Independent Scrutiny and Investigation into the care and treatment of

Mr XY

Commissioned by NHS London

NHS London

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Acknowledgements

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

The scrutiny team wishes to thank Mr XY for consenting to the team having access to his records for the purpose of this scrutiny and the Camden and Islington NHS Foundation Trust for providing those records in a timely manner.

We are grateful to the Trust's Chief Executive, Director of Nursing and Associate Director Governance for attending the workshop with the scrutiny team to discuss the issues they raised from the information examined by them.

Executive Summary

Introduction

Mr XY, on 26th April 2006, stole a van (with a man loading at the back who had to jump off), drove down a road causing damage to four vehicles, jumped a red light and narrowly missed children waiting at a bus stop. He finally ran into the victim who was cycling on a major road and continued driving with the victim's bicycle still under the van. He hit a further two cars. At the time of the incident Mr XY was receiving mental health services from Camden and Islington NHS Foundation Trust (the Trust).

An internal review was commissioned by the Trust to examine Mr XY's care and treatment.

NHS London commissioned an independent scrutiny and investigation in January 2010 under HSG (94) 27 to assess the Trust's internal review and make further recommendations if necessary.

A panel undertook the review which was completed in January 2007. An independent scrutiny investigation is a narrowly focussed investigation conducted by one or more investigators who have the relevant expert knowledge. The panel included a non-executive director of the Trust.

Methodology

The scrutiny team had access to the Trust's internal review report and the case notes relating to Mr XY's care and treatment.

The scrutiny was divided into two parts, a detailed analysis of the internal review and Mr XY's case notes and a workshop with senior Trust staff to discuss any issues raised by the scrutiny team. No individual interviews took place.

Outline of the Case

Mr XY was born on the 22nd March 1986, one of twin boys, of an Irish mother who is reported to have been a crack cocaine user and his father is Jamaican and reported to be a paranoid schizophrenic. Mr XY does not appear now to have any contact with either parent.

There is very little history in relation to his early years. It is reported that he had behavioural difficulties, did not like school nor get on with either pupils or staff. He was frequently involved in fights and was subsequently excluded. He left school aged 14 years old without any formal qualifications.

Mr XY had admitted to spending £60 to £70 per week on cannabis and was imprisoned in Feltham Young Offenders Institute for three years at the age of 15 years for firearms, robbery and drug offences.

He has two children from a previous relationship but his contact with them is not clear. At the time of the incident Mr XY had had a partner for three years. She had a six year old child from a previous relationship and they all lived together in two bedroom council flat at the time of the incident.

He had been on remand for common assault during 2005 and for burglary in 2006. At the time of the incident he was on probation for his most recent burglary offence.

Contact with Psychiatric Services

Mr XY's first known contact with psychiatric services was when he was seen by a psychiatrist whilst he was in the Feltham Young Offenders Institute. No diagnosis was made or medication prescribed.

On the evening of Tuesday 18th April 2006 Mr XY was arrested by police after allegedly assaulting his partner and barricading himself in the flat. The police requested that he was assessed under the Mental Health Act 1983. He stated that his partner's child from a previous relationship was his, and that he was a Jihad bomber who was being pursued by the government. He also admitted to sleeping with a knife under his bed (or pillow).

The assessing doctor recorded the risk to Mr XY's partner and child. It was agreed to detain Mr XY under Section 2 of the Mental Health Act (MHA) and he was admitted to the Skipton Unit at Abbeydale Hospital, a private facility, as no beds were available more locally. On admission he tested positive for cannabis.

The following day (19th April 2006) Mr XY, when reassessed, denied any previously bizarre ideas in regard to his partner's son, or to being a Jihad bomber. The assessing psychiatrist contacted the ward to ask that Mr XY's partner be informed of Mr XY's whereabouts as it was known he had threatened her with a knife.

Later that day Mr XY became agitated, checking the doors and windows and pushing them which resulted in him being moved to the Psychiatric Intensive Care Unit at Abbeydale hospital.

When Mr XY was reviewed at the afternoon ward round it was recorded that he thought the world was coming to an end that Friday and that he had seen the people from Abbeydale in his dreams. He expressed no remorse for the assault on his partner.

During the evening of 20th April 2006, when he was reported by as having been calm and interacting during the day, Mr XY was assessed by an independent psychiatrist in preparation for his Section 2 MHA appeal report. In the independent psychiatrist's opinion he was not detainable.

A NHS bed was found to be available at the Trust and Mr XY was transferred the next day with a nurse escort and photocopies of all his records. The nurse informed the ward staff of the requirement to inform his partner and police if he left the ward.

A Senior House Officer (SHO) reviewed Mr XY later that day and recorded the diagnosis as a brief psychotic episode secondary to using cannabis. No psychosis was found during the interview. Mr XY gave the SHO a history of his involvement with drug dealers and expressed his concerns about money that he owed. He was prescribed an anti-anxiety drug Lorazepam, an anti-psychotic, Haloperidol and a drug for side effects, Procyclicline. A plan was agreed for blood tests, regular urine drug screening and observation.

On 23rd April as no psychotic symptoms were evident he was allowed escorted leave in the garden.

On 24th April 2006 Mr XY was assessed by his new psychiatrist and reported that his "talking rubbish" was due to having used cannabis during the two weeks prior to his arrest and he was regretful about harming his partner. No psychotic symptoms were found. The plan was to refer him to the Early Intervention Services and it was agreed that he could have 30 minutes escorted leave each day.

Later that same day during escorted ground leave he absconded. The ward staff informed his partner and the police. Mr XY returned to his home where his partner persuaded him to return to hospital. During the night he presented at a police station and was returned to the ward by the police at 07.00 hours the following morning. When seen by his consultant psychiatrist he was found to be deluded, thought he was a Prince of Persia, that MI5 had hired him to kill his family, and again expressed the delusion that he was the father of his partner's son.

Later that morning he denied taking drugs and appeared calm and coherent, asking for unescorted leave. At midday he was seen by his consultant, the ward manager and two nurses. He stated that he wanted time to play football. It was agreed he could have unescorted leave until 16.00 hours on the condition he gave a urine sample on his return to the ward.

Mr XY had a conversation with his consultant at 13.15 hours where it was emphasised that he would be trusted to come back to the ward. He left the ward

at 13.30 hours, neither his partner or the police were informed, nor was a risk assessment completed.

At 14.45 hours the police had contacted the ward to reaffirm that they should be notified if Mr XY left the ward. The nurse taking the call was not aware of his unescorted leave and told the police that he was on the ward.

Mr XY did not return to the ward and was reported missing to the police and his partner at 19.55 hours, four hours after he went missing.

The following day, 26th April 2006, Mr XY stole a van (with a man loading at the back who had to jump off), drove down a road causing damage to four vehicles, jumped a red light and narrowly missed children waiting at a bus stop. He finally ran into the victim who was cycling on a major road and continued driving with the victim's bicycle still under the van. He hit a further two cars.

Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review report did not provide a fully detailed analysis of the care and treatment provided to Mr XY however the findings and recommendations were appropriate and the Trust have progressed their action plan.

The scrutiny team wish to commend the following areas of good practice found by the internal review by the staff providing care to Mr XY.

Positive Factors

On examination of Mr XY's case records there were areas of good practice.

- The high standards in regard to care plans and alerts set out by staff both at Abbeydale and the Trust.
- Record keeping and the communication between the private and Trust services.
- Trust staff on the ward all having received Dual Diagnosis training.

Scrutiny Team Independent Findings

Whilst acknowledging the very limited contact with Mr XY that the services had, there are some issues that the scrutiny team feel were not given enough prominence in their internal review report.

The internal review panel did not include an external member. It is considered that the addition of an external specialist in Dual Diagnosis with experience of the impact of this on domestic violence and safeguarding of both adult and children would have been appropriate.

The internal review report's Terms of Reference included the statement that they should explore "the role of the Care Trust inpatient mental health services in dealing with people suffering from short term drug induced psychosis." This showed that before the review commenced there was a clear assumption that Mr XY had a short term drug induced psychosis.

In the opinion of the scrutiny team it was too early to make the diagnosis of a drug induced psychosis without the benefit of Mr XY having a period when he was drug free. There was a history of some psychiatric problems when Mr XY was detained in Feltham Youth Offenders Institute. No plans for further exploration of his mental state and provisional diagnosis were found in his case notes.

The scrutiny team found that although the Trust staff had in theory followed the Trust's policies and procedures as detailed in the internal review report there were some omissions, in particular with regard to Mr XY's second absconsion from the ward. The ward staff did not inform Mr XY's partner or the police for a total of four hours after he was first found missing and when the police contacted the ward shortly after he had left for unescorted leave they were informed wrongly that he was still on the ward.

In addition although it was stated that the decision to allow Mr XY unescorted leave was a team decision made at the meeting with him there is no evidence of a formulised risk assessment or risk management plan.

At this time Mr XY had been detained under the MHA for 7 days, had been directly under the care of this team for 6 days of which 2 nights was spent Absent Without Leave.

There appeared to be no evidence of a CPA process.

The consultant did discuss "Trust" with Mr XY in regard to unescorted leave. There did not appear to be an assessment of whether he did have the capacity to understand the concept of trust given his delusional state earlier that day. The scrutiny team acknowledge that this was an attempt to develop a positive therapeutic relationship with Mr XY.

The internal review found that the Trust Risk Assessment policy did not cover domestic violence and in addition, at that time, did not refer to Safeguarding Children.

Issues discussed at the Trust Workshop

The following areas were discussed at the workshop with the Trust.

Action Plan

The Trust have completed the actions required as a response to the internal review report's recommendations and have also implemented other areas of service improvement as a result of the progress made. This includes building on Dual Diagnosis training and monitoring its effectiveness.

The Trust has also provided six inpatient beds which are allocated for the assessment and treatment of patients with early onset of psychosis.

Safeguarding – Children and Adults

The Trust does not run a Child and Adolescent service, this is provided by Islington Primary Care Trust. There are transition protocols in place to transfer care between services.

The Trust has Safeguarding polices and a Safeguarding Lead professional in place. The initial assessment form has a mandatory section to be completed that identifies issues with family members regarding safeguarding. Regular audits take place on compliance with policy and the staff are required to complete a score card audit which details how targets have been met within this area.

In addition the Trust are further developing the assessment tools to include a link to domestic violence.

Police Liaison

Each of the boroughs have established police liaison officers who are the Trust's main contacts. The local MAPPA has a multi-agency membership which includes representatives from the Trust, police, probation and is chaired by a ex-police officer who also provides advice and support to the Trust. Protocols for information sharing are in place and each borough also has a risk management panel.

Drug and Alcohol Services

The Trust run their own service and have community drug and alcohol teams which use CPA. A Dual Diagnosis strategy has been developed and a protocol is in place to determine criteria for access to the service. Joint training is undertaken between the general mental health and the drugs and alcohol services.

CPA and Risk Assessments

The application of CPA is monitored by the inpatient ward managers. It is included in the balance score card completed by all staff teams. An annual CPA, audit, which is part of the clinical governance audit process is completed, and reported to the Trust board. The same process applies to Risk Assessment which is part of the CPA process.

Family contact

The Trust have a "Being Open Policy" and do now make contact with both the families of victims and perpetrators after incidents such as this one under review.

Scrutiny Team Recommendations

The scrutiny team commend the Trust on the progress made since these events in 2006 and would only make the following recommendations in relation to their investigation process.

Investigation of Serious Untoward Incidents

It was unclear whether staff interviewed during the internal review process had that interview recorded and transcribed.

Recommendation One

It is recommended in accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise that all interviews undertaken for internal reviews are recorded and transcribed verbatim. These transcriptions are for the purpose of ensuring the investigation team can also check and validate their findings. Following NHS London's guidance it is further recommended that an independent investigator is a panel member for all cases of homicide.

Terms of Reference

It was found that the internal review report's Terms of Reference were too restrictive in their direction to the panel.

Recommendation Two

It is recommended that Terms of References should be worded in such a way so as not to restrict the breath of the investigation or concentrate on a preconceived assumption.

1. Introduction

Mr XY, on 26th April 2006, stole a van (with a man loading at the back who had to jump off), drove down a road causing damage to four vehicles, jumped a red light and narrowly missed children waiting at a bus stop. He finally ran into the victim who was cycling on a major road and continued driving with the victim's bicycle still under the van. He hit a further two cars. At the time of the incident Mr XY was receiving mental health services from Camden and Islington NHS Foundation Trust (the Trust).

The Trust commissioned an internal review of the incident which was completed in December 2006. The internal review was conducted by a panel consisting of a Non-Executive Director, Consultant Psychiatrist, Director of Nursing and Head of Clinical Governance.

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

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

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

2. Terms of Reference

Part One - Internal Review

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

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

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

To compile a chronology of events.

Part Two

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

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

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

3. Purpose of the Scrutiny and Investigation

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

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

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

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

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

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

4. Methodology

It was agreed at the start of the scrutiny that the team would examine the internal review undertaken by the Trust. The scrutiny team would set out its findings in regard to the process undertaken and the Trust's progress against their internal review's recommendations. In addition the scrutiny team was to undertake a detailed analysis of Mr XY's case records held by the Trust prior to the death of the victim. Mr XY did authorise access to these records via his solicitor.

The scrutiny was separated into two parts as set out in the Terms of Reference. This comprised of a detailed analysis of both the internal review and Mr XY's care and treatment as stated in his case records. The template used by the scrutiny team for analysing the internal review can be found in Appendix One.

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

It was agreed that no individual interviews would take place, so our report was based purely on the written documentation provided. A workshop was held with the Trust to discuss the issues raised by the scrutiny team following their review of the documentation. A letter inviting the Trust to attend the workshop that also identified the areas for discussion was sent to the Trust's Chief Executive. The Trust's Chief Executive, Director of Nursing and Associate Director of Clinical Governance attended the workshop held on 4th August 2010 and the scrutiny team were informed of the progress made against the recommendations from the internal review.

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

This report has been drafted to include an analysis of the Trust's internal review, a brief history of Mr XY and a detailed consideration of the care and treatment provided to him by the Trust.

5. Scrutiny Team Members

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

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

6. Outline of the Case

The following is an outline of the events that relate to Mr XY and his care and treatment. They have been compiled from the records available to the scrutiny team and from the accounts provided by Mr XY in his case records. A full chronology can be found in Appendix Two.

6.1 Background

Mr XY was born on the 22nd March 1986, one of twin boys, of an Irish mother who is reported to have been a crack cocaine user. His father is Jamaican and reported to have paranoid schizophrenia. Mr XY does not appear now to have any contact with either parent.

Records refer to an incident that took place when he was one year old when he apparently had been left in a house fire by his mother.

It is reported that he had behavioural difficulties, did not like school or get on with either pupils or staff. He was frequently involved in fights and was subsequently excluded. He left school aged 14 years without any formal qualifications.

He had admitted to spending £60 to £70 per week on cannabis. Mr XY was imprisoned in Feltham Young Offenders Institute for three years at the age of 15 years for firearms, robbery and drug offences.

Mr XY is reported as having worked for four months in late 2004 and early 2005 as a sales representative.

He has two children from a previous relationship but his contact with them is not clear. At the time of the incident Mr XY had had a partner for three years. She had a six year old child from a previous relationship and they all lived together in two bedroom council flat at the time of the incident..

More recently he had been on remand for common assault in 2005 and burglary in 2006. At the time of the incident he was on probation for his most recent burglary offence.

6.2 Contact with Psychiatric Services

Mr XY's first known contact with psychiatric services was when he was seen by a psychiatrist whilst he was in the Feltham Young Offenders Institute. No diagnosis was made or medication prescribed.

On the evening of Tuesday 18th April 2006 Mr XY was arrested by police after allegedly assaulting his partner and barricading himself in the flat. The police requested that he was assessed under the Mental Health Act 1983, (MHA). He stated that his partner's child from a previous relationship was his and that he was a Jihad bomber who was being pursued by the government. He also admitted to sleeping with a knife under his bed (or pillow).

His partner was interviewed as part of the MHA assessment and described the changes in Mr XY's behaviour over the past seven days. He was frightened, didn't play football with his team, was reading the bible and had became preoccupied with its meaning. Mr XY insisted his partner's son was his. He also tried to persuade her to move to Birmingham for safety.

The assessing doctor recorded the risk to Mr XY's partner and child. It was agreed to detain Mr XY under Section 2 MHA and he was admitted to the Skipton Unit at Abbeydale Hospital, a private facility, as no beds were available more locally. Mr XY on admission tested positive for cannabis.

The following day (19th April 2006) Mr XY, when reassessed, denied any previously bizarre ideas in regard to his partner's son or that he was a Jihad bomber. The psychiatrist contacted the ward to ask that Mr XY's partner be informed of Mr XY's whereabouts as it was known that he had threatened her with a knife.

Later that day Mr XY became agitated, checking the doors and windows and pushing them which resulted in him being moved to the Psychiatric Intensive Care Unit at Abbeydale hospital.

When Mr XY was reviewed at the afternoon ward round it was recorded that he thought the world was coming to an end that Friday and that he had seen the people from Abbeydale in his dreams. He expressed no remorse for the assault on his partner.

During the evening of 20th April 2006 when he was reported by staff as having been calm and interactive during the day Mr XY was assessed by an independent psychiatrist in preparation for his Section 2 MHA appeal report. In the independent psychiatrist opinion he was not detainable.

A NHS bed was found to be available in the Trust and Mr XY was transferred the next day with a nurse escort and photocopies of all his records. The nurse informed the ward staff of the requirement to inform his partner and police if he left the ward.

A Senior House Officer (SHO) reviewed Mr XY later that day and recorded the diagnosis as a brief psychotic episode secondary to using cannabis. No psychosis was found during the interview. Mr XY gave the SHO a history of his involvement with drug dealers and expressed his concerns about money that he owed. He was prescribed an anti-anxiety drug Lorazepam, an anti-psychotic, Haloperidol and a drug for side effects, Procyclicline. A plan was agreed for blood tests, regular urine drug screening and observation.

On 22nd April 2006 it was recorded in Mr XY's records that he didn't feel he should be in hospital, no psychotic symptoms evident.

The next day, 23rd April 2006 as no psychotic symptoms were evident he was allowed escorted leave in the garden. Later that evening he became restless and irritable and had a discussion with a nurse about non-prescribed drugs and the effect they had on mental health. Mr XY agreed to having help with stopping taking drugs, anger management and counselling.

On 24th April 2006 Mr XY was assessed by his new psychiatrist and reported that his "talking rubbish" was due to having used cannabis during the two weeks prior to his arrest and was regretful about harming his partner. No psychotic symptoms were found. The plan was to refer him to the Early Intervention Services and it was agreed that he could have 30 minutes escorted leave each day.

Later that same day during escorted ground leave he absconded. The ward staff informed his partner and the police. Mr XY returned to his home where his partner persuaded him to return to hospital. During the night he presented at a police station.

On 25th April 2006 Mr XY was returned to the ward by the police at 07.00 hours. He was seen by his psychiatrist who found that he was deluded, thought he was a Prince of Persia, that MI5 had hired him to kill his family and again expressed that he was the father of his partner's son.

Later that morning he denied taking drugs and appeared calm and coherent, asking for unescorted leave. His consultant psychiatrist said she would discuss this with the ward staff and let him know later. It was recorded that there was a potential risk of violence towards his partner and of absconsion. At midday he was seen by his consultant, the ward manager and two nurses. He stated that he wanted time to play football. It was agreed he could have unescorted leave until 16.00 hours on the condition he gave a urine sample on his return to the ward.

Mr XY had a conversation with his consultant at 13.15 hours where it was emphasised that he would be trusted to come back to the ward. He left the ward at 13.30 hours, neither his partner or the police were informed, nor was a risk assessment completed.

At 14.45 hours the police contacted the ward to reaffirm that they should be notified if Mr XY left the ward. The nurse taking the call was not aware of his unescorted leave or that he was not on the ward.

Mr XY did not return to the ward, he was reported missing to the police and his partner at 19.55 hours, four hours after he first went missing..

Mr XY, apparently had gone home, had threatened his partner and run off when she contacted the police.

The following day on 26th April 2006, Mr XY stole a van (with a man loading at the back who had to jump off), drove down a road causing damage to four vehicles, jumped a red light and narrowly missed children waiting at a bus stop. He finally ran into the victim who was cycling on a major road and continued driving with the victim's bicycle still under the van. He hit a further two cars.

7. Consideration of the Internal Review Report

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

7.1 Internal Review Report – Process Comments

The internal review report did describe the facts behind Mr XY's care and treatment, however it lacked a clear analysis of the information and did not follow the Root Cause Analysis process. Terms of Reference were set but firstly made assumptions about the diagnosis before any analysis of the evidence. Secondly the Terms of Reference were not followed explicitly and therefore areas for consideration were not followed through. The report's purpose was clearly stated as the provision of a confidential report for the Chief Executive with recommendations to further improve services.

The internal review's method of investigation was set out in the report and detailed the number of times that the panel met, who they interviewed and what information they had access to as well as that that was not available to them. Information was also accessed in regard to Mr XY's condition following the incident.

A note within the internal review report refers to staff providing statements to the panel. However this does not appear to have happened and the interviews with staff were not recorded or written up. They did however interview two senior managers to discuss the impact of substance misuse on inpatient services.

The internal review panel did write to Mr XY's partner but it is unclear whether she did meet with them to discuss her concerns about him prior to the incident or whether the initial letter was followed up with further attempts to contact her. The Trust's Women Health Lead also wrote to her offering support.

The composition of the internal review panel was:

- Trust Chairman acting as the panel chair
- Consultant Psychiatrist
- Director of Nursing
- Head of Clinical Governance

All were internal to the Trust.

The internal review panel did comment on the Trust's staff adherence to both National and local policies and came to the conclusion that the Risk Assessment, Care Programme Approach and Absent Without Leave policies were followed by the staff involved in Mr XY's care and treatment. The scrutiny team would not agree with this.

7.2 Internal Review Report – General Comments

The scrutiny team considered how well the internal review panel examined and commented on the evidence provided to them. The internal review panel did consider whether the events of the incident could have been foreseen and thus prevented and came to the conclusion that they could not. The scrutiny team support this conclusion.

In the internal review report the Terms of Reference included a section on the background to Mr XY's admission and the quality of care provided in the private sector and the Trust's services. The internal review panel did consider this in their report but their analysis was based on limited information and did not include additional information such as that from the police and probation services.

It is acknowledged by the scrutiny team that the contact Mr XY had with the Trust's services totalled six days with an additional three days within the private sector. Of those six days Mr XY was absent without leave on two occasions spending two nights away from the ward despite being detained on Section 2 MHA.

8. Scrutiny Team Findings and Recommendations

The scrutiny team found that the internal review report did not provide a fully detailed analysis of the care and treatment provided to Mr XY however the findings and recommendations were appropriate and the Trust have progressed their action plan.

The scrutiny team wish to commend the following areas of good practice found by the internal review by the staff providing care to Mr XY.

8.1 Positive Factors

On examination of Mr XY's case records there were areas of good practice.

- The high standards in regard to care plans and alerts set out by staff both at Abbeydale and the Trust.
- Record keeping and the communication between the private and Trust services.
- Trust staff on the ward all having received Dual Diagnosis training.

8.2 Scrutiny Team Independent Findings

Whilst acknowledging the very limited contact with Mr XY that the services had there are some issues that the scrutiny team feel were not given enough prominence in their internal review report.

The internal review panel did not include an external member. It is considered that the addition of an external specialist in Dual Diagnosis with experience of the impact of this on domestic violence and safeguarding of both adult and children would have been appropriate.

The internal review report's Terms of Reference included the statement that they should explore "the role of the Care Trust inpatient mental health services in dealing with people suffering from short term drug induced psychosis." This showed that before the review commenced there was a clear assumption that Mr XY had a short term drug induced psychosis.

In the opinion of the scrutiny team it was too early to make the diagnosis of a drug induced psychosis without the benefit of Mr XY having a period when he was drug free. There was a history of some psychiatric problems when Mr XY was detained in Feltham Youth Offenders Institute. No plans for further exploration of his mental state and provisional diagnosis were found in his case notes.

The scrutiny team found that although the Trust staff had in theory followed the Trust's policies and procedures as detailed in the internal review report there were some omissions, in particular with regard to Mr XY's second absconsion from the ward. The ward staff did not inform Mr XY's partner or the police for a total of four hours after he was first found missing and when the police contacted the ward shortly after he had left for unescorted leave they were informed wrongly that he was still on the ward.

In addition although it was stated that the decision to allow Mr XY unescorted leave was a team decision and made at the meeting with him there is no evidence of a formulised risk assessment or risk management plan.

At this time Mr XY had been detained under the MHA for 7 days, had been directly under the care of this team for 6 days of which two nights were spent Absent Without Leave.

There appeared to be no evidence of a CPA process.

The consultant did discuss "Trust" with Mr XY in regard to unescorted leave. There did not appear to be an assessment of whether he did have the capacity to understand the concept of trust given his delusional state earlier that day. The scrutiny team acknowledge that this was an attempt to develop a positive therapeutic relationship with Mr XY.

The internal review found that the Trust Risk Assessment policy did not cover domestic violence and in addition, at that time, did not refer to Safeguarding Children.

8.2.1 Issues discussed at the Trust Workshop

The following areas were discussed at the workshop with the Trust.

<u>Action Plan</u>

The Trust have completed the actions required as a response to the internal review report's recommendations and have also implemented other areas of service improvement as a result of the progress made. This includes building on Dual Diagnosis training and monitoring its effectiveness.

The Trust has also provided six inpatient beds which are allocated for the assessment and treatment of patients with early onset of psychosis.

Safeguarding – Children and Adults

The Trust does not run a Child and Adolescent service, this is provided by Islington Primary Care Trust. There are transition protocols in place to transfer care between services.

The Trust has Safeguarding polices and a Safeguarding Lead professional in place. The initial assessment form has a mandatory section to be completed that identifies issues with family members regarding safeguarding. Regular audits take place on compliance with policy and the staff are required to complete a score card audit which details how targets have been met within this area.

In addition the Trust are further developing the assessment tools to include a link to domestic violence.

Police Liaison

Each of the boroughs have established police liaison officers who are the Trust's main contacts. The local MAPPA has a multi-agency membership which includes representatives from the Trust, police, probation and is chaired by a ex-police officer who also provides advice and support to the Trust. Protocols for information sharing are in place and each borough also has a risk management panel.

Drug and Alcohol Services

The Trust run their own service and have community drug and alcohol teams which use CPA. A Dual Diagnosis strategy has been developed and a protocol is in place to determine criteria for access to the service. Joint training is undertaken between the general mental health and the drugs and alcohol services.

CPA and Risk Assessments

The application of CPA is monitored by the inpatient ward managers. It is included in the balance score card completed by all staff teams. An annual CPA, audit, which is part of the clinical governance audit process is completed, and reported to the Trust Board. The same process applies to Risk Assessment which is part of the CPA process.

Family contact

The Trust have a “Being Open Policy” and do now make contact with both the families of victims and perpetrators after incidents such as this one under review.

8.3 Scrutiny Team Recommendations

The scrutiny team commend the Trust on the progress made since these events in 2006 and would only make the following recommendations in relation to their investigation process.

Investigation of Serious Untoward Incidents

It was unclear whether staff interviewed during the internal review process had their interviews recorded and transcribed.

Recommendation One

It is recommended in accordance with best practice and to ensure that staff have the opportunity to check that the evidence they have given to internal reviews is accurate and reflects the issues that they wish to raise that all interviews undertaken for internal reviews are recorded and transcribed verbatim. These transcriptions are for the purpose of ensuring the investigation team can also check and validate their findings. Following NHS London’s guidance it is further recommended that an independent investigator is a panel member for all cases of homicide.

Terms of Reference

It was found that the internal review report’s Terms of Reference were too restrictive in their direction to the panel.

Recommendation Two

It is recommended that Terms of References should be worded in such a way so as not to restrict the breath of the investigation or concentrate on a preconceived assumption.

Scrutiny Template

Appendix One

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

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

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

medication and concordance with that medication -			
- any previous psychiatric history, including alcohol and drug misuse			
- any previous forensic history			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
The extent to which X's care complied with:			
- statutory obligations			
- Mental Health Act code of practice			
- Local operational policies			
- Guidance from DOH including the Care Programme Approach			
The extent to which X's prescribed treatment plans were:			
- adequate			

- documented			
- agreed with him/her			
- carried out			
- monitored			
- complied with by X			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
To consider the adequacy of the risk assessment training of all staff involved in X's care			
To examine the adequacy of the collaboration and communication between the agencies involved in the provision of services to him/her			

To consider the adequacy of the support given to X's family by the Mental Health team serving the community and other professionals			
To consider such other matters as the public interest my require			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
In terms of the conduct of the Internal Investigation were:			
- carers and relatives of victim and perpetrator involved if they wished to be			
- appropriate statutory bodies involved in the process			

- suitable methodologies identified (for example root cause analysis)			
- these methodologies followed in practice			
- appropriate individuals recruited to the panel			
- the case notes reviewed systematically			
- significant events included in a chronology			

- appropriate individuals asked to provide statements and/or interviewed			
- views expressed or information contained in external reports such as forensic reports taken account of (if available at the time of the investigation)			
- the case notes scrutinized in terms of accessibility, legibility, comprehensiveness			
- the case notes identified containing a current risk assessment, CPA documentation, care plan			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**
In terms of the Internal Report Recommendations do they:			
- make clear the legislative and other constraints thus			

providing a realistic yardstick against which clinical decisions were assessed			
- recommend a course of action for each problem identified or indicate why improvement is not possible			
- refer to commendable practices			
- acknowledge that all clinical decisions involve the assumption of risk			
- address whether any application of the MHA was appropriate and completed legally			
Item under scrutiny	**Achieved or not**	**Evidence**	**Comments**

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

Chronology of Events Appendix Two

2001-2004	Mr XY detained in Feltham Young Offenders Unit (aged 15-19) for burglary He reports being seen by a psychiatrist, no diagnosis was made.
2001-2004	Mr XY reports living with girlfriend during this time and fathering two children, No contact appears to be had later with these children.
2004 (or 2003)	Mr XY moves in with his current partner and her (then 4 year old) son.
2005	Mr XY on remand for common assault.
2006	Mr XY committed a Burglary and was placed on Probation.
18/04/06	Mr XY arrested for allegedly assaulting his partner by strangulation and threatening her with knife and barricading himself in flat with other knives. He was assessed by a Forensic Mental Health Nurse and referred for Mental Health Act assessment. He reported that he believed his partner's son was his own. He told police he was a Jihad bomber and that the government was after him. He was sleeping with a knife under his bed or pillow. A MHA assessment was undertaken, his partner described changes in his behaviour over the last seven days. He was frightened – not playing football with his team – reading the bible and preoccupied with its meaning. He was insisting that his partner's son was his and trying to persuade her to move to Birmingham for safety. The assessing doctor recorded a risk to the partner and her child. Mr XY was detained under Section 2 MHA and admitted to Skipton Unit at Abbeydale Hospital as no beds were available locally. He tested positive for cannabis.
19/04/06	Mr XY reassessed, denying previous ideas re his partner's child being his and that he was an Jihad bomber. Risk assessment completed. An Abbeydale psychiatrist on-call phoned Skipton Ward to ask that the partner be informed of Mr XY's movements (as she had be threatened with a knife). Later that morning at 1200 Mr XY became agitated "checking all the windows and doors and pushing them" so was moved to the Psychiatric intensive Care Unit at Abbeydale and reviewed by the consultant at a ward round late afternoon. The consultant

recorded that Mr XY thought the world would end on that Friday and had also has seen people from Abbeydale in his dreams. He expressed no remorse for the assault on his partner.

During the evening he told the nurse that he and girlfriend had made up story of her assault so that they could claim benefits.

20/04/06 Calm and interacting on PICU. In the evening Mr XY was assessed by an independent psychiatrist in preparation for Section 2 MHA appeal. The report was faxed on 24/04/06 to his local Mental Health Centre with diagnosis "drug induced Psychosis" and that he found him not detainable.

21/04/06 A bed was found to be available locally and he was transferred in the afternoon with a nurse escort and photocopies of all records. The nurse passed on information to the ward staff re the requirement to inform his partner and police if he left the ward.

21/04/06 Mr XY was reviewed by the ward's SHO who found that he had had a brief psychotic episode secondary to cannabis. No psychosis found during interview. Mr XY gave a history of involvement with drug dealers and money that he owed. He was prescribed lorazepam, haloperidol and procyclidine.

It was planned that he would have blood tests, regular urine drug screening and would be placed on 4 x per hour observations. A note in records re contacting his partner if he leaves the ward.

22/04/06 No psychotic symptoms evident – Mr XY felt he should not be in hospital.

23/04/06 No psychotic symptoms evident and Mr XY allowed an escorted leave to the garden. In the evening he was described as restless and irritable – he had a discussion with a nurse regarding drugs and their effect on mental health. He agreed to accept help with stopping drugs, anger management and counselling.

24/04/06 Assessed by (new) consultant psychiatrist. Mr XY thought his "talking rubbish" had been due to heavy cannabis use in the 2 weeks prior to arrest, and was regretful for harming his partner. No psychotic symptoms were found. He was to be referred to the Early Intervention Service (EIS), and agreed he could have 30 minutes escorted leave each day.

During the afternoon escorted ground leave Mr XY absconded whilst returning to the ward. The ward staff informed his partner

and the police promptly. He had returned to his home and his partner persuaded him to return to hospital – during the night he presented at the police station.

25/04/06 Police returned him to ward at approx 07.00 hours. Seen by his consultant who notes that delusions were present – he was Prince of Persia, MI5 had hired him to kill his family and that he was father of his partner's son. Mr XY understood that he had different views the previous day. He denied taking drugs and appeared calm and coherent.

Mr XY asked for unescorted leave, his consultant said she would discuss with the ward staff and give him an answer later in the day. She recorded the potential risk of violence to his partner and his risk of absconsion. Arranged for a ward discussion with Mr XY. At mid-day – Mr XY seen by consultant, ward manager and 2 nurses. Mr XY said he wanted the time to play football.

Ward Team Discussion – it was agreed that he could have unescorted leave till 16.00 hours on condition he gave a urine sample.

Entry at 13.15hours, consultant has conversation with Mr XY and emphasises "Trust". He left the ward at 13.30 – his partner and police not informed. No risk reassessment undertaken.

At 14.45 hours the ward received a telephone call from police asking to be notified if Mr XY left the ward. Qualified nurse taking the call was not aware of unescorted leave or that he was not on the ward.

Mr XY did not return. He was reported AWOL to police and his partner at 19.55 hours.

26/04/06 Mr XY stole a van (with a man loading at back who had to jump) and caused a number of accidents (4 other vehicles), jumped a red light and nearly missing children at a bus stop. Finally running into victim who was cycling on A4 and driving off with his bicycle still under the van hitting a further 2 cars.

Police contacted the ward to inform them that Mr XY had gone to his home the previous afternoon, had threatened his partner and had run off when she contacted the police.