Independent investigation into the care and treatment of Ms T

August 2012

A report for NHS London
Undertaken by Verita

NHS London

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1. Introduction, approach and structure

The incident

1.1 Police arrested Ms T early on Sunday 17 June 2007 on suspicion of stabbing her uncle, Mr U. Her brother Mr V and father Mr W were also arrested there. Mr U had been stabbed 111 times and died later in hospital. Ms T's brother recorded the incident on a mobile phone. Ms T, her brother and father were charged with murder.

1.2 Ms T had also stabbed her uncle two days earlier. He went to accident and emergency (A&E) and reported the stabbing as a work related injury. He was treated and discharged. Ms T reported the stabbing to the police, accompanied by her local authority leaving care social worker. She said that her uncle had previously sexually assaulted her. The police pursued this aspect of her complaint but they did not investigate the stabbing. After the interview the police allowed Ms T to go to her father's home.

1.3 The leaving care social worker contacted the community mental health team (CMHT) care coordinator. The care coordinator reported the matter to the senior practitioner who in turn reported it to the locum staff grade doctor and her service manager because the CMHT manager was on leave. The clinical director covering for the responsible consultant was not contacted as should have happened.

1.4 The forensic medical examiner at Shepherd's Bush Police Station asked for Ms T to be assessed under the Mental Health Act 2007 (MHA) on the morning of 17 June 2007. The forensic examiner suspected Ms T was acting under the influence of auditory hallucinations.

1.5 Ms T seemed distressed when the duty Mental Health Act (MHA) approved social worker saw her and asked about the events earlier that morning. She described seeing another version of herself entering and leaving the police cell and at times appeared to be engaging in a conversation with this other version of herself. Ms T was placed on Section 2 of the MHA and was transferred to a private mental health hospital.

The Trial

1.6 Ms T's brother and father were found not guilty of murder and acquitted in a trial in July 2008. In September 2008 Ms T was found guilty of manslaughter on the grounds of diminished responsibility. The judge said she should serve at least three years in prison.

Ms T's mother

1.7 Ms T's mother committed suicide in September 2007.

Approach and structure

1.8 We conducted the investigation in private and took as our starting point the West London Mental Health NHS Trust (the trust) internal investigation and action plan. We were also provided with a copy of the Hammersmith and Fulham Children's Services single agency review and a summary of the individual management review (IMR) conducted by the Metropolitan Police. We reviewed source documents, trust policies and procedures.

1.9 The contemporary reports we reviewed were generally of a high standard and we have undertaken this investigation by building on the investigations already completed rather than re-interviewing trust and local authority staff directly involved in the care of Ms T. We therefore interviewed key members of the current south recovery team and senior trust and local authority managers. We also interviewed representatives from the Metropolitan Police Service. A list of interviewees is at appendix A. All interviewees had the opportunity to be accompanied to meetings and to check the accuracy of their interview transcript.

1.10 In our report we have provided a summary chronology and identified the key care issues and other organisational matters that are relevant now and will contribute to ongoing learning for clinical and managerial staff.

1.11 We invited Ms T to meet with us but none of our letters to her received a reply.

1.12 We have referenced sources of information within the report only where it helps the understanding of the information presented.

2. Terms of reference

Commissioner

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

Terms of reference

The aim of the independent investigation is to evaluate the mental health care and treatment provided to Ms T to include:

- a review of the trust's internal investigation to assess the adequacy of its findings, recommendations and action plans
- reviewing the progress made by the trust in implementing the action plan from the internal investigations
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident
- an examination of the mental health services provided to Ms T and a review of the relevant documents
- the extent to which Ms T's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- the appropriateness and quality of assessments and care planning
- consider the effectiveness of interagency working
- consider a other such matters as the public interest may require
- complete an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

3. Executive summary and recommendations

Executive summary

The incident

3.1 Ms T was arrested during the early morning of Sunday 17 June 2007 on suspicion of stabbing her uncle, Mr U. Her brother, Mr V, and father, Mr W, were also arrested. Mr U had been stabbed 111 times and died later. Ms T, her brother and father were charged with murder. Ms T's brother filmed the attack on a mobile phone.

3.2 Ms T had also stabbed her uncle two days earlier. He went to accident and emergency (A&E) and said the stabbing was a work related injury. He was treated and discharged. Ms T reported the stabbing and that her uncle had previously sexually assaulted her to the police at Hammersmith police station during the morning of the 15 June 2007, accompanied by her leaving care social worker. Ms T was redirected to the Sapphire Unit at Fulham police station where she reiterated that her uncle had previously sexually assaulted her. The police investigated this aspect of her complaint but not the stabbing. After interview the police allowed her to go and stay at her father's home.

3.3 Ms T's brother and father were found not guilty of murder in a trial in July 2008. In September 2008 Ms T was found guilty of manslaughter on the grounds of diminished responsibility.

Family history

3.4 Ms T was born in Peru in September 1986 and was nearly 21 at the time of the incident. She had been brought to London in June 1992 at the age of six by her mother who was seeking political asylum. Her brother, who was five, came with them. Ms T's father, Mr W came to England from Peru two years later, also to seek asylum.

3.5 Ms T was a troubled child from a troubled family. Her mother, Ms X, was mentally ill and was receiving mental health services. She had had a number of hospital admissions. She committed suicide in 2007 following the death of Mr U. Ms T and her mother had a

poor relationship. The Hammersmith and Fulham single agency review identifies that at various times there were allegations of bullying, domestic violence and poor parenting. Both Ms T and her brother remained on the child protection register for four years. They were in the care of the local authority for 11 years, during which time they lived mainly with their parents, with some periods in foster care.

3.6 Ms X discharged herself from a mental health hospital against medical advice in April 1993. A few days after discharge she pushed Ms T and her brother off London Bridge before jumping herself. They all suffered serious but not permanent injuries.

3.7 Both children were placed on the child protection register, fostered and an interim care order was granted. Ms T and her brother received child therapy from a Spanish-speaking therapist. Ms T also told professionals that her mother had tried to drown her in the bath. Ms T said she felt unloved, vulnerable and found it hard to establish healthy relationships with her family.

3.8 Ms T was also diagnosed in 2005 with a deteriorating eye condition with a prognosis of eventual blindness. Her father had the same condition.

3.9 Ms T changed her accommodation several times in the years before the 2007 assault - living with her uncle, her father and from 2006 in her own housing association property. Her uncle also lived with Ms T for a time in her own property and she also lived at his flat with him and his two sons.

Allegations of abuse

3.10 Allegations that Ms T had been sexually abused by her uncle Mr U began as a young teenager and had been made over a period of four years by Ms T, her parents and some from her uncle's children.

3.11 Some of the allegations were investigated by the children's service, others by the police. No action was taken as in most instances Ms T denied that the assaults took place. At other times she withdrew her allegations.

3.12 Despite Ms T's denials, her parents continued to believe that abuse had taken place. In August 2001 they visited the uncle and smashed his car windows. On another occasion they physically attacked him and accused him of abuse.

Therapy and CMHT involvement

3.13 Concerns were raised about Ms T's mental health in 2002 by her social worker as Ms T had dropped out of school and cut off her hair. She said she felt unlovable, and that *"not even my spit is worth anything"*. In February 2002 her therapist diagnosed adjustment disorder[1] with dissociative symptoms[2]. Ms T became agoraphobic[3] and virtually housebound.

3.14 Ms T turned 18 in September 2004 and the formal care order ended but Hammersmith and Fulham Children's Services leaving care team remained involved.

3.15 A consultant from the CMHT saw Ms T as an outpatient in March 2005. She was assessed and diagnosed with moderate to severe anxiety, although the consultant found that there was no evidence of major mental illness and no medication was required. She was referred to the trust psychology services for cognitive behaviour therapy. The CMHT did not take her on at this time.

3.16 Ms T began cognitive behaviour therapy with a trust psychologist in January 2006. Ms T admitted during the sessions to feelings of anger and aggression towards others and in particular towards her uncle. She said that on at least one occasion she had stabbed him and that she had attacked her mother but we have no details of this attack.

3.17 The clinical psychologist referred Ms T back to the CMHT in October 2006 and she was assessed by a staff grade psychiatrist. Ms T was considered by the psychiatrist to have emotionally unstable personality traits and to be distressed by her recent diagnosis of retinitis pigmentosa. No medication was thought necessary at this point.

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[1] Adjustment disorder (AD) is a stress-related, short-term, non-psychotic disturbance.

[2] Dissociative symptoms include: Depersonalisation – a feeling that your body does not quite belong to you or is disconnected from you; Derealisation – a feeling that you are disconnected from the world around you or 'spaced out'.

[3] Agoraphobia is an anxiety disorder characterized by anxiety in situations where it is perceived to be difficult or embarrassing to escape.

Risk

3.18 A range of professionals involved with Ms T met in October 2006. The meeting heard that Ms T had been violent towards her mother in the past. The possible risks her uncle presented were discussed and it was noted that Ms T had neither confirmed nor denied the allegations of abuse. The meeting was concerned to note that Ms T had made threats during psychology sessions to stab and blind her uncle.

3.19 The clinical psychologist was so worried about Ms T's risk to her uncle that he wrote to him in October saying that Ms T had admitted to a history of violence towards him and still had thoughts and desires to cause him harm. The uncle was asked to take the information into consideration in his continued contact with his niece.

3.20 During a home visit by the staff grade psychiatrist in November 2006 Ms T told the psychiatrist that she had not left the house for a number of weeks because of anxiety. She had stopped attending psychology appointments and had not been seeing her leaving care social worker. Also that she had become reliant on her uncle for shopping and said she valued his input.

3.21 The staff grade psychiatrist saw Ms T on 12 December 2006. Ms T said things were going downhill. She told the doctor that thoughts of going blind had been playing on her mind and said repeatedly she wanted to be left alone to die. She was offered an inpatient admission but the offer made her more agitated. She said she would rather go home with her uncle, who had accompanied her to the appointment.

3.22 The doctor assessed Ms T as at risk of impulsively acting on thoughts of self-harm and so at risk of accidental suicide and of acting on thoughts to harm others. The plan after this assessment was to offer crisis resolution team assessment and input with an increase in the prescribed sertraline medication. The crisis resolution team began additional support to Ms T in January 2007.

3.23 A protection of vulnerable adults (POVA) meeting took place on 23 January 2007, attended by the staff grade psychiatrist, psychologist, leaving care social worker and care coordinator. The care coordinator looking after Ms T's mother also attended, as did a representative from the crisis resolution team. The police were invited but were unable to attend.

3.24 The care coordinator reported that Ms T was more settled, less anxious and ready for discharge back to the CMHT from the crisis resolution team. The plan at the POVA meeting was for Ms T to be referred to low-support housing and for the leaving care team to stop their involvement with Ms T by September 2007, when she became 21.

Continuing support

3.25 Ms T's care coordinator phoned her six times in February 2007. Ms T failed to attend an outpatient appointment on 1 February and was not at home when a home visit was organised by the care coordinator on 9 February 2007.

3.26 The staff grade psychiatrist and care coordinator did however see Ms T at home on 14 March 2007. Ms T said she had been too anxious to attend appointments and that her mood had deteriorated because she had run out of medication two weeks earlier. She said she still relied on others to shop for her and that she had recently had an argument with her uncle, throwing things at him but not attacking him directly.

3.27 At a home visit on 1 May 2007 the care coordinator found her calmer than over the previous weeks. She had run out of medication and the care coordinator liaised with the GP and organised a repeat prescription for Ms T to collect later that day.

3.28 The last face-to-face contact before the homicide was on 10 May 2007 when Ms T was seen by a trainee psychologist from the early intervention service and her care coordinator. She spoke of past events and current difficulties. She talked about *"ending it all"* and harming her uncle in order to appease her parents. After this meeting the trainee psychologist organised a detailed assessment scheduled for 17 May 2007.

3.29 The trainee psychologist phoned Ms T on 17 May 2007. She said she would attend the appointment but when she did not, the trainee psychologist phoned again and left a message.

3.30 The care coordinator made no further home visits to Ms T, despite the signs of possible increase in her threats to others and possible deterioration of her mental health.

Key themes

3.31 We identify several themes arising from the investigations that we set out in this report. We consider three of these key to the actions taken by professionals over the weekend of the 15-17 June 2007. They are transition arrangements, escalation and the police response.

Transition arrangements

3.32 Ms T was transferred to the local authority children's service's leaving care team when she was 18 in preparation for her move into adult mental health services. She had complex needs so she was managed by the mental health services under an enhanced care package. She was allocated a care coordinator who worked with the leaving care team worker who had known Ms T for several years. The leaving care worker had the closest working relationship with Ms T but she was not trained or experienced in mental health.

3.33 We agree with the internal investigation report that "*mental health professionals made incorrect assumptions as to the leaving care social worker's role and responsibilities*". Most notably the care coordinator had an unreasonable expectation that the leaving care social worker would be able to undertake a specialist assessment of Ms T's mental state.

3.34 Ms T had been placed on enhanced CPA so the role of the care coordinator was vital in ensuring that a care plan was produced and that coordination of the professionals working with Ms T was effective.

3.35 The records show that the care coordinator wrote no care plans and that these were produced by the staff grade psychiatrist and the psychologist. The care coordinator did not discuss Ms T's case in supervision or at any team meetings.

3.36 The internal investigation report noted that "*the roles and responsibilities of the respective professional groups and services should have been readily apparent*" and that "*erroneous assumptions were made regarding the relative specialisms of those involved*". This lead to a recommendation that a protocol for transition from local authority children's services or children and adolescent mental health services to adult mental

health services be produced. The joint working protocol has been completed. We understand that the local authority is now progressing with the transition protocol at the time of writing this report (April 2012).

Escalation

3.37 We set out below a summary of what happened after Ms T went with her leaving care social worker to Hammersmith police station on 15 June 2007 when she confessed to stabbing her uncle.

- During the morning of 15 June Ms T contacted her leaving care social worker to say that she had stabbed her uncle. She also repeated her allegation that her uncle had raped her (in 2000) and that no one had helped her.
- Ms T was redirected to the Sapphire Unit at Fulham police station where she reported the rape allegation and the stabbing again.
- She was not questioned about the stabbing.
- After an interview about the rape allegation she was allowed to go and stay at her father's home.

3.38 The leaving care social worker told the care coordinator about Ms T's confession and her visit to the police station. The care coordinator told her senior practitioner who in turn told his line manager and the locum staff grade doctor. No contact was made with the clinical director who was covering for the responsible consultant. The care coordinator arranged for an appointment with the staff grade on Monday 18 June, but no one arranged to see Ms T on 15 June and conduct a risk assessment. The mental health staff relied entirely on the information supplied by the leaving care worker.

3.39 All the professionals the trust interviewed considered that Ms T's greatest risk was to herself, even though the care coordinator knew that Ms T had planned (with her father) to blind her uncle.

3.40 The stabbing of Ms T's uncle on 15 June 2007 was not fatal but it provided the opportunity to reassess Ms T's risk and act accordingly. If senior clinical staff had been properly engaged it is likely that this would have taken place. This was clearly a lost opportunity to avoid the fatal stabbing two days later.

The police response

3.41 Ms T was sent after the initial report of the stabbing and the historical rape to Fulham police station to be interviewed by the Sapphire Unit. The focus of the interview was the rape allegation and not Ms T's confession that she had stabbed her uncle, which was not investigated by police at either station.

3.42 The police investigation after the trial notes this failure to pursue Ms T's confession that she had stabbed her uncle and that this was a failure to follow procedures. It was also a missed opportunity to review Ms T's risk of further violence and to consider what if any actions might be needed to reduce a further risk of violence.

Findings

F1 The lack of clarity on the care coordinator's part regarding their role and the role of the leaving care social worker in working with Ms T, partly contributed to a failure to support Ms T effectively when she was at the police station reporting the stabbing of her uncle on 15 June 2007.

F2 The care coordinator failed to exercise her responsibility to ensure that the trust's guidance on CPA was followed for Ms T. She did not take the lead in ensuring care planning meetings took place or in producing care plans for Ms T.

F3 The staff grade psychiatrist and psychologist diligently sought to ensure that the care needs of Ms T and the risks she posed to herself and others were addressed.

F4 Although there is general guidance about transferring cases, no specific guidance is available covering the transfer of a young person in receipt of services from local authority children's services into the adult mental health services.

F5 We were impressed by the level of adult safeguarding understanding and training evident in the south recovery team and the commitment by senior managers to support this.

F6 The failure by the care coordinator or another mental health professional to go to the police station when Ms T reported stabbing her uncle was a missed opportunity to assess her mental state and assist the police. At that time mental health staff could also have requested a Mental Health Act assessment. We cannot assume such an assessment would have led to compulsory or even a voluntary admission to hospital but it may have done, thus avoiding the fatal stabbing two days later.

F7 The failure to respond to information around the stabbing of Ms T's uncle on 15 June 2007 was a failure by experienced clinicians and managers to ensure best practice, through consultation with other members of the mental health team.

F8 Whilst Ms T had threatened to physically harm her uncle on previous occasions these were part of generalised threats made by Ms T. There is no evidence that we have seen that should have alerted the care coordinator or others that the stabbing on 15 June was an imminent or likely event.

F9 The stabbing of Mr U by Ms T on 15 June was the apparent trigger that then led to the further attack on 17 June. The attack on 17 June that led to Mr U's death also involved Ms T's father who had been involved in attacks against her uncle. As a direct consequence of the failure of mental health staff to attend at the police station on Friday 15 June when Ms T reported stabbing her uncle a potential opportunity was lost to prevent the involvement of Ms T in the fatal stabbing of him on Sunday 17 June.

F10 The police failure to investigate the stabbing of Mr U on 15 June 2007, like the non-attendance of mental health staff at the police interviews was a serious missed opportunity to assess Ms T's risk of further violence.

Recommendations

R1 The trust should ensure that a transition policy providing guidance on the transition from local authority children's services to adult mental health services is produced and sent to all staff that need to know about it.

R2 We recommend that the trust issue guidance to clinical staff that whenever a report is received of a service user subject to CPA attending at a police station a mental health practitioner should always go to the police station to offer support to the individual and to assist the police.

R3 The trust, in consultation with its local authority partners, should produce guidance on how NHS and local authority staff in the community mental health teams can have access to the children's element of Framework I[1] whenever appropriate to their work.

R4 The trust should review whether clinical risk training, with updates at regular intervals, is being delivered to all community staff whatever the professional or clinical background.

R5 The trust should review with social service colleagues how community teams implement the recovery approach and ensure concordance between the board level guidance and the approaches local teams are taking.

[1] This is the local authority electronic client information programme

4. Summary chronology

4.1 The following chronology has been drawn from a detailed chronology we compiled from source documents and reports we reviewed. The events here provide the reader with information needed to understand the key features of the care Ms T received from various agencies and the impact that this may have had on Ms T prior to the killing of her uncle Mr U.

Family History

4.2 Ms T was born in Peru in September 1986 and was almost 21 at the time of the incident. Her mother, who was seeking political asylum, brought her to London in June 1992 when she was six. Her brother, who was four at the time, came with them. Ms T's father, Mr W came to England two years later, also to seek asylum. He seems not to have known much about where his family was before he arrived in London.

Ms T aged 6-12: 1992-1998

4.3 Ms T's mother Ms X experienced deteriorating mental health and had concerns about her immigration status. In April 1993 she was admitted to hospital but discharged herself against medical advice later that month.

4.4 After her discharge, she tried to persuade Ms T and her brother to jump off London Bridge with her. She then pushed them both off the bridge and jumped herself. Ms T suffered a fractured pelvis and her brother facial and elbow injuries. Ms X fractured her spine.

4.5 Both children were then put on the child protection register and fostered; an interim care order was granted. Ms T and her mother had a poor relationship, with allegations of bullying, domestic violence and poor parenting. Both Ms T and her brother remained on the child protection register for four years. They were in the care of the local authority for 11 years, living for the most part with their father and mother, with some periods in foster care.

4.6 Ms T and her brother received child therapy from a Spanish-speaking therapist after the incident at London Bridge.

4.7 Ms T's father came to England in February 1994. Social services assessed him and he became the 'protective parent' to both Ms T and her brother.

4.8 Ms T's mother became increasingly unwell in 1995 and it appears that her concerns about her immigration status prompted repeated threats to kill herself and her children. Both children saw her cut herself and take an overdose. She was admitted to hospital, starting a pattern of deteriorating mental health which culminated in her leaving the family home early in 1998.

Ms T aged 12-18: 1998-2004

4.9 In 1998 Ms T's uncle separated from his wife. He had two sons and an elder daughter.

4.10 In 1998 Ms T's father was diagnosed with a degenerative eye condition, which his daughter inherited. He was told he might be blind within a year.

4.11 The relationship between Ms T and her mother remained poor. Ms T and her brother made allegations that their mother hit them. She left home after one such incident.

4.12 By 2000 Ms T began to stay with her uncle Mr U, moving between her parents' home and her uncle's.

4.13 In 2000, at the age of 14, Ms T locked herself in her uncle's flat and refused to come out. She was placed in foster care but absconded and returned to her uncle's flat after staying with a friend for a while. Later the same month the foster carer reported that Ms T had told another child that her uncle had abused her. The social worker who looked into the allegation thought there had been no abuse and it appears that no further action was taken.

4.14 Ms T's parents alleged in February 2001 that the uncle behaved inappropriately towards Ms T and complained for the first time to the local authority children's service. Both Ms T and her uncle denied these allegations. Ms T continued to deny that any inappropriate behaviour had taken place and the police took no further action. Ms T returned to live with her uncle, despite the fact that children's services had not approved the placement. After discussion in the department the divisional manager did not pursue a recovery order[1].

4.15 The police individual management review[2] (IMR), produced following the homicide, noted that the police Local Child Abuse Investigation Team (CAIT) investigated the allegations of abuse in February 2001. The police criticised children's services in Hammersmith and Fulham for allowing Ms T to stay overnight with her uncle when he was facing such a serious allegation.

4.16 The police IMR noted that the social worker was not happy with the senior management decision and felt that the police had correctly challenged this decision. Ms T had no foster placement and the social worker agreed to monitor her safety while she was staying with her uncle.

4.17 Police picked up Ms T's cousin in July 2001. She told them she was afraid to go home and that she had seen her father with Ms T on the sofa at home. She said that her father was shirtless and putting on his trousers when she saw him with Ms T. The police went to the flat and spoke to Ms T, who said she was happy to stay.

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[1] A recovery order is defined in section 67Q of the *Family Law Act 1975*. It is an order of the court that can require a child be returned to a:

- parent of the child
- person who has a parenting order that states the child lives with, spends time with or communicates with that person, or
- person who has parental responsibility for the child.

A recovery order can authorise or direct a person or persons, such as police officers, to take appropriate action to find, recover and deliver a child to one of the people listed above. As well, a recovery order can provide directions about the day-to-day care of a child until the child is returned or delivered.

A recovery order can also prohibit the person from again removing or taking possession of the child. In these cases, a recovery order can authorise the arrest (without warrant) of the person who again removes or takes possession of the child.

[2] Appendix B provides information on IMRs

4.18 Ms T's parents continued to believe that her uncle was abusing her, despite her denials. They visited the uncle in August 2001 and smashed his car windows.

4.19 The police IMR says that in January 2002 a psychiatrist phoned them to say that Ms T was at home and threatening to harm herself. Police went to the address but no one was in.

Comment

We can find no record in Ms T's clinical notes of a phone call to the police by a psychiatrist. NHS services were not engaged with Ms T at this point but they were involved with her mother, so the report may have come from a psychiatrist involved with her mother. This is not a matter directly relevant to later events and we have not pursued it.

4.20 Concerns were raised by Ms T's social worker relating to her mental health. Ms T in 2002 had dropped out of school and cut off her hair. She said in a therapy session that she was unlovable and that *"not even my spit is worth anything"*. In February 2002 her therapist made a diagnosis of adjustment disorder with dissociative symptoms. She also became agoraphobic and virtually housebound.

Ms T aged 18-20: 2004-2006

4.21 Ms T was 17 in January 2004 and had returned to live with her uncle. That May she repeated her allegation made while she was in foster care in 2000 that her uncle had raped her when she was 14. Police held an achieving best evidence interview. Few details are available of that interview. In any case, Ms T did not wish to pursue a court hearing so no further action was taken.

4.22 The police IMR found that this investigation was not carried out in accordance with standard operating procedures. The investigation was not supervised, dealt with in an expeditious manner or recorded satisfactorily in line with instructions. The police IMR

made recommendations for improving the working procedures of both the central child abuse investigation team and Hammersmith and Fulham Police.

4.23 Ms T returned to live with her father in February 2004 after an incident involving her uncle's two sons who were taken into care following allegations that their father had punched one of them in the face.

4.24 Ms T turned 18 in September 2004 and the formal care order ended but Hammersmith and Fulham Children's Services leaving care team remained involved.

4.25 Ms T was seen as an outpatient in March 2005 by a consultant from the CMHT. The clinical notes of her assessment record that she was diagnosed with moderate to severe anxiety with no evidence of major mental illness and no medication required. She was referred to the trust psychology services for cognitive behaviour therapy.

4.26 Ms T moved into supported accommodation in 2005 and continued to see her uncle. At some point in 2005 (the date is unclear from the records) her uncle's sons returned to live with their father.

4.27 In May 2005 Ms T was assessed and accepted for cognitive behaviour therapy with a trust psychologist. The consultant clinical psychologist at assessment noted that she displayed "*emotionally unstable and impulsive traits*".

4.28 Ms T was diagnosed with glaucoma in 2005. This would later develop (in 2006) into a diagnosis of retinitis pigmentosa - a degenerative eye condition that would lead to severe impairment of Ms T's sight and possible blindness.

Comment

This diagnosis and its consequences for Ms T added significantly to the emotional pressures she faced. They also featured as part of the future psychological therapy she was to receive.

4.29 Ms T's parents attacked her uncle in November 2005, shouting that he had raped her and that he was now using her to look after his children. The outcome of this incident is unclear but both parents were evidently unhappy with the continuing contact between their daughter and her uncle.

Ms T aged 20: 2006

4.30 In January 2006 Ms T started cognitive behaviour therapy[1] with a trust psychologist although she struggled to keep her appointments. Ms T was provided with support at the sessions from the leaving care support worker who attended with her but did not get involved in the therapy. During these sessions Ms T admitted to having feelings of anger and aggression towards others and in particular towards her uncle. She said at least once that she had stabbed him and that she had attacked her mother, but we have no details of this attack.

4.31 The staff grade psychiatrist assessed Ms T at the team base after referral by the clinical psychologist on 6 October 2006. Representatives from psychology, leaving care and the crisis resolution team felt that CMHT input would be helpful.

4.32 Ms T appeared low in mood at this assessment and told the assessing psychiatrist about her suicidal ideation though she had no clear or immediate plans to end her own life. She also described what the psychiatrist believed might be pseudo-hallucinatory experiences relating to her early life.

4.33 Ms T was considered by the staff grade psychiatrist to have emotionally unstable personality traits and was being affected and distressed by her recent diagnosis of retinitis pigmentosa. No medication was thought necessary at this point.

4.34 In October 2006 Ms T told her psychologist that she was feeling more and more helpless and had engaged in more self-harm and angry and aggressive behaviour. The psychologist noted that between the ages of 15-18 she had been aggressive towards her uncle and claimed that she had stabbed him on several occasions.

[1] Cognitive Behaviour Therapy (CBT) is a short-term talking treatment that aims to change patterns of thinking or behaviour that are behind people's difficulties.

4.35 The clinical psychologist was so worried about Ms T's risk to her uncle that he wrote to the uncle on 5 October. He made it clear in the letter that Ms T had admitted to a history of violence towards the uncle and still had thoughts and desires to cause him harm. In the letter Ms T's uncle was asked to take the information into consideration in his future contact with his niece.

4.36 The leaving care social worker, care coordinator, staff grade doctor and psychologist attended a meeting on 24 October 2006. It decided that Ms T was at both a direct and indirect risk of harming herself since the eye disease diagnosis.

4.37 The meeting discussed Ms T's relationship with her mother and noted that Ms T had been violent towards her mother in the past. The risks presented by her uncle were also considered and the meeting noted that Ms T had neither confirmed nor denied the allegations of abuse. The meeting was concerned to note that Ms T had made threats during psychology sessions to stab and blind her uncle.

4.38 Ms T told the visiting staff grade psychiatrist in November 2006 that she felt *"really bad"* and described overwhelming anxiety. She had been unable to leave the house for a number of weeks so she had stopped attending psychology appointments and had not been seeing her leaving care social worker. Ms T had become reliant on her uncle for shopping and said she valued his input.

4.39 The staff grade doctor wrote to the GP in November 2006 setting out the details of the meeting held on 24 October 2006 saying that Ms T had emotionally unstable personality traits and impulsivity, along with low self-esteem and social anxiety driven by past traumatic experiences and childhood memories. Ms T was started on the anti-depressant medication sertraline and a care coordinator (who was also a community psychiatric nurse) was allocated and agreed to visit Ms T alongside her leaving care social work colleague.

4.40 Ms T's care coordinator visited her at home on 21 December 2006 and found her extremely distressed. Her uncle's 12 and 13-year-old children were in the house and she felt that they were mocking her. The care coordinator took advice from the staff grade psychiatrist who saw Ms T that day at the CMHT offices.

4.41 Ms T felt things were going downhill for her. She said that her mood was initially better after the prescription of sertraline but she now felt that life was not worth living and that she was struggling to see a future. She told the doctor that the thoughts of going blind had been playing on her mind and she often said she wanted to be left alone to die. The staff grade psychiatrist offered to admit Ms T. She said she would rather go home with her uncle, who had accompanied her to the appointment. The doctor spoke of her concerns at the degree of hopelessness that Ms T was expressing but Ms T became more agitated when a possible hospital admission was again offered.

4.42 The doctor felt that Ms T was at risk of acting impulsively on her thoughts of self-harm and consequently of accidental suicide. The clinical record noted a risk of Ms T acting on thoughts to harm others. She had expressed no intention to do so at that time but she had a history of hitting both her uncle and her mother.

4.43 The plan following this assessment was to offer crisis resolution assessment and input and to increase Ms T's sertraline medication.

4.44 Ms T changed her accommodation several times in the years before the 2007 assault - living with her uncle, her father and from 2006 in her own housing association property. It appears that her uncle also lived with Ms T for a time in her own property and that she also lived at his flat with him and his two sons.

Ms T Aged 21: 2007

4.45 The crisis resolution team were asked to give additional support to Ms T following the professionals meeting held in October 2006 convened by the clinical psychologists working with Ms T. The crisis resolution team started to give Ms T extra support in January 2007. Ms T's care coordinator visited her on 28 January 2007. She said at first that she was feeling *"not bad"*. She did, however, admit to having heard frightening voices at night and in the morning from a woman she could sometimes see as well as hear. She had been prescribed the anti-psychotic risperidone on 12 January.

4.46 The staff grade psychiatrist, psychologist, leaving care social worker and care coordinator held a protection of vulnerable adults (POVA) meeting on 23 January. The

care coordinator looking after Ms T's mother also attended, as did a representative from the crisis resolution team. The police could not attend.

4.47 The care coordinator said Ms T was more settled, less anxious and ready for discharge back to the CMHT from the crisis resolution team. The allegations of abuse by Ms T's uncle were discussed, in particular that these allegations had not been fully investigated but that a decision had been made to keep the matter under observation but take no further action.

4.48 The plan at the POVA meeting was for Ms T to be referred to low-support housing and for the leaving care team social worker to work with her until September 2007, when she became 21.

4.49 Ms T's care coordinator phoned her six times in February 2007. Ms T failed to attend an outpatient appointment on 1 February and was not at home when a visit was made on 9 February 2007.

4.50 The staff grade psychiatrist and care coordinator saw Ms T at home on March 14 2007. Ms T said she had been too anxious to attend appointments and that her mood had deteriorated because she had run out of medication two weeks earlier. She said she still relied on others to shop for her and that she had recently had an argument with her uncle, throwing things at him but not attacking him directly.

4.51 Ms T's care coordinator visited her on 20 March 2007. She said she had been thinking of negative past events. She was taking her medication and agreed to arrange a further appointment. No contact had been made by 14 April and the care coordinator left a message for Ms T asking her to call.

4.52 The care coordinator visited Ms T at home on 1 May 2007 and found Ms T feeling calmer than in previous weeks. She had run out of medication so the care coordinator liaised with the GP and organised a repeat prescription for Ms T to collect later that day. The care coordinator planned to see Ms T after her meeting scheduled with a trainee psychologist for the early intervention service (see below). This did not happen due to staff illness and nothing was rescheduled.

4.53 The last formal contact before the homicide was on 10 May 2007 when Ms T was seen by a trainee psychologist from the early intervention service and her care coordinator. This appointment with the trainee psychologist was as a result of a referral made by the clinical psychologist who saw Ms T in September 2006. She spoke of past events and current difficulties. She spoke about issues in relation to *"ending it all"* and harming her uncle in order to appease her parents.

4.54 She explained that she still visualised and heard images of herself, a critical version of herself who she felt would be angry with her that evening for speaking with the doctor. The trainee psychologist organised a detailed assessment scheduled to occur on 17 May 2007.

4.55 The trainee psychologist phoned Ms T on 17 May. She confirmed that she would attend her appointment. When she did not attend she was phoned by the psychologist a second time and a message left for her.

Comment

The care coordinator made no further home visits despite signs Ms T's anxiety threats to others and the possible deterioration of her mental health.

15 – 17 June 2007

4.56 The clinical record shows no contact with Ms T after the trainee psychologist's attempted detailed assessment on 17 May until 15 June 2007.

4.57 The CMHT duty social worker took a phone call from the leaving care social worker on 15 June 2007 to say that Ms T had stabbed her uncle. Ms T attended the police station with her leaving care social worker and her mother to report the stabbing and alleged sexual abuse from 2000.

4.58 The leaving care social worker made contact the same day with the care coordinator and told the care coordinator that Ms T wanted to tell the police the whole story and had admitted that her uncle had sexually abused her.

4.59 Ms T told the care coordinator she felt her uncle had been *"winding her up"* by saying he was going to bring his own daughter to England from Peru *"to make her life hell"*. She said *"I just felt rage then I stabbed him in the back with a knife"*.

4.60 Ms T was tearful on the phone to her care coordinator, asking if she was angry with her and repeatedly apologising for her actions. At the time of this conversation Ms T was waiting to be taken to Fulham police station to be seen by the specialist sexual assault team at the Sapphire Unit. The police IMR makes clear that only the sexual abuse issues were dealt with when she arrived at the station. The duty officer did not appear to know about the stabbing and the leaving care social worker did not raise it with officers.

Comment

We would have expected the care coordinator, as the key mental health professional working with Ms T to arrange to go to the police station to assess and support Ms T. She would also have been able to assist the police and the leaving care social worker in their engagement with Ms T.

4.61 Ms T returned to her father's house. She previously had told her care coordinator and the leaving care social worker that she would feel safe there. The care coordinator made contact with the A&E department doctor treating the uncle who said he was about to be discharged. The uncle had told doctors that he had suffered a work related injury, falling back onto a metal implement. He was treated with sutures and discharged home.

4.62 The care coordinator reported the matter to one of the CMHT senior practitioners who sought advice from a CMHT doctor who offered Ms T an urgent review appointment on Monday 18 June. The care coordinator phoned Ms T who agreed to attend.

Comment

In contacting the senior practitioners the care coordinator sought advice and escalated the matter appropriately.

Sunday 17 June 2007

4.63 Ms T was arrested early on 17 June on suspicion of murdering her uncle, Mr U. Her father and brother were also in the uncle's flat and were also arrested. Mr U was stabbed a total of 111 times. The police were called by Mr U's children who raised the alarm by calling to passerby's from the window of a bedroom where they had been locked.

4.64 A forensic medical examiner assessed Ms T at the police station. Following further assessment by mental health staff she was placed on Section 2 of the MHA and transferred to a private mental health hospital. She was later convicted of killing her uncle and transferred to prison.

Comment

This chronology makes clear that Ms T was a troubled young person from a troubled family. Her mother's mental health had had a significant impact on her emotional development. This, along with her deteriorating eye condition, left Ms T feeling unloved and vulnerable and caused her difficulty in establishing healthy relationships with her family.

We asked several times to see Ms T's Children and Adolescent Mental Health Services (CAMHS) notes but they were not made available. We were told they were too extensive to copy and we were directed to the single agency review that contains some references to CAMHS's involvement. Consequently we have been unable to review the involvement of this service that played an important part in Ms T's early development.

A review of Ms T's clinical notes and clinical letters shows good liaison between the psychology services, GP and the staff grade psychiatrist, who was the main CMHT contact, after Ms T's referral to the CMHT for assessment in March 2005 and up to just before the killing of Mr U. Assessments were comprehensive and communicated in a timely manner, risks were identified and plans put in place.

We identify a number of themes arising from our overview of Ms T's care which we deal with below. Many of the issues in our chronology have significantly changed and

improved since these events. We have therefore focused on whether the changes address the weaknesses in care we found.

5. Diagnosis

5.1 Ms T was in contact with mental health services from 2002-2003 when she was receiving therapy from a psychologist. The initial diagnosis was that she was experiencing an adjustment disorder.

5.2 Ms T was referred again for psychological treatment by a consultant psychiatrist from the CMHT who assessed her in March 2005 and referred her for cognitive behavioural therapy to help her manage her severe phobic anxiety and agoraphobia.

5.3 A mental state examination by a staff grade psychiatrist from the CMHT in November 2006 concluded that she might be experiencing pseudo hallucinations, noting suicidal ideation though no plans about how she might take her own life. The assessment also identified that Ms T had emotionally unstable personality traits and impulsivity, with low self-esteem and social anxiety. It was evident to the staff grade psychiatrist that the deterioration in her sight was also having an impact on her emotional instability and lowering her mood.

5.4 In November 2006 Ms T started taking the anti-depressant sertraline but remained without a formal diagnosis throughout her involvement with mental health services.

Comment

The lack of a formal diagnosis for Ms T during her contact with the adult mental health service did not feature in our investigation as significant in the treatment she received.

6. Transition arrangements

Transfer to the CMHT

6.1 The CMHT as it was configured at the time had accepted a referral made directly to it by the London Borough of Hammersmith and Fulham (LBHF) leaving care team in September 2006. The lead worker for Ms T at the time of the referral was the social worker from the leaving care team. The referral stated that "*in the context of some changes in her mental health, she had developed retinitis pigmentosa and she had become quite low in mood as a result of that*".

6.2 The CMHT plan was to work with the leaving care team in preparation for her move into adult mental health services. Because she had complex needs she was managed under an enhanced care package with a care coordinator working with the leaving care team social worker who had worked with her for a number of years.

6.3 It would seem that either by explicit agreement or in practice it was the leaving care team worker who was considered to be the lead worker in the management of Ms T's care.

6.4 In their comments to us on the draft report LBHF, adult services told us:

> *"It is not uncommon for professionals to have different perspectives/understanding of each other's roles and responsibilities and this seemed to be an aspect of this case. Children's Services did some work on this last year with the local CAMHS service and arguably may need to do the same with adult mental health.*
>
> *Ultimately the failure to recognise the appropriate role of the leaving care social worker rested with the CMHT. The leaving care social worker did inform the care coordinator of the stabbing and thus did fulfil her responsibilities."*

6.5 At the time of referral to the CMHT Ms T was not in contact with CAMHS although she had been engaged with that service up to September 2004 when she became 18. The CMHT first became involved with Ms T in 2005 when she was assessed and a referral made

to the psychology department, which at that time operated separately from the CMHT. An accelerated acceptance of the referral by psychology led to a series of sessions with a clinical psychologist. At psychology sessions with Ms T the leaving care social worker was often present to provide non participatory support to her client.

Finding

F1 The lack of clarity on the care coordinator's part regarding their role and the role of the leaving care social worker in working with Ms T, partly contributed to a failure to support Ms T effectively when she was at the police station reporting the stabbing of her uncle on 15 June 2007.

Care plans and care coordination

6.6 As Ms T was subject to enhanced CPA the role of the care coordinator was vital in ensuring that she had a care plan and that there was effective coordination of the different professionals working with her.

6.7 The records show that Ms T's care plans were produced by the staff grade psychiatrist and the psychologist and not the care coordinator. The care coordinator did not discuss Ms T's case in supervision or at any of the team meetings.

6.8 The care plans, though not in the format required as part of the trust's CPA policy, did address Ms T's risks and set out actions to be taken by those working with her. We set out two examples below.

6.9 Following the POVA meeting held on 23 January 2007 the staff grade psychiatrist wrote the agreed plan in Ms T's case notes. There was therefore no stand alone plan available but the staff grade psychiatrist did write the plan in letters to all the attendees. The plan at this meeting was:

- discussion to take place with Ms T's mother about Ms T making statements about killing herself
- Ms T to be offered support to reduce her reliance on her uncle

- to facilitate improvements in her relationship with her father
- psychology input to continue
- a referral for assessment to be made to the trust early intervention in psychosis team.

6.10 The care plan written by the staff grade psychiatrist following a home visit to Ms T on 14 March 2007 set out the following actions:

- Ms T to restart her risperidone and sertraline which she had stopped taking without consultation
- the care coordinator to see Ms T fortnightly instead of monthly
- chase a referral to housing support previously made.

Findings

F2 The care coordinator failed to exercise her responsibility to ensure that the trust's guidance on CPA was followed for Ms T. She did not take the lead in ensuring care planning meetings took place or in producing care plans for Ms T.

F3 The staff grade psychiatrist and psychologist diligently sought to ensure that the care needs of Ms T and the risks she posed to herself and others were addressed.

Transition Protocol

6.11 The trust investigation's action plan undertook to produce a protocol specifically dealing with movement of younger people from social services to adult mental health. The action plan said the Local Safeguarding Children's Board would endorse this protocol in July 2009.

6.12 We reviewed an undated protocol that deals only with the transfer of clients from the CAMHS service to the adult services in Hammersmith and Fulham. The appendix to the protocol contains a reference to the need for a wider perspective: *"The interface with social services will need to be specifically considered"*.

6.13 We were told that a similar protocol or procedural document covering transition from local authority children's services to adult mental health services had not been produced.

Finding

F4 Although there is general guidance about transferring cases, no specific guidance is available covering the transfer of a young person in receipt of services from local authority children's services into the adult mental health services.

6.14 In response to the draft report LBHF, adult services told us:

> *"There remains work to be done to complete the transition protocol due to changes in service configuration and personnel."*

6.15 The trust in their response told us:

> *"[It is] concerning that this was not addressed in the initial action plan, Local services need to review this with the local authority to establish if this is required"*

6.16 Whilst local services need to address the implementation of serious incident reviews, it is also important that the trust has a process at executive board level that ensures that all recommendations from serious incident reviews are tracked and that the trust board can be assured of their implementation.

Recommendation

R1 The trust should ensure that a transition policy providing guidance on the transition from local authority children's services to adult mental health services is produced and sent to all staff that need to know about it.

Current transition arrangements

6.17 The referral route and subsequent joint working arrangements between the mental health team and the leaving care team in 2006-2007 have been radically changed with the reconfiguration of services. A borough wide assessment team assesses all referrals to the trust and if the referral is accepted, either refers them to other services or works with them for a maximum of one year. The assessment team refers anyone needing longer-term support to geographically focused recovery teams. Younger people showing signs of the onset of mental illness are provided assessment and engagement by the FIRST team. This team provides intensive support to young adults who are diagnosed with a serious mental illness to help them avoid the effects of a chronic illness emerging.

6.18 The referral route now in place for a young person like Ms T involves initial engagement with either the FIRST team or the assessment team with a possible progression to the recovery team dependent on need. We heard evidence that this process is in place, backed by a transfer-protocol between CAMHS and the trust adult mental health services.

Comment

We have concerns about the transfer-protocol's range. The document focuses on referrals and practice exclusively in health service provision. The detail is impressive and helpful within those limits but its health-only focus is insufficient given the lack of clarity in this case about where responsibility rested and an apparent assumption about the mental health knowledge base of the leaving care social worker. Some interviewees, including the south recovery team manager and team senior practitioners, told us they were not aware of this protocol, though it appears that medical staff had received it through their medical communication processes.

6.19 Providing support to family members where a parent or carer has a mental illness has been addressed in a joint health and social services protocol, *Achieving best outcomes*

for children through working together, dated October 2009 and reviewed September 2010.

Comment

We received no evidence that this protocol was known about by the staff in the CMHT. In the case of Ms T the application of such a protocol would have been helpful to professionals working with Ms T and her family.

7. Safeguarding

7.1 Ms T suffered significantly as a child: her mother tried to kill her by pushing her off London Bridge. She had suffered non-accidental injuries and her family situation caused her distress. She was sometimes in foster care because home circumstances were intolerable. When she was 14 and living with a foster family, she said her uncle had sexually abused her. The social worker involved at the time appears not to have taken her seriously and no further action was taken.

7.2 The childcare practice in regard to Ms T, and her brother was the focus of a single agency review carried out by Hammersmith and Fulham Children's Services in 2007 after the homicide. Ms T's formative years clearly included pressures and concerns of a kind that one would expect to make her the subject of active safeguarding work today.

7.3 The mental health staff had significant concerns about Ms T's safety and vulnerability in September and October 2006 when she was 20. A POVA meeting was held in January 2007. The police did not attend and nothing in the record suggests anyone followed up with them the possible sexual abuse of Ms T. On this issue Ms T was inconsistent in what she said, and had denied the disclosure she had made as a 14-year-old. Apparently her mother was adamant that the uncle had abused her.

7.4 Other than being the subject of this POVA meeting, Ms T was not considered a vulnerable adult. The focus of adult safeguarding was more geared at this time to specific protection issues than to safeguarding more widely.

Comment

The real opportunities to safeguard Ms T, in what must be acknowledged as a demanding case, were when she was a child; by the time she was 20, this was harder.

7.5 Front line practitioners, trust and local authority managers told us that current adult safeguarding practice would have identified Ms T as a vulnerable adult and would

have resulted in a protection plan that could be expected to focus engagement with her more positively than was the case.

7.6 At the time that we conducted our investigation the CMHT that Ms T had been assigned to no longer existed due to the reconfiguration of community teams. Therefore to test out how the trust's internal investigation recommendations had been implemented we interviewed community staff from the south recovery team, individually and as a group. All the staff we spoke to in the south recovery team were trained to Safeguarding Level 3 covering recognising and acting upon a safeguarding concern. 'Cases for concern' is a standing agenda item at the weekly team meeting. All the staff we spoke to thought that under today's procedures Ms T's issues would be recognised as a safeguarding concern and an appropriate course would be followed.

7.7 We discussed with LBHF adult services managers their audit processes for maintaining a high quality approach to safeguarding. The processes described to us appear robust and effective. The head of quality assurance has provided us with a summary of those processes which is included at appendix C.

Finding

F5 We were impressed by the level of adult safeguarding understanding and training evident in the south recovery team and the commitment by senior managers to support this.

Comment

The apparent absence of positive safeguarding work with Ms T and her brother in the early and mid 1990s made it more difficult to take protective actions in regard to Ms T's relationship with her uncle once she was an adult.

8. Escalation

8.1 In this section we outline again the steps that were taken after Ms T attended the police station with her leaving care social worker on 15 June 2007 when she confessed to stabbing her uncle.

- During the morning of 15 June Ms T contacted her leaving care social worker to say that she had stabbed her uncle that morning. She repeated her allegation that her uncle had raped her and no one had helped her to address this in the past.
- Ms T along with her leaving care social worker attended Hammersmith police station to report the stabbing and the rape.
- Ms T was redirected to the Sapphire Unit at Fulham police station where she reported the rape allegation and the stabbing again.
- She was not questioned about the stabbing.
- She was interviewed about the rape allegation and afterwards allowed to go to her father's home.

8.2 The leaving care social worker told the care coordinator what had happened and the care coordinator in turn told her senior practitioner. The trust report deals with this in some detail:

> *"…the senior nurse practitioner did not give the care coordinator substantial instruction and supervision in the appropriate management of this psychiatric emergency; instead he focused on ensuring that…Staff Grade Doctor… within the team and the service manager, his line manager, were informed of events. He did not make any clinical judgement. He was unaware of either previous allegations of sexual abuse by* [Ms T]*'s uncle or previous issues of risk to* [Ms T]*'s uncle, even though these were extensively documented in* [Ms T]*'s notes."*
>
> *"No one, including the senior nurse practitioner, substantially questioned the care coordinator's assessment or established the provenance of the information on which it was based."*

8.3 The report to the senior practitioner was from a care coordinator who was already being performance managed by the senior practitioner because of a failure to maintain contact with some of her service-users.

Comment

This should have at least led to the senior practitioner reviewing with the care coordinator what action should and must take place.

8.4 As part of the process of giving individuals who are subject to criticism within an investigation the opportunity to review and respond to the draft report we offered interviews to the senior practitioner and the care coordinator. We received no response from the care coordinator who had left the trust. The senior practitioner did meet with us and provided us with his perspective on the criticisms contained within the trust report and the potential criticism within our report.

8.5 He told us in respect of his role on Friday 15 June:

> *"…when… [the care coordinator]…reported to me and we said, 'Shall we go and see?' – that was my first reaction, 'Shall we go and see?'. The time we planned it was I think eleven o'clock. Then in the meanwhile [the care coordinator]… had been communicating with the day* [leaving] *care social worker who was with her in the police station and I think I did speak to her too myself,- and she said,* '[Ms T] *is with me. She is very calm. We are at the police station'. I did ask, 'Do you want me and [the care coordinator] to come?' She said, 'No, you don't have to because I am with her and she is calm, she is safe and if any issues come up, if we are concerned, then we will give you a call.'*

8.6 We asked whether Ms T's risk to others was taken into account and he told us that as she was going back to her father's house she was not likely to be a further danger to her uncle.

8.7 We asked the senior practitioner who he consulted with on that day. He told us:

> *"I discussed the case with the psychiatrist - the staff grade doctor. I discussed the case with the senior practitioner and my colleagues, the practitioner social worker, who was on duty that day. The plan was discussed with – not my line manager, who was not on duty that day - but my line manager's manager, the sector manager. It was discussed, so it was not only my decision not to go and see her."*

8.8 The trust report says all the professionals interviewed considered that Ms T's greatest risk was to herself. This was despite evidence known to the care coordinator that Ms T had planned (with her father) to blind her uncle and that there was *"…an adequate risk assessment document dated 26 January 2007 and several letters written by the clinical psychologist which included a description of* [Ms T]*'s threats to and attacks on her uncle"*.

8.9 No one arranged to see Ms T and conduct a risk assessment and the mental health staff relied entirely on the information supplied by the leaving care social worker.

8.10 The stabbing of Ms T's uncle on 15 June 2007 was not fatal but it provided the opportunity to reassess Ms T's risk and act accordingly.

Comment

This failure to assess Ms T, to conduct a risk assessment and for senior clinicians to review her records in particular previous risk assessments was a serious failure. As there was no attendance by trust mental health staff at either interview, Ms T's risk history was not made known to the police in particular her history of previous violence and threats of violence against her uncle. A review of the records and a face-to-face risk assessment could have led to further discussion with the police or a MHA assessment with a view to admission. This might have happened if all relevant professionals had been consulted and was clearly a lost opportunity to avoid the fatal stabbing two days later.

A consultant psychiatrist was available for advice but was not called. The use of consultation when concerns are escalating is an important foundation to safe practice and should be firmly established, understood and reinforced at team level.

Findings

F6 The failure by the care coordinator or another mental health professional to go to the police station when Ms T reported stabbing her uncle was a missed opportunity to assess her mental state and assist the police. At that time mental health staff could also have requested a Mental Health Act assessment. We cannot assume such an assessment would have led to compulsory or even a voluntary admission to hospital but it may have done, thus avoiding the fatal stabbing two days later.

F7 The failure to respond to information around the stabbing of Ms T's uncle on 15 June 2007 was a failure by experienced clinicians and managers to ensure best practice, through consultation with other members of the mental health team.

8.11 In relation to this finding LBHF adult services told us:

> *"It was our conclusion that the service manager* [who was the next line manager above the CMHT team manger] *was the appropriate person to make the decision. The service manager was an experienced statutory mental health social worker. There was no requirement on her to consult a medical practitioner and nor would there be.*
>
> *The accountability of the service manager on the day was ultimately to her social care employers and not to WLMHT clinical staff. No clinical staff could have taken responsibility for her decision."*

Comment

We agree that the service manager was professionally competent to and should have instructed the senior practitioner or the care coordinator to attend at the police station and support Ms T.

We do not accept that in consulting the consultant, the service manager was in any way diluting their professional competence or handing over their responsibility to* "a medical practitioner". *In making the decision it would have been best practice for the service manager to have discussed the case with other members of the multi disciplinary team, including the most senior medic. Had this been done, they may have made a better decision (though we cannot say that for certain).

The value of an integrated service is the very availability of different professionals sharing their expertise particularly in times of crisis.

No MHA assessment occurred but one may have been arranged if someone from the mental health team had attended to support Ms T at the police station. In deciding whether a MHA assessment was needed, consultation with the mental health team would also be best practice. Such consultation does not remove the approved mental health practitioner's statutory responsibility to make a decision to conduct a MHA assessment.

Findings

F8 Whilst Ms T had threatened to physically harm her uncle on previous occasions these were part of generalised threats made by Ms T. There is no evidence that we have seen that should have alerted the care coordinator or others that the stabbing on the 15 June was an imminent or likely event.

F9 The stabbing of Mr U by Ms T on 15 June was the apparent trigger that then led to the further attack on 17 June. The attack on 17 June that led to Mr U's death also involved Ms T's father who had been involved in attacks against her uncle. As a direct consequence of the failure of mental health staff to attend at the police station on Friday 15 June when Ms T reported stabbing her uncle a potential opportunity was lost to prevent the involvement of Ms T in the fatal stabbing of him on Sunday 17 June.

Recommendation

R2 We recommend that the trust issue guidance to clinical staff that whenever a report is received of a service user subject to CPA attending at a police station a mental health practitioner should always go to the police station to offer support to the individual and to assist the police.

9. Use of the electronic record - RiO

9.1 The trust was still using paper notes at the time of the incident in June 2007. The RiO electronic record was introduced later that year and through 2008. The trust investigation found:

> *"The care coordinator states that she was not familiar with important information in* [Ms T]*'s case notes. She did not review case notes in supervision."*

> *"On June 15th [2007] the care coordinator did not conduct a face to face assessment of* [Ms T]*'s mental health and did not adequately consult* [Ms T]*'s case notes."*

We have therefore considered the introduction of RiO because we think the changes to access and the operation of record-keeping are significant.

9.2 Staff we interviewed welcomed the introduction of RiO. They considered that clinical records were clearer and provided a contemporaneous record that could not be easily changed or lost. Clinicians could now access records rapidly and examine care plans, risk assessments and an individual's continuous record whenever issues arose with individual service-users.

9.3 A senior clinician told us that a consultant could now track the progress of an individual daily and discuss the case with the care coordinator if a team meeting identified a service-use as a potential case for concern. A consultant psychiatrist said:

> *"...in comparison to paper records there is no doubt that it is an enhanced tool, particularly in terms of risk management. It is available 24 hours a day, whichever site you are on in the trust and the writing is self evidently legible. There are structures for risk management which were not really there in the paper records."*

9.4 All staff in the ward and community teams now use the RiO electronic record resulting in a significant improvement in completed risk assessments. Analysis of records can determine any lack of quality or compliance with the requirement to complete key fields and quality can be monitored with a high level of sophistication.

Comment

RiO has benefited both clinical practice and service-user care. The trust and team managers have obviously worked hard to promote and embed RiO as the core records system and are evidently monitoring its usage through supervision.

RiO and Framework I

9.5 Local authority social workers in the CMHT are required to operate two different computer systems - RiO and Framework I. The two do not directly interface and the Framework I system is not accessible from community team sites. This problem is not unique to the trust, and social services staff have to enter information twice. This presents difficulties for this particular group in the community team workforce.

9.6 A significant amount of Ms T's history was in children's services records but local authority social workers in the CMHT could not access these records. Access is restricted for sound reasons but staff need access to child service records when it is important for mental health staff. For example, where a child is a member of the family of a service-user the recovery team is supporting.

9.7 The local authority senior manager thought that this problem had been resolved. He believed he had gained permission for mental health staff to have restricted access. By contrast, senior health managers and south recovery team practitioners told us there was still no access to the children's element of Framework I.

Comment

This confusion should be resolved at a senior level and guidance issued regarding when and how access to the children's element of Framework I can be made.

9.8 The LBHF, adult services told us in response to the draft report that:

"Access to Framework I is being arranged but is taking longer than anticipated. Although there are data protection issues about "blanket" access to the ICS data-base, access can be given on an individual basis as the need arises. It should never however be the default position or an alternative to the respective caseworkers having a proper discussion."

Recommendation

R3 The trust, in consultation with its local authority partners, should produce guidance on how NHS and local authority staff in the community mental health teams can have access to the children's element of Framework I whenever appropriate to their work.

10. Supervision

Staff supervision

10.1 The trust's supervision policy (dated February 2009) sets out clearly how management and clinical supervision should operate within the trust. In section 3 and 4 the policy sets out the purpose and frequency of management supervision, it states:

> *"It should be interactive and used as a means of ensuring that staff are able to do their job effectively and are assisted in their own personal development."*

> *"It is recommended that these sessions are held at least monthly. Supervision is an important way of picking up problems around performance at an early stage, so that hopefully they can be dealt with before they become too serious."*

10.2 The trust report says:

> *"The Senior Nurse Practitioner did not provide effective supervision for the Care Coordinator. This was during a period when the Care Coordinator was known to have performance related issues including latterly in relation to concerns that she was not maintaining adequate contact with her service users. The Senior Nurse Practitioner did not review case notes in supervision and did not use case notes to review care plans."*

10.3 In our interview with the senior practitioner he told us that he disagreed with this aspect of the trust report. He was critical of the process the trust followed in completing the report as he was not given his transcript to amend, and was not shown the trust draft panel report to comment on before it was completed.

10.4 The senior practitioner told us that he did review case notes in supervision and that he did review care plans. He told us that he would randomly pick cases to review in supervision. In respect of why he did not pick up with the care coordinator the lack of care plans for Ms T was because: *"Basically she [Ms T] was still under their [leaving care team] care at that time.*

Comment

It is clear to us that the understanding of the respective roles of professionals who were joint working with Ms T was unclear and was interpreted too rigidly to mean the leaving care team were the lead agency. We have dealt with this elsewhere in the report. This also emphasises the importance of the development of a joint protocol to cover transition from children's services to adult mental health services.

10.5 The supervision of the care coordinator directly involved in the care and treatment of Ms T was inadequate. It failed to identify that the care coordinator had not put in place a CPA care and risk plan that addressed Ms T's living arrangements, her complex relationship with her uncle or her allegations.

10.6 Supervision of medical staff occurred weekly and in the case of Ms T involved mostly the staff grade doctor. This included discussing the case with the responsible consultant. Management of the case fell to the care coordinator when the staff grade doctor left. The original trust investigation panel thought that this led to a loss of ownership and leadership.

Current supervision arrangements

10.7 The newly formed recovery team has one senior manager and two practice specialists responsible for supervising social work, nursing and allied healthcare professionals working as care coordinators. Social services staff follow a particular training route through the local authority. Performance management is incorporated into their appraisals.

10.8 The team manager and two practice specialists told us that the overall purpose of supervision was to examine the work of care coordinators and to identify any training needs. Understanding varied of the kind of supervision to be used. The team manager saw supervision as for management purposes, whereas the nursing practice specialist felt that the purpose was to examine clinical issues rather than business matters. This difference of views, however, did not appear to diminish the value the trust placed on both management and clinical supervision, a value clinicians recognised and appreciated.

10.9 Supervision under the current arrangements has a set format. It comprises an analysis of case notes presented on RiO to check that mandatory fields and assessments are up to date and clearly completed by the individual care coordinator. Staff mandatory training is covered in the supervision process and supervisors can access the trust computer training record (Exchange) for an individual member of staff.

10.10 In addition to the weekly team meeting, supervision gives an individual an opportunity to highlight any cases for concern.

10.11 As we have explained above, team structures have changed and the CMHT that Ms T was assigned to no longer exists. We interviewed members of the south recovery team who told us that all referrals now come through a trust-wide assessment team. All service-users referred to the recovery team will have been assessed by the assessment team. Better background information is now available than applied in the case of Ms T.

Comment

Staff in the recovery teams are now in a better position as a result of these changes to develop a care plan and an informed risk assessment.

10.12 The director of nursing told us that improved management processes provided regular reports on the provision of nursing supervision.

Use of RiO in Supervision

10.13 Trust staff use only RiO for patient records while social services staff in mental health teams use both RiO and the social services Framework I system.

10.14 Supervisors can now review core elements of the RiO record including risk assessments, care plans and care programme approach records with care coordinators. We learned that teams could also now review an individual service-user's case records once every three months.

10.15 Senior staff involved in the supervision process agreed that RiO had added an openness and accessibility to clinical records. Previously, and at the time of the Ms T incident, records were generally held by the care coordinator and not reviewed as a matter of course under supervision. RiO has allowed rapid access by those who need to read and scrutinise records. Supervising managers described the system as *"everybody's property"*.

10.16 RiO allows managers to review caseloads and case weighting when allocating new cases to care coordinators, ensuring as far as possible that cases are appropriately allocated to a worker with the skills and capacity to provide the right level of support to the individual service-user.

10.17 The introduction of RiO has removed from the supervision process the reliance on self-reporting by care coordinators. A senior manager in the trust told us that self-reporting was standard practice at the time of the homicide. The team manager can now set out the expectations of supervision sessions and ensure that the specific areas of the case record which form part of performance management requirements is reviewed. He or she can clearly understand individual caseloads through reviewing key performance criteria and practice standards.

Comment

Supervising care coordinators to ensure that they follow key performance targets is a significant part of the supervision process. It also provides an opportunity for clinical discussion. We are also confident that care coordinators have the opportunity to seek senior advice and guidance with their manager and consultants outside the established forum of team meetings.

11. Service reconfiguration

Team working

11.1 All referrals to the north and south recovery teams are channelled through a trust-wide assessment team. The recovery team comprises two consultant psychiatrists, one staff grade doctor (middle grade doctor employed in a permanent position) and junior doctors (those recently qualified and gaining experience in psychiatry). The junior medical staff have responsibilities both in the community team and on the inpatient wards. Consultants and staff grades are allocated either to inpatient or community services and are therefore more available to community team staff as they are located within the team base and work exclusively with community service users.

11.2 We met the manager of the south recovery team, two senior practitioners, and a group of staff working in a multidisciplinary context in the CMHT.

Comment

Both the recovery team and the assertive outreach team are based in the office and an ethos of working as part of a wider team was evident.

11.3 Members of the recovery and assertive outreach team said caseloads were well balanced and matched with the experience of the individual care coordinator.

11.4 In 2007 the allocation of work in the CMHT was dependent on individual staff coming forward to take on individual cases. We heard that a managed allocation process now sought to match cases, experience and skills to the needs of service-users.

11.5 From the recovery team perspective, the introduction of an assessment team best ensures that cases are handed over in a more structured way with the appropriate amount of history and risk information. Caseloads now appear to be balanced with newer staff generally having a caseload of between 16 and 18 service-users.

11.6 The feeling among staff in the assertive outreach and recovery teams was that referrals were now easier to organise because both teams were based in the same building with an established process for escalating cases of concern. An away day in 2011 enabled staff to plan integration of assertive outreach and recovery teams. Most staff thought this was a positive step enabling communication pathways to be examined and established.

11.7 Staff we interviewed considered team reconfigurations to have been generally positive. Individual and professional roles in the newly configured teams continued to evolve. Nursing staff and social workers usefully share practices but they told us that social workers would do more of the complex social circumstances assessments. The dual diagnosis worker in the team also had a more specific caseload instead of mostly generic work. A housing worker in the team has a generic caseload but is able to provide his specialist input to colleagues in terms of housing advice and support. The occupational therapist in the team said her responsibilities included group work as well as care coordination.

Team meetings

11.8 The team manager told us that any particular concerns relating to an individual case in 2007 would be discussed at the team meeting and followed through as required by the medical team and consultant. This was not a managed and consistent process. The team manager also told us that the allocation of cases to care coordinators in 2007 appeared to have been haphazard and dependent on team members volunteering to take on particular cases.

Comment

The approach to organising team meetings and referral meetings is more structured than it was. Holding a senior management allocation meeting separate from the general team meeting - along with the RiO records system - has made a big impact in allocation and supervision. In addition a specific 'cases of concern' element to the weekly team meeting provides a more soundly managed case review system.

11.9 One of the changes the trust has implemented has been reallocating the work of consultants and creating a dedicated community team consultant. This change, along with the changes to team meetings, supervision and management structures, allows for problems with a case not raised by a care coordinator to be picked up as part of the structured supervision sessions. Care coordinator caseloads appear to be below 30 service-users, with newly qualified staff having lower caseloads. Staff turnover in the recovery team is low, allowing closer scrutiny of the work of individual clinicians and more opportunity to discuss and highlight concerning cases at team meetings.

Medical staff involvement

11.10 We have already mentioned the change in the role of consultants in the team. The current system provides greater clinical leadership from the consultant to the team. Junior medical staff still operated across wards and community teams. The team told us that accessing medical input could sometimes be a problem but it was rare not to be able to find a doctor. The attendance of consultants at team meetings, along with a specific agenda item to discuss cases of concern, meant risks could be addressed before they became crises.

11.11 GPs are sent invitations to CPA meetings but GPs are rarely able to attend because of their work patterns. It was clear to us from meeting with the team that any specific physical health issues that arose could be passed to the relevant GP practice.

Comment

Encouraging care coordinators to maintain and develop specific professional skills and competencies will play an important part in team work.

All care coordinators will have shared generic responsibilities but it was obvious that individual professionals valued the specific and specialist elements of their work. It is encouraging to note that they were beginning to use these elements more under the new team structure.

Team members spoke about the reflective practice group established in the team but it seems to have fallen away as a result of scheduling and attendance difficulties. Some junior staff told us they would welcome the reintroduction of such a group.

Team training

11.12 We were told that by the south recovery team that risk assessment training for community staff was not mandatory. Following receipt of the draft report the trust told us that clinical risk training is mandatory.

11.13 The local authority told us in response to the draft report:

> *"… that all social workers undertake risk assessment and risk management training and that participation is monitored locally but not centrally by the trust and is not included in the Trust score card."*

11.14 Locum staff (some who had been in a locum position for many months) in the south recovery team told us that they had not been offered risk assessment training. Though we were told all staff have been trained to level three in safeguarding investigations. Staff we interviewed did not think that training would be refused if requested and relevant to the job role.

Comment

Whether risk assessment and risk management training for all community staff is part of the trust mandatory training requirements is unclear to us.

Recommendation

R4 The trust should review whether clinical risk training, with updates at regular intervals, is being delivered to all community staff whatever the professional or clinical background.

12. Recovery model

12.1 The trust had not formally adopted a recovery model of care at the time of the homicide as this approach was still in early development nationally. The trust has now adopted a recovery rather than pure treatment model of care and has configured its services around this approach. We have therefore considered the trust's implementation of the recovery model underpinning its service model.

12.2 In February 2011 the trust became one of six trusts engaged in an Implementing Recovery-Organisational Change (IMROC) project aiming to support people more effectively to lead meaningful and productive lives.

12.3 The ethos underpinning a recovery approach is that services provide a holistic view of mental illness that focuses on the person, not just on their treatment and medication.

12.4 The recovery approach contains the implicit belief that an individual can have a life worth living beyond any distressing experiences arising from their mental health problems.

12.5 The focus is on helping a person to identify their own expectations and attitudes and for services to work closely with them in order to maintain optimism and commitment during continuing care, which should be seen as a journey towards recovery.

12.6 There is a strong link between the recovery process and social inclusion. Supporting people to regain their place in their communities and to take part in mainstream activities and opportunities is a key role for services.

12.7 The objective in the trust core values statement is "*to build an engaged workforce which is focused on recovery and the needs of service users and carers*".

12.8 Our interviews identified that the recovery approach appeared to mean different things to different members of the multi-disciplinary team. All team members interviewed considered that promoting recovery rather than a continuing emphasis on treatment based on diagnosis was a positive way forward. There were, however, varied approaches employed by different teams. Two away days had been held involving the

recovery team and this team had developed their own specific recovery journal prior to the trust promoting its own recovery approach and model.

12.9 The trust has a personal recovery plan on its website that includes four elements:

- my feel good plan
- my plan for moving on after relapse
- my plan for managing highs and lows
- my plan for following my hopes and dreams.

It is unclear how the recovery plan the CMHT uses differs from this and how it adheres to the trust standard document.

12.10 One interviewee said social work traditionally operated a recovery approach and balanced the treatment model used by community psychiatrists and nurses. Staff felt that the reorganisation of community teams based on the recovery model provided the opportunity to deliver a "*different type of servic*e". The borough clinical director endorsed this approach and many interviewees told us he is a good champion in promoting the model.

12.11 More than one interviewee told us the trust was a long way from embedding the understanding of recovery in continuing clinical practice and that a more clearly managed process to embed this approach was needed.

Comment

The trust has provided a firm commitment to putting service-users at the heart of decisions relating to their care emphasising the recovery approach but some staff do not fully understand what this involves.

It will be important a year on from engaging with the IMROC project to ensure clarity and a structured way forward for all staff, in all disciplines and involving service-user stakeholders. We were told that a plan was in place to have individual service-users work with their care professional to construct their own care plans. This idea fits with the principles of the care programme approach. All disciplines from both

the trust and local authority should be fully engaged, trained and supported in pushing forward a clear trust approach with a single set of principles and available resources.

The move towards adopting a recovery approach shows that the trust is taking the right steps in providing holistic care.

Clinicians and practitioners in teams were not completely clear about the approach being taken or what recovery means to the trust, even though this information appeared on the website.

Recommendation

R5 The trust should review with social service colleagues how community teams implement the recovery approach and ensure concordance between the board level guidance and the approaches local teams are taking.

13. Partnership working

13.1 Managers and staff spoke positively about their work with partner agencies and this appeared to reflect the positive working relationship between senior health and social services managers.

13.2 Key managers in the trust described positive working relationships with both the police and the borough across its range of services. This was reflected in the approach of individual members of staff in multidisciplinary teams sharing management and practitioner responsibilities. One of the strengths of the local arrangements, for example with the police, housing and the anti-social behaviour team is that staff responsible for the borough service know each other and are aware of key issues.

13.3 The constraints on partner agencies are understood and working arrangements are mainly positive and supportive with help available when sought.

Comment

The partnership arrangements appear strong and well developed, particularly with adult social care.

Changes in neighbourhood policing will give officers greater areas to cover. The trust should be aware that this change could destabilise a key partner agency.

Our discussions with police officers and members of the trust and social services suggest this is a widely understood danger and steps are being taken by trust staff and the police to try to maintain and develop positive working relationships.

The changes in key personnel in Hammersmith and Fulham social services may also affect this positive working relationship.

14. Post incident investigations

Trust investigation

14.1 The trust completed a management 24-hour report then convened a serious incident (SI) review panel chaired by a non-executive director. The report is dated 14 April. No year is given, nor information about when the panel was set up. Other documentation shows the SHA review group considered the report on 22 October 2008. The SI investigation was jointly commissioned by the trust and LBHF services.

14.2 Terms of reference for the panel investigation included:

- to review the history and chronology of Ms T within both the trust and children's services
- to review the risk assessment and management of Ms T within both the trust and children's services
- to review the events of 15 June and the appropriateness of staff action in light of the agreed care plan and risk assessment
- to make recommendations which might reduce the likelihood of recurrence
- to identify a member of the panel to keep Ms T's mother informed of progress
- to report to the safeguarding children's board, the safeguarding adults board and the trust board.

14.3 An action plan was developed following the completion of the investigation with four headline actions.

- To develop a health and social care transition protocol.
- To review risk assessment and management training with Area 2 CMHT to have completed training by Autumn 2007 and other teams to have completed by December 2008.
- For a review to be completed of the Area 2 CMHT supervision and care plan monitoring practice and to roll out lessons learned across the service. This to include an examination of the need for a management investigation of the service manager and an investigation into the caseload of the care coordinator directly involved with Ms T.
- To agree a mental health services performance management policy.

14.4 We reviewed the internal trust report and found it to be a largely robust examination of the care and treatment provided to Ms T. The Metropolitan Police service contributed to the report. Most areas in the action plan appear to have been addressed either as a direct response to the internal investigation or as part of trust service developments since 2007. We commented above on the work still needed to develop a transition policy from local authority children's services or children and adolescent mental health services to adult mental health services.

14.5 The report also lacks significant detail in relation to the actual incident and the outcome for Ms T and the other family members involved.

14.6 One of the panel members of the trust investigation had been involved in assessing Ms T for psychology involvement. We do not believe that his involvement on the panel inappropriately influenced its work.

Comment

It is important that professionals who have been involved with the service-user should not be part of a panel investigating a serious incident as this has the potential to reduce the objectivity of the panel. This is now part of trust guidance.

Single agency review

14.7 Hammersmith and Fulham Children's Services conducted a single-agency review of the care of Ms T and her brother. Our terms of reference did not include examining the actions of the children's service before Ms T's referral to trust services. We have therefore used the single agency review to help provide us with contextual information and to develop our chronology. The single agency review report sets out its purpose:

> *"Look critically at the organisational and individual social work practice in relation to both* [Ms T] *and* [Mr V]. *In particular,*

1) *The department's response to* [Ms T] *on those occasions when in the past she alleged abuse by her uncle, and the adequacy of the subsequent safeguarding arrangements.*
2) *The social work response to* [Ms T] *over the weekend of the 15-17 June, immediately prior to the death.*
3) *The transfer process and joint working arrangements between the Leaving Care Service and West London Mental Trust in relation to* [Ms T]*'s care.*

- *To identify the "lessons learned" and whether changes in practice could and should be made.*
- *To identify how any such changes may be introduced.*
- *To propose any other action required"*

14.8 The review was documentary and did not include interviews. The report said it benefited from the SI investigation the trust undertook in conjunction with LBHF.

14.9 The report made four recommendations in the form of summary comment and encouragement to good practice. Consequently, it is difficult to extract the actual recommendations and even more difficult to track their implementation.

Police individual management review

14.10 The trust report said the police would undertake their own review of police actions in this case. Neither the trust nor the local authority has seen the police report.

14.11 We interviewed the police officer who led the murder inquiry and corresponded with the officer who conducted the police review. He told us the police initially thought that a serious case review (SCR) was to be conducted into Ms T's care and as a result they conducted an IMR as per the SCR guidance. The reviewing officer told us in an email:

> *"The Trial Judge was critical of actions of both Police and Social Care leading up to the murder and it was made aware to him that a Joint Agency, Serious Case Review (SCR) would be initiated and that the Specialist Crime Review Group (SCRG) would facilitate this."*

14.12 Subsequently the LBHF decided that this case did not meet the criteria for a serious case review. The police did not share their IMR with other agencies.

14.13 The police have provided us with a summary of their IMR. It says "*the review was extensive and took into account CP [child protection] and Domestic Violence issues within the family*".

14.14 The report is clear that operating procedures were not always followed effectively and that police staff and officers could have taken more assertive action to protect Ms T even when she had withdrawn allegations.

14.15 The report contains seven recommendations that focus on improving operational procedures, supervision and training and partnership working with other agencies.

14.16 We were told that the recommendations had been passed to operational commanders in the relevant areas.

Comment

We understand that this case may not have strictly complied with the criteria for a SCR but it could have used a SCR approach, jointly commissioned by the LBHF adult and children's services, the Metropolitan Police service and the trust.

A SCR approach would have allowed each party to complete an IMR and an overview report to be written. This would have ensured consistency in approach by each agency and provided a more focused approach to recommendations and perhaps more effective tracking of the implementation of the recommendations.

14.17 One aspect of the police review of particular importance is what happened when Ms T reported the first stabbing at Hammersmith police station. The summary provided to us says:

> *"On 15 June 2007, Police reopened the original rape allegation, as* [Ms T] *had attended Hammersmith Police Station to report it with her mother and a Social Worker, again accusing her uncle of raping her. She told a Station Officer that she had just stabbed her uncle because he had raped her in 2001.There was some confusion with the handover to the Sapphire Unit at another station who deal with Rape and Sexual offences. It would appear that the stabbing was not verified at that stage to the SOIT* [sexual offences investigative technique] *Police Officer and the Social Worker did not tell the officer."*

14.18 After the initial report of the stabbing and of the historical rape Ms T was sent to Fulham police station to be interviewed by the Sapphire Unit. The focus of that interview was the historical rape allegation and not Ms T's confession that she had stabbed her uncle, which was not investigated by police at either station.

14.19 This failure to investigate the confession that Ms T had stabbed her uncle is acknowledged in the police IMR as a failure to follow procedures.

Finding

F10 The police failure to investigate the stabbing of Mr U on 15 June 2007, like the non-attendance of mental health staff at the police interviews was a serious missed opportunity to assess Ms T's risk of further violence.

15. Management of serious incidents

Care Quality Commission

15.1 The Care Quality Commission (CQC) in an assessment in 2008 raised concerns about investigating and reporting incidents in the trust, the time it took to investigate and report on incidents and the dissemination of any learning and action points resulting from a final report[1]. The CQC reviewed 37 reports of which 22 showed no final review date and 15 indicated an average nine months from incident to report completion.

15.2 The director of nursing who joined the trust after the CQC assessment said far more robust processes were now in place for managing serious incidents and incidents. A new incident reporting (i8) policy was in operation and the director of nursing felt that all staff in the various parts of the organisation were clear about how and what to report. The trust is now a leader in reporting incidents and according to the director of nursing has a culture of promoting positive risk-taking, as part of the developing the trust recovery approach.

15.3 A review of processes based on CQC recommendations in 2010 led to a trust review of the management of risk. As a consequence the trust introduced a clinical risk facilitator post to help the trust chair coordinate the investigation process and ensure that key actions and deadlines were met[2].

Comment

The trust has made significant improvements in its serious incident reporting and investigation process, acting on CQC recommendations.

It is important for the trust to build on developments and ensure that all lessons learned and action plans from incidents are not only reviewed at senior management level but also discussed in all relevant clinical teams.

[1] CQC Investigation into West London Mental Health NHS Trust. pp 14-24.

[2] CQC Report of the findings from the follow up visit by the CQC in March 2010. Published July 2010

15.4 The CQC criticised the trust for taking too long to tell staff about lessons learned. It also found that the commissioners appeared to have no way of holding the trust to account for actions and gaining assurance that agreed actions had been embedded, signed off and closed. Commissioners now sit on the local incident monitoring group to oversee the actions from report recommendations.

Comment

The trust encompasses a wide range of services from adult psychiatry to forensic services at Broadmoor Hospital and it appears from a review of the new i8 policy that reporting is clear and that the trust expects incidents to be identified, reported and timescales for investigations adhered to.

It will continue to be important for the trust to ensure that action plans are reviewed by their commissioners and that they help the trust provide an external monitor and target specific issues wherever possible.

15.5 The trust followed through on the actions from the Ms T investigation but, as we say earlier, the dissemination of relevant information is still not robust.

Comment

Ensuring that lessons learned and relevant actions are clearly communicated to front-line operational teams is an integral part of the trust's governance structure. The proposed introduction of a trust community services serious incident review meeting should lead to important lessons from serious incidents being passed down to team level. In the case of Ms T many staff members knew about the incident but only those directly involved appear to have been told of any recommendations arising from the incident review. Any issues emerging from a trust investigation that have an impact on the work of a clinical team should be effectively fed back to them.

Appendix A

List of interviewees

A - consultant psychiatrist
B – consultant psychiatrist
C – investigating officer (detective inspector), Hammersmith and Fulham Police
D - assistant director of community services and managed adult social care
E – executive assistant to director of community services and managed adult social care
F - detective inspector, Hammersmith and Fulham Police Community Safety Unit
G – head of partnerships
H - community mental health team manager
I - psychologist
J – consultant psychiatrist
K - responsible consultant psychiatrist
L – senior nurse practitioner
M – community services manager, Hammersmith and Fulham Police Community Safety Unit
N - care coordinator, community psychiatric nurse
O – director of nursing and patients' experience
P - care coordinator, senior social work practitioner (not involved in Ms T's care)

Appendix B

Individual management reviews

An individual management review is carried out as part of a serious case review (SCR). A SCR is set up when a child who is being supported by statutory or voluntary agencies dies or is seriously harmed. The purpose of a SCR is to establish what lessons can be learned about the way local professionals and organisations work together to safeguard and promote the welfare of children.

As part of a SCR each agency will complete an individual management review (IMR). The aim of IMRs is to look at the context within which people were working to see whether improvements could and should be made and, if so, how those changes are made.

Appendix C

Quality assuring safeguarding practice, London Borough of Hammersmith and Fulham

1. Quality assuring safeguarding practice

1.1 Safeguarding practice is quality assured through an audit programme. The purpose of the audit is to ensure that all safeguarding work is at an adequate or above level of performance. The audit outcomes inform the actions taken to improve safeguarding practice including the commissioning of learning and development opportunities and, where appropriate, performance management.

1.2 Audits are quarterly, with three audits of 25 cases and one of 50 cases per year. The number of cases audited per social work team is proportionate to the number of new safeguarding alerts per social work team received in the quarter being audited.

1.3 An audit tool is used to standardise the review of practice.

1.4 Where the outcome of the audit is less than adequate, a proportionate response is required from the relevant manager. The audit protocol sets out the relevant requirements for the response.

1.5 An audit report is written within one working week of the audit and consists of an overview of safeguarding practice for general dissemination and a review of safeguarding practice per service area and per worker, not for general dissemination. The audit report is presented to the divisional management team.

Appendix D

Document list

Clinical records

- CMHT Area 2 notes
- WLMHT RiO notes

Policies and guidance

- Policy C2 – Care programme approach, October 2010
- Policy C16 - Clinical supervision for nurses, February 2011
- Policy C18 - Safeguarding children, February 2011
- Policy C30 - Capability policy, March 2011
- Policy D4 - Disciplinary policy, March 2011
- Policy ICP26 - Risk assessment policy for admission, transfer or discharge, November 2009
- Policy O1 - Enhanced engagement and observation policy, February 2011
- Policy R1 - Risk management strategy & policy, August 2004 & November 2007
- Policy S26 - Supervision policy, February 2009
- Policy S28 - Safeguarding adults policy and reporting procedure, October 2009 & July 2010
- Procedure S21 - Procedure for pursuance of sanctions following alleged criminal activity, February 2011
- Assessment team operational policy, January 2011
- Mental Health and Children's Services Joint Protocol
- CAMHS – Adult MH transition protocol
- IAPT risk assessment and management protocol
- IAPT & CMHT referral criteria

Reports

- 24 hour - serious untoward incident report
- 72 hour- untoward incident report
- Level 2 Incident Review, report into the death of Ms X
- Hammersmith and Fulham Children's Services - Single Agency Review of the case of Ms T and Mr V
- WLMHT serious untoward incident review
- Action plan from the serious untoward incident review, updated 2008 & 2009

Additional documents

- Police liaison meeting minutes – January, May and September 2011
- Minuets of multi-agency meeting to discuss Ms T SI, 22 June 2007
- Clinical risk training records
- Summary of clinical documentation audit, January – March 2009
- CQC investigation report, published July 2010
- Staff statements from social worker, CPN and senior practitioner
- General correspondence between agencies

Appendix E

Team biographies

Antony Adkin

Antony is an assistant director, patient safety and nursing for Barnet, Enfield and Haringey Mental Health NHS Trust. This role covers complaints, serious incidents and coroner's inquiries.

Antony is a qualified RGN and RMN. He has worked in adult mental health managing inpatient and community services. He has also taught Msc mental health studies and currently teaches root cause analysis and investigation methodology.

Antony has completed and coordinated a large number of serious incident investigations, and has conducted nursing note reviews for trusts outside London. He has also contributed to board level and external inquiries from a nursing practice perspective.

Nick Georgiou

Nick is an independent consultant, non-executive director of an NHS public health agency, and is a trustee of Oxfordshire Mind.

Nick has extensive social services director level management experience. He has managed an NHS London mental health service and has been a PCT non-executive director.

Nick has been involved in a number of mental health homicide inquiries. He is the independent chair of an adult safeguarding board and has carried out domestic homicide and serious case reviews as an independent chair.

Tariq Hussain

Tariq is a senior consultant at Verita. He is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.