizophrenia) and acute manic episodes associated with bipolar I disorder.

Paranoia : is a Paranoid thinking typically includes persecutory beliefs concerning a perceived threat towards oneself.

Piportil : a depot injection which contains the active ingredient pipotiazine palmitate, which is a type of medicine called a phenothiazine antipsychotic. Pipotiazine is sometimes described as a neuroleptic or a 'major tranquilliser', though this is misleading, as this type of medicine is not just a tranquilliser, and any tranquillising effect is not as important as its main mechanism of action in psychiatric illness.

RMO : Responsible Medical Officer under the Mental Health Act 1983 providing the care and treatment to a patient under the Act.

Schizophrenia : a psychiatric diagnosis that describes a mental disorder characterised by abnormalities in the perception or expression of reality.

Subutex : a substitute drug for heroin. Essentially buprenorphine can prevent or reduce the unpleasant withdrawal symptoms. Many people stay on buprenorphine long-term, but some people gradually reduce the dose and come off drugs altogether.

RiO : an electronic computerised system for the recording of information about patients which replaces the handwritten clinical notes and documentation.

Zoning : a traffic light system to illustrate the level of care service users currently require based on a risk assessment and mental health state examination. People deemed to be in the red zone are likely to be confined in some way and to be given more intense treatment, or have more staff checking that they are safe.

Appendix 1

MH Timeline

1987	MH convicted of false imprisonment and was fined £200.
1987	MH imprisoned for 2 years for robbery and residential burglary
1988	21 months custody for robbery and burglary – MH reports this as his first episode of mental ill health
1991	30 months custody for a residential burglary
92-93	Sought help for heroin and cocaine problems at Healthworks . Given Methadone prescription.
07/04/ 1995	Informal Admission to Claybury Hospital – had had nervous breakdown whilst in prison. Had been released in November 1994. Drug misuse reported to have started in 1993
21/04/1995	Entry in notes saying MH not to be allowed to leave the ward – Clopixol to be tried.
17/05/1995	Section 3 MHA as MH wanted to leave ward – he was assessed as presenting a danger of intimidation and violence to others.
23/06/1995	MH discharged
3/12/95	OPD appointment feeling very depressed wanted to kill himself
24/01/1996	Informal admission to Claybury Hospital (Oak Ward).presenting illness one of depression Mention that mental health problems had started when MH went to Surrey University to read aeronautical engineering when he joined 'wrong crowd' and took cannabis

28/02/1996	Discharge Planning Meeting (TL present) medication on discharge lofepramine,droperidol.procyclidene/depot clopixal
05/07/1996	Informal admission for 4 weeks following 6 months of substance misuse, hearing voices and depression over brother's death –grief reaction.
05/08/1996	Discharge from hospital
11/07/1997	MH went to Pakistan for an arranged marriage to a cousin he "had known all his life."
January 1998	MH returned to England but was unwell.
March 1998	MH stopped claiming benefits – his sister was his appointee.
29/04/1998	MH assessed under the MHA 1983 but no decision to admit. MH was in flat waiting for his wife to be allowed to join him in England – she was expecting twins. Seen by PJ CPN and overtly psychotic the week before but settled somewhat by mental health act assessment I week later. Diagnosis of drug induced psychosis at this stage in view of settlement. Also considerable significance for chances of engagement. SHO Diagnosis comorbidity for Drugs and Paranoid Schizophrenia.
06/05/1998	MH referred by neighbour to housing as he had loud music, was shouting obscenities until 04.00 – several occasions listed.
08/06/1998	PJ visited MH – he reported kicking down the door of a female friend as she owed him £10 and was not in. Had an argument with shopkeeper who would not give him credit for cigarettes – MH wanted to kill him. Reported he had been walking around with a knife and hammer and would have used them on anyone who got in his way.
11/06/1998	MH admitted into hospital.
18/06/1998	MH was assessed to have only escorted leave – he went out unescorted for 30 minutes and returned 10 hours later and appeared glazed and laughing inappropriately. Refused to provide a urine sample.
19/06/1998	Other patients on ward alleged MH was selling drugs on and off the ward. When challenged he was angry and claimed to have only come to hospital to see a social worker. He insisted on discharging himself and was allowed to go

	have only come to hospital to see a social worker. He insisted on discharging himself and was allowed to go.
15/10/98	Street robbery
25/11/1998	Notes mentions that MH charged with robbery. Day before his arrest he had argued with his wife and felt like hitting someone. He was confused and could not remember the robbery – alleged to have grabbed a lady's handbag whilst on central reservation crossing a road with little regard to her safety as she hung onto her bag.
26/11/1998	Request from Dr T to Dr McK at Pathways Unit (Goodmayes Hospital) for S48 transfer from Wormwood Scrubs where MH on remand for robbery.
14/12/1998	MH admitted to Pathways (PICU) section 48
10/01/1999	Transferred to Stoneleigh Unit – under Dr T – for discharge planning as his sentence for the robbery was almost completed.
14/01/1999	MH discharged. MH did not keep his appointments with CPN – DM.
21/1/99	Extensive discharge summary from Dr McK's PICU at Goodmayes
22/3/99	Seen Dr C at Health works
April 1999	Charged with demanding money with menances /dropped during admission
13/04/1999	Informal Admission - MH had relapsed. His wife had left the week before after MH had dropped one of the twins due to being heavily under the influence of drugs . Note made to review placing family on Child Protection Register should his wife and twins return. Social Worker told by MH that he overdosed on valium prior to admission. Relapse prepcipitated by separation from wife. Urine screen positive for cocaine- command hallucinations to kill himself. Prescribed - Risperidone, methadone 65 depixol. Tried to leave after second day with his money - Dr D locum consultant stopped this. Mental state settled in 4 days. Bail cancelled and case dropped. MH was stroppy when procyclidine was reduced.

24 /4/99	S/B DrT on ward round -escorted leave and liaison with Drug team.
11/05/1999	MH discharged to 42b White House Estate, Green Road, Leyton. Letter sent to LBWF SSD had concerns should the twins return to live at this address with their father. The discharge plan was for: • weekly methadone prescription from Healthworks • attend Bank Day Centre programme at St James Street x5 per week • see TL at Healthworks • LA to maintain contact and CPN to monitor mental state and administer depot • placed on Supervision Register • referred to OT – this took at least 14 weeks to arrange due to staff leaving
01/06/1999	MH did not attend OP appointment.
04/06/1999	Letter from Dr T to GP Dr M – prescribed Methadone 60ml pd – Depixol 60mg every 2 weeks – Procyclidine 5mg tds and advised to increase the dose to 10mg mane – 5mg midday – 10mg nocte
9/12/99	CPA review ; Attending Healthworks(CDAT) for methadone, OPD attendance encouraged. Twins getting support. Relapse plan in place about voices. Drugs and aggressive behaviour.
12/02/2001	MH convicted of a burglary and will serve 12 months. He served all his remand on bail so release due in February 2002.
27/03/2001	Dr G locum for Dr T, wrote to Dr Aki consultant forensic psychiatrist at Chase Farm for help with MH
12/06/2001	Letter from Dr C from the North London Forensic Service (Chase Farm) to Dr Y at HMP Pentonville – he felt MH suffers with a paranoid illness which is very likely paranoid schizophrenia and polysubstance misuse. Confirm depot of Flupenthixol Decanoate 40mg two weekly and Procyclidine 5mg tds, though an increase may well be warranted. Also considered that Olanzapine at 10mg nocte be added. Referral to CARATS team advised. Dr Cl warned off high risk of heart problems due to family history
June to Dec 01	Appears to have been discharged from service because of lack of engagement. Was on supervision register. Dr T writes first to Dr F of North London Forensic Service asking for a secure admission and then to SP on 07/12/01 asking for a PICU

01	admission. On 19/10/01 MH complains about being caught in the middle of two differing opinions. MH awaits decision in prison
25/01/2002	MH admitted to Pathways PICU from HMP Pentonville. Good OT Report by JS
25/02/2002	Released from prison on licence. Section 48
26/02/2002	MH transferred from Pathways PICU to Stoneleigh Unit. Burglary to obtain drugs. Settled by the time he had reached Stoneleigh. Allegedly threatened wife during admission
21/03/2002	MH discharged from Stoneleigh Unit. Dr W becomes RMO at some stage here.
7/4/2003	MH attends Dr W and says his wife has left him because of continued drug misuse. Dr W points him toward Healthworks £5000 rent arrears. Admitted cut hand was acquired during attempted burglary.
02/04/2002	OP appointment – Dr W was running late but MH could not wait and left
18/04/2002	OP appointment – dna
07/05/2002	OP appointment – attended. Social Worker trying to stave off bailiffs due to rent arrears
18/06/2002	OP appointment - dna
4/7/2002	CPA
05/07/2002	OP appointment – attended – relatively upbeat and positive report on MH sent to GP but MH smoking occasional spliff.
01/08/2002	OP appointment – attended
15/08/2002	OP appointment - dna

30/08/2002	OP appointment - attended
17/12/2002	OP appointment - dna
28/01/2003	OP appointment - dna
25/03/2003	OP appointment – attended. MH reported that his wife had left him and he was 'down'. He was not overtly psychotic.
15/4/03	Investigation for disappearance of Giro-cheque
06/05/2003	OP appointment - dna
10/06/2003	OP appointment – dna. It appears from the notes that at this stage MH was discharged from mental health services.
25/09/2003	MH re-referred to mental health services by Quadrant Housing Association – a number of complaints about his behaviour and causing harassment and nuisance to neighbours. On assessment MH was clearly unwell. Also assessed by Dr W and found to be psychotic but not needing detention
07/10/2003	MH admitted to Nasebury Hospital under S136 from the court -very aggressive and demanding to staff. Drug screen positive for cocaine. MH having to face up to idea of divorce. MH under Section 3 MHA. Settled reasonably quickly. Seen by Dr F and taken off section on 11/1/03 and discharged next day.. Also referred to AOT on discharge
11/10/2003	MH absconded from the ward and was returned by police a week later (17/10/2003)
28/10/2003	CPA Meeting held – it was agreed that MH required a home OT assessment (31/10/2003), a new CPN and there was concern that he was not engaging with services. A discharge CPA was fixed for 11/11/2003.
05/11/2003	MH was found smoking cannabis on the ward – his position was reviewed at the ward round and Dr F, SHO, rescinded the MHA Section and made him informal. CPA held on the ward with decisions that: • MH be referred to the AOT

	• RS (social worker) to act up as care coordinator • MH needs a new male CPN • MH to attend drop in sessions at Healthworks. A Crisis Plan was also prepared showing the early signs of relapse as being: • Aggressive and violent behaviour • Increased use of illicit drugs • Neglect of self • Non-compliance with medication and care plan.
06/11/2003	MH was discharged due to his unacceptable behaviour on the ward. Dr H, SHO to Dr W, referred MH to the AOT, with medication being Piportil depot 100mg every 4 weeks.
16/04/2004	Admitted to Stoneleigh after voluntarily attending Access Clinic hearing voices, worried about doing something stupid. Carrying knives for defence. Worried he might attack someone. Missing depot of Piportil, Plan:- informal admission for withdrawal and reestablishment of medication Three weeks prior to admission command hallucinations telling him to harm someone. Dr T of AOT completes risk assessment.
22/04/2004	Failed to return from leave . Discharged in his absence
22/4/2004	Returned to ward and readmitted because of increased hallucination and suicidal feelings after taking heroin. CPA 29/4/04. Rent arrears still at £5000
30/04/2004	Quadrant Housing Association seeking to close tenancy due to anti-social and nuisance behaviour by MH.
09/06/2004	Discharged the day before from Stoneleigh for using giro-cheque for drugs. Telephone conversation recorded in notes by Dr T about SG of AOT being unhappy about information about MH vulnerability report to Housing. AOT asked to take over consultant follow up
06/05/2004	RS's Transfer summary- MH house raided and police find evidence of crack den . MH to be evicted. Referred to AOT in Nov 2003

	2003
03/06/2004	Email – MH homeless and is regarded by LBWF as intentionally homeless.
	MH used giro-cheque and spent money on alcohol and cannabis. Staff refused to give him a second chance on Stoneleigh Unit so as he was homeless he was given a list of open access hostels.
04/06/2004	Dr W wrote to Vulnerability Panel stating MH subject to S117 aftercare. He was due to be evicted under an ASBO on grounds of: • Rent arrears of £5000 also asks SHO to discharge him because he broke his agreement • Operating a known 'crack house' from the address • Persistent and prolonged anti-social behaviour. MH banned from entering house for a period of three months.
08/06/2004	MH living in B&B in Chingford.
09/06/2004	Detailed recording in case notes as SG of AOT angry that Dr Williams had not supported MH in his letter to Vulnerability Panel as much as AOT, and his word had counted for more. AOT felt MH needed high level supported accommodation but Dr W felt he would not benefit from this.
10/06/2004	Social Worker went to Homeless Persons Unit with MH – told to return next morning – given accommodation at Ridgeway Hotel for two nights so he was more local. He was deemed intentionally homeless and therefore not eligible for housing other than B&B. Also RK, Mental Health Act Manager wrote letter of concern about apparent lack of S117 measure on discharge
22/06/2004	MH stating that he wanted to give up alcohol and drugs and reunite with his family. He saw his children as his brother acted as go-between with his wife who did not want contact unless MH could prove he was off drugs.
July 2004	MH living in Palmer's Green – a long way from Waltham Forest and his home area.

06/09/2004	OP appointment - dna
13/09/2004	SHO Review (NR) – MH given monthly supply of medication but only a week at a time with balance stored at Larkswood Centre. MH admitting using £20-£30 on cannabis - £40 on crack cocaine and £30 on heroin plus consuming large amounts of high volume alcohol. He refuses to take his depot – eventually persuaded to accept Olanzapine but warned that it needed SHO to monitor regularly – dose 5mg nocte for two days and then 10mg.
14/09/2004	OP appointment - dna
20/09/2004	MH given one week's supply of Olanzapine 10mg
21/09/2004	OP appointment - dna
28/09/2004	FP10 given to MH for month – Olanzapine 10mg – Procyclidine 5mg qds – Zopidene 7.5 nocte.
04/10/2004	OP appointment - MH attended Larkswood Centre
10/10/2004	OP appointment – MH said he had spent £120 on heroin and had begged for money.
21/10/2004	OP appointment – collected his medication.
18/10/2004	OP appointment - dna
02/11/2004	OP appointment – collected FP10 (as above)
19/11/2004	MH wanted food vouchers and access to his old property to get some clothes and a prayer book. He saw ZH and was given £11 vouchers for food. It was discovered that his flat had been emptied and his property disposed of.
26/11/2004	MH had spent much of his giro-cheque on a mobile phone and went to Larkswood Centre for food. SG took him to local shops and said he could have £20 – MH furious and very aggressive and stormed out of shop without any food.

	He later returned and saw CP and was angry and verbally threatening.
29/11/2004	OP appointment - assessed by Dr R SHO. FP10 collected. He will be homeless again from B&B on 15/12/2004 – the Ridgeway in Chingford. He has not been referred to Ferguson Centre and SGI needs to see if his belongings can be retrieved or not.
08/12/2004	Healthworks confirmed that MH attending regularly and is on Subutex 16mg daily.
01/12/2004	MH apologised for his bad behaviour
13/12/2004	OP appointment – SHO meant to increase Olazapine to 15mg with Zopidene at 7.5mg – will do this next month. It was noticed that MH stocking up on the Procyclidine so this will be stopped – assumed MH selling it. DL took MH shopping for £100 of clothes. Also took him to his new flat – 23A Church Road Leyton E10
14/12/2004	MH says he wants to work and do volunteering – had made appointment with Instant Muscle (New Deal project) DL suggested he make an appointment for MH to visit Quest re work – he agreed.
16/12/2004	MH wanting to concentrate on re-establishing contact with his family – will do via his brother and children.
18/12/2004	OP appointment – MH said he had attended Stonelea one weekend in crisis with very powerful auditory hallucinations to kill his brother. Admitted using £100/200 on crack. Lives near two other AOT clients who use crack.
20/01/2005	MH failed to attend appointment with Quest. New appointment made for 04/02/2005 but was cancelled (not known by who)
04/02/2005	SHO (NR) states that “I totally understand the team’s view of this man and that personality issues do play a strong part. I do get the feeling that this man wants to feel human and I think we should try and do the basic things for him. If we fail we fail. It

	is not the end of the world." She adds – " please feel free to alter the above".
11/02/05	Transfer summary by SG –sophisticated report outlining counter transference potential with splitting . Also sees need for Dual Diagnosis approach- This is first mention of a methodology which goes to the core of his relapses and is trying to prevent a deterioration in his mental state by treating co-morbidity in a dual approach. Mentions that MH is also seen By DDART team at Larkswood Centre.
14/02/2005	Transfer care coordination from SG ZH, CP to be second worker and DL will have input as appropriate.
17/02/2005	MH angry when told he will have no more vouchers and that he must budget. MH feels his complaint is not being dealt with – he was advised to put it in writing. AOT manager had seen complaint and had faxed it to the NELMHT complaints department.
22/02/2005 & 24/02/2005	MH demanding vouchers and was refused. He had lost some which had been stolen. He blamed SG for the £30k of belongings he had lost at the flat.
28/02/2005	ZH, KOB (CPN) and DL went to visit MH at his home. He opened door and said there were no other people there. When they went in there were five men there and they were obviously under the influence of drugs. ZH gave MH appointment for 02/03/2005. Another AOT client appeared to be sleeping in the flat.
02/03/2005	MH dna the appointment
04/03/2005	MH drug use in flat reported to the SSD Commissioner of the accommodation – he was required to move.
09/03/2005	MH presented asking for vouchers – he was refused. MH very aggressive and demanded to see a doctor – none available. MH claimed to be hearing voices and he was going to kill himself. He went to reception and claimed ZH had called him a Paki and was racist and he was not going to leave until he had seen a doctor. KOB assisted ZH. This day's incident started with a 1:1 with CP where it was pointed out to him that MH had to take responsibility for better decision re money and vouchers . CP used phrase " concept of choice". MH eventually became aggressive.

14/03/2005	MH wants help accessing his children – he feels he is not being treated fairly. Also long file note by Dr R (staff grade) about MH's unhappiness with vouchers. On Olanzepine 10 mgs. Dr R wants to increase it to 15 mgs. Next day MH was threatening to CP. Discussed again at clinical meeting and Olanzepine increased to 20 mgs
16/03/2005	B&B at Elite Lodge organised for MH should it be necessary – it would be fourth move in 3 months.
16/03/2005	CP wrote to JW (CEO) saying the AOT was not providing clients with appropriate S117 support. She stated that there was a group of AOT clients who were very hard to manage as they cannot access any planned care for the use of crack cocaine or engage with DDART as they have no secure home as LBWF deems them to be intentionally homeless. JW replies that she doesn't see why she was sent the email and sent it on to Chief Operations Officer. Also letter from CP to BMcA (Interim Service Manager) noting that landlord says MH's placement is not safe.
	She adds "I feel VERY strongly that we are failing our statutory S117 duty, and would like to reiterate for about the 20th time, that a member of the public will sooner or later get hurt/robbed or that one of these patients may, on impulse, kill themselves."
31/03/2005	Home visit to Elite Lodge – manager is worried by MH's behaviour and has warned him.
05/04/2005	CPA Meeting – dna despite reminders.
06/04/2005	ZH in Elite Lodge visiting another client – hears MH in corridor doing a deal and later sees him outside acting very suspiciously with another man.
07/04/2005	Outpatient Appointment - dna
14/04/2005	MH wanted a clothing grant – angry when not provided. He denied the circumstances of the ASBO and the loss of his flat. Blamed AOT for the loss of his possessions.
13,14,18,22/4	Regularly attending CDAT and confirmed regular attendance at Pharmacy for daily prescription.

19/04/2005	Outpatient Appointment - dna
21/04/2005	MH attended Larkswood Centre. Medication given. He wanted financial support – he was told he had to budget and he left abruptly. He was asked to attend on 26/04/2005.
26/04/2005	MH dna
27/04/2005	Elite Lodge phone to report MH is being disruptive and hassling other residents for money. MH visited but denies the allegations.
29/04/2005	CP emails BMcA about need to provide S117 and whether they should get forensic help. Also CP trying to re-provide B and B for MH after he is sequentially thrown out for his behaviour. A few days previously MH was found to not be psychotic and told to stop pestering residents for money and be less racially abusive.
02/05/2005	Elite Lodge report MH is verbally aggressive to staff and disruptive at night. The staff want him moved – ZH agrees. Legal advice is sought.
03/05/2005	CP has telephone answer from legal department suggesting MH be placed out of Borough in a B&B. MH placed in the Barking Park Hotel – which had a good ethnic mix including the Asian Community – MH agrees. Email from CP to RK " the only meaningful input from us is his meds script weekly" later MH found intentionally homeless by panel.
03/05/2005	Attends CDAT. Denies heroin or crack but asking CDAT and GP for Benzoes. Warned about cross dependence . Told CDAT the hostel accommodation was OK.
10/05/2005	HV to B&B – MH not there.
11/05/2005	MH went to Larkswood Centre but as he had no appointment he was asked to return the next day.

12/05/2005	MH dna
17/05/2005	Attended CDAT, said drug free and agreed to attend CPA next week.
20/05/2005	Visit to B&B. Manager said MH was fine but kept leaving the oven on.
24/05/2005	CPA Meeting. CDAT worker found MH extremely agitated, threats to kill, consultant present didn't feel MH was psychotic. Unhappy about both housing offers. The plan was for: • Regular contact with AOT at least x2 pw • Ongoing monitoring of medication x1 pw • Ongoing search for appropriate housing • An MHA assessment to be undertaken if it is felt MH is deteriorating. (Care coordinator named for all tasks)
25/05/2005	Medication given to MH - mental state fine.
29/05/2005	Attended CDAT and apologised for behaviour at CPA; evidence of passivity feeling though "ancestral spirits" speaking "through him". More settled with accommodation in Barking but feels he needs more supported accommodation.
02/06/2005	MH attended Larkswood Centre for his medication – one day late. He was happy at Barking B&B and had no problems. He had had money stolen so was given £15 voucher for food. ZH to visit on 08/06/2005 at 13.00
08/06/2005	Boots Chemists phone, due to MH's abusive attitude to pharmacy staff they are no longer prepared to offer methadone dispensing to MH. T/C from ZH to CDAT advising that MH hasn't collected script. CDAT concerned about Methadone script and ZH says he will visit twice a week because he, too, is worried. ZH also mentioned that MH said he no longer wants Subutex but insists he is off all substitutes.
08/06/2005	Home Visit – MH in low mood. Paranoid about public. Denied thoughts to harm them – planned to visit again that week.

10/06/2005	ZH and DL visited MH – he seemed better. Had used £10 heroin the day before.
13/06/2005	CDAT; MH attends and again says he wants to stop the Subitex. After three days he got back pain and bought heroin. Team persuaded him to reconsider. Subitex and for higher doses but only if he attends. Apologises for problems with chemist but now has to find a new one. But feeling more settled and wanting to see solicitor about access to children. Agreed to attend CDAT for 17/6.
17/06/2005	Missed CDAT appointment so no script for methadone over the weekend.
20/06/2005	MH Attended CDAT and apologised for DNA. Admitted having to use heroin. Dr Ak involved-restart Subitex at 4 mgs. Told about need to keep opiates in system steady to stablilize- big motivating factor for getting clean for MH was need to get back with wife and children. MH said he would attend AOT for prescription for antipsychotic same day. CW saw MH, he admitted using heroin.
21/06/2005	ZH visited B&B – manager said there were no problems with behaviour. MH reported all well but he had lost some medication replacement given. ZH noticed hockey stick – MH said he might take up hockey again but would take it back as it was bent.
24/06/2005	File note that MH had called the AOT office asking to speak to ZH (Care Coordinator) but other staff (J and TL) saw him at Larkswood Centre and arranged emergency food. ZH had seen MH on 21/06/05 and found him well and his landlord stated that MH's behaviour was OK. MH complained that £90 had been stolen from him that morning, he had put the money down whilst taking a wash and then it had gone. MH had reported it to the police and showed a MET receipt with reference number. MH was given food vouchers from Sainsbury's.
25/06/2005	MH murdered Mr Allah Ditta at Barking Park Hotel at 17.00.

Writing highlighted in Yellow show potentially significant examples of MH's mental state

Sections highlighted in Green are those where MH's behaviour put him into conflict with those around him and where he posed a risk to other people and to himself.

Writing in Highlighted in blue shows evidence of substance abuse