An independent investigation into the care and treatment of MB

A report for NHS London

January 2010

NHS London

Contents

1. Introduction

1.1 MB was an inpatient in the care of East London and the City Mental Health NHS Trust when he was arrested for the homicide of JC. MB left the Conolly ward of Homerton Hospital on the afternoon of 7 July 2006 and pushed JC in front of a train at Highbury and Islington underground station. This was his fourth admission which had started on the 1 June 2006. He first came into contact with mental health services in May 2005.

1.2 On 15 December 2006 MB pleaded guilty to manslaughter on the grounds of diminished responsibility. After an assessment at Broadmoor Hospital, he was sentenced to life imprisonment with a recommendation that he serve at least four-and-a-half years. He had just passed his 20th birthday at the time of his arrest.

1.3 NHS London, with the full cooperation of the City & Hackney Teaching Primary Care Trust (the PCT) and the East London NHS Foundation Trust (the trust), commissioned this independent investigation as part of their responsibilities for performance-managing the NHS locally. The investigation was commissioned in accordance with guidance published by the Department of Health in circular HSG (94) 27, *the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36 issued in June 2005.

1.4 Immediately after the incident the chief executive of the East London and City Mental Health Trust (the trust responsible for MB's care at the time of the incident) commissioned an internal investigation, chaired by the associate medical director of the trust. The other members of the panel were the director of nursing & operations Central and North West London Mental Health NHS Trust and the associate director for assurance of the trust. The trust board received the report of the investigation on 5 October 2006 and agreed an action plan.

1.5 This investigation began in March 2008 shortly after we obtained copies of MB's records and other relevant documentation. We held 18 individual interviews and met with seven others in two groups. The terms of reference are set out below. This investigation was commissioned to build on and not replicate the internal

investigation. Consequently, we invited to give evidence only those we thought could help us to examine areas of practice which needed further exploration. These were:

- compliance with the care programme approach
- risk management
- transitions between services
- diagnosis and medical management
- the specific impact of the child protection investigation
- issues related to MB's needs as a young person
- sensitivity to his family cultural background
- post-incident support and action.

1.6 Everyone we invited to interview agreed to do so and spoke to us freely and openly. We were unable to trace some of the medical staff but we had copies of the internal investigation interview notes so our inability to talk to them did not have a material impact on our investigation. We interviewed all those we believe were key to helping us to fulfil the terms of reference.

1.7 The trust supplied us with all relevant documentation and we were also granted access to relevant records from the local authority children and young people's department. We are grateful for all the help we received from the trust, the local authority and all our witnesses.

1.8 We met MB's parents, to help ensure that the investigation was informed as far as possible by a thorough understanding of the incident from the perspective of those directly affected. They gave valuable insights that were not available to the trust's internal investigation. We also met, towards the end of the investigation, the brother of JC. This provided us with the opportunity to hear about any concerns from his family.

1.9 We followed established good practice in the conduct of interviews, for example, offering the opportunity for interviewees to be accompanied and to be able to comment on the factual accuracy of notes taken of their interviews. All interviews were conducted in private.

1.10 Following factual accuracy checking and comment by interviewees and amendments made following legal review the report was submitted to the commissioners (NHS London) in January 2009.

2. Terms of reference

We set out below the terms of reference as agreed with NHS London.

The aim of the independent investigation is to evaluate the care and treatment of MB and to identify any contributory factors to the homicide of JC and to learn appropriate lessons. It will also review the trust's internal investigation report and the progress that the trust have made in implementing the action plan arising from it. Where appropriate recommendations based on best practice in mental health care will be made.

Specifically, the independent investigation will:

1. Compile an accurate chronology of events from MB's first point of contact with psychiatric services up to and including the immediate events following the homicide.

2. Investigate and comment on the mental health care and treatment offered and provided to MB.

3. Assess the adequacy both with which MB's risk was assessed and actions consequent upon the assessment(s).

4. Review the extent to which agencies adhered to statutory obligations, relevant national guidance and local operational policies.

5. Review the actions taken by the trust in response to the death of JC and comment on the way in which the trust managed this incident, including the quality of any contact that the trust has had with the families.

6. Review the trust's internal investigation and assess the adequacy of its findings and recommendations and the progress made in their implementation.

7. Establish and make reference to any other relevant investigations relating to MB and his family which are being or have been undertaken by organisations outside of the trust.

8. Assess in relation to this case and within the context of the local psychiatric morbidity, the provision, organisation and management of inpatient and community mental health care in the trust. This will include making particular reference to medical and nursing staffing arrangements, the management of patient risk and compliance with the requirements of the care programme approach.

9. Make clear, sustainable and targeted recommendations based on the contributory factors or root causes of the events leading to the homicide and aimed at ensuring that any lessons are learned, acted upon and shared.

10. Provide a written report including recommendations to NHS London.

The investigation team conducted its work in private.

3. Executive summary and recommendations

Executive summary

Contact with mental health services

3.1 MB's first contact with mental health services was on 1 June 2005 when he was admitted to Conolly ward in the East London and City mental health centre, part of Homerton Hospital, having been taken initially to the North Middlesex Hospital. He appears to have suffered a psychotic episode. He was admitted under section 4 of the Mental Health Act 1983, for a day and then became a voluntary inpatient until October 2005 when he went to Turkey. MB had three further hospital inpatient admissions after his return. During each of his admissions he made many threats of self-harm and harm to others but there is no record of his acting upon any of them.

3.2 MB also received care from a number of the trust's community teams. He was visited by the trust home treatment team (HTT) mostly on a twice-daily basis for a month between January 2006 and February 2006 and was then transferred to the care of the trust south east locality team (SELT) before he was admitted briefly to Conolly ward at the end of February 2006. He was also admitted briefly again to Conolly ward at the end of March 2006.

3.3 His final hospital admission began on 1 June 2006 and he remained a voluntary inpatient until his arrest on 8 July 2006. During this admission he was at various times allowed to leave the ward. His medication was increased as he made more threats to others. On 6 July 2006 he was granted two to three hours' unescorted leave. He left the ward on the morning of 7 July 2006. He returned for lunch and an 'activities for daily living' assessment. He went out again in the afternoon. During this time he pushed JC onto the tracks at Highbury and Islington underground station and then returned to the ward. He was arrested early on 8 July 2006.

Predicting risk

3.4 Everyone we interviewed said that they had been surprised and shocked by MB's actions, even though he had threatened to harm others or himself on numerous occasions over the previous 13 months. None of the medical or community- based staff believed that he would carry out these threats.

3.5 This could lead us to the conclusion that what happened was unpredictable and therefore unpreventable. It was certainly not predicted but that is not the same as saying it could not have been. Our investigation suggests there were a number of factors which contributed to the inability of those involved to identify MB as a real risk. It's impossible to say whether identifying him in this way would have prevented what took place, but it might have. And it might have meant better-focused care for MB. One of the central features of this case seems to us to have been the absence of any real understanding of or engagement with MB as an individual and it was this that led to the surprise that everyone felt when they heard what he had done. This report is mainly structured around those factors we believe contributed to the failure to identify him as a risk.

Context of care

3.6 The internal trust report highlights the overall context in which Conolly ward and the other assorted services were operating at the time. We have been told but have not verified that Hackney has one of the highest rates of mental illness in the country and staff had to deal with extremely high levels of risk. We accept that an inner city mental health service operating in a deprived London borough deals with complex and demanding mental health issues. The context of care is important as we can see that this could lead to two things: the first is that staff simply did not have (or did not think they had) the time to understand individual patients. The second is that their tolerance of risk may simply have been too high. This is understandable but it is not acceptable. Otherwise, the implication is that patients from areas with high levels of mental stress will simply have to put up with poorer standards of care.

Medical care

3.7 We include a detailed narrative of the medical care given to MB as it seemed to the investigation that one of the core issues was the problem that the medical team had in diagnosing MB and in maintaining consistent treatment. Contrary to the principles in the care programme approach, the approach to MB's treatment was predominately based on a narrow medical view of care.

3.8 MB's care was compromised by the apparent general lack of communication between medical staff, despite a complex structure of management and ward rounds. The joint consultant model operated by the ward at the time only added confusion.

3.9 There was a lack of clarity about consultant responsibility, especially in relation to care provided in the community and decisions were taken without consultation with the relevant consultant or in contradiction to their views.

3.10 MB was difficult to diagnose. From the start of his contact with mental health services he was diagnosed as having a schizophrenic type illness. As time went on and he appeared unresponsive to the medication clinical staff's views began to change. By the time MB killed JC, a consultant psychiatrist (A) was of the view that he had a personality disorder with anti social traits, while the underlying basis of his medical treatment was that of schizophrenia.

3.11 There was an assumption that any psychosis may have been drug induced. Despite MB's own assertions that he regularly smoked cannabis and that this badly affected his mental state, there was only one positive drug screen for illicit drugs recorded for the entire time he was known to mental health services.

3.12 It is clear that MB was a difficult patient to diagnose which created problems in formulating a treatment plan. We are not critical of the fact that no conclusive diagnosis was made while MB was a patient of the Homerton Hospital. In fact, a number of possible diagnoses were considered, including a tentative diagnosis in February 2006 of hebephrenic schizophrenia (the current diagnosis). We do criticise the fact that this diagnosis (like others) played little part in his subsequent treatment

and was ignored or overlooked in further considerations of his medical care. This shows clearly that however comprehensive assessments are and however accurate the consequential diagnosis, without effective communication and care planning arrangements they are of little value.

Care planning

3.13 One of the central factors in this case was the almost total absence of care or discharge planning that conformed to the principles and procedures of the care programme approach (CPA). We have concluded that the review process in place was in effect a modified version of consultant ward rounds purporting to be CPA reviews. In relation to MB, the lack of effective CPA care or discharge planning was identified as a key issue in the internal report. We think this is one of the main contributory factors to the failure to understand what was wrong with MB and to treat him effectively. It led to views being taken about him which were based on immediate observation rather than on any longitudinal study. As the internal reports says there was *"…an over reliance on passive observation as opposed to active inquiry as regards MB's mental state and risk management"*.

Risk assessment and management

3.14 Risk assessment and management (an integral component of CPA) was another area lacking in MB's case. Forms were either missing or incomplete. We accept that passive form-filling does not necessarily equate with active risk assessment but there is little if any evidence that this took place – so it was not a mere failure to complete documentation. There was occasional noting of risk but never any real assessment or management of it. Indeed, there is some evidence that the consultants did not view risk assessment as a useful activity.

3.15 This is again covered by the internal report and there were a number of occasions where the absence of risk assessment and of care planning meant that crucial events in MB's life were missed or badly handled. The intervention of the London Borough of Hackney's children and young peoples' department which led to MB being effectively made homeless was characterised by a complete absence of planning

or risk assessment in relation to him. Similarly the absence of proper care management and risk assessment meant that deterioration in his mental state in the middle of June 2006 was not appropriately assessed and managed.

3.16 The trust has assured us that risk assessment and risk management have improved – as has care planning. In taking this forward they have seen a close correlation between the quality of engagement with individual service-users and the quality of the risk assessments and care planning. Good risk assessments take place where staff are engaged and enthused about an individual and their care. This reinforces our view that the absence of effective care planning and risk assessment in MB's case arose in part from a lack of engagement with him.

Care transitions

3.17 MB went through a number of what we have called transitions during his contact with mental health services. We identified the four key ones as:

- his discharge and subsequent move to Turkey in October 2005
- the transfer of his care from the home treatment team to the south east locality team in February 2006
- his subsequent discharge from hospital in the same month
- his discharge into the community in April 2006.

3.18 These all show a failure of planning with far too much reliance being placed on MB to manage his own care. Some of these transitions were effected by MB himself (e.g. his visit to Turkey) but others were not (e.g. the transfer from the HTT to SELT). But all were characterised by their abruptness and a failure either to manage his expectations or to understand what the impact on him might be.

3.19 There are evident links to the general failure of care planning and risk assessment which meant that changes not only happened abruptly but also without much forethought. The reasons for the transitions are unclear. They seem unrelated to any real assessment of MB and where his care was going and on at least one occasion (the transfer from the HTT to the SELT) seem to have arisen because of an

organisational view that care by the HTT could only last for a month, regardless of the patient's needs. In the context of the high demand and high risk in which the teams were working it was not always clear to us that decisions about transferring a patient from one service to another were made with the patient's interests in the forefront. The absence of effective documentation setting out the rationale behind decisions meant that we were not always able to understand why some of these decisions were made and then carried out in the way they were.

Referral to the child protection service

3.20 The details within the section dealing with the referral to the child protection service have been abridged to ensure confidentiality of children involved. We include in that section enough information to understand the implications of this aspect of the investigation. The full text of the section is included in a confidential annexe and will not be published. It will be made available on a strictly limited basis to managers and professionals in the trust to ensure that they have the context for our conclusions and recommendations.

3.21 We have included a section on this because it had a devastating impact on MB. It highlights dramatically the flaws in decision-making and the absence of focus on MB and his needs. This issue is not specifically considered in the internal report although the impact of it is. The decision-making which led to the referral to the child protection services is unclear. The decision to refer was entirely unrelated to any medical assessment of MB and unrelated to the consultant's assessment of his risk at that time.

3.22 No thought was given to the impact on MB by any of the services responsible for his care. The consultants with responsibility were not even told. Hospital and community staff did not seem to be alert to the appropriate way to deal with child protection issues, including their identification.

3.23 The referral is evidence of the flawed decision-making which dogged MB. It was unplanned; it showed little understanding or concern about him; it was not based on any understanding of the risks he might have posed and even his care coordinator did not really believe his claims.

3.24 This report is concerned with issues arising for the trust in respect of MB's care and so the investigation has not looked in any detail at the practice of the children and young people's department or the police. As this was not formally part of our investigation, we have not interviewed either of these two agencies about this and our thoughts are based on the documentary evidence we have seen and the interviews we conducted.

Conolly ward occupancy rates

3.25 Ward staff told us that bed occupancy on Conolly ward could reach 140-175%. In other words, there were 20 beds, but 35 or so patients being cared for by the ward staff in various ways. This arose because of the high percentage of patients allowed leave from the ward. There are legitimate reasons why a patient might be on leave, especially as part of a managed transition to the community.

3.26 MB was a patient on Conolly ward from 1 June 2005 to 27 October 2005 and he spent most of that time on leave, without any support in the community. He returned to the ward regularly for his medication but medical staff had little idea of what he was doing or how he was coping while he was away from the hospital. No conditions were placed on his leave and the periods of leave were not part of a plan to return him to the community on a more stable basis.

3.27 The general impact of what seems to have been a ward policy on leave (rather than a response to over-demand) was to introduce an unnecessary level of pressure into what was already an area of high demand and high risk. This approach led to a failure to use the resources of the various community teams effectively and to make thought-through decisions about leave and discharge. The ward was staffed for the number of beds and not for the number of patients but any one of the up to 15 patients on leave could return at any time and require attention or a bed. This added

a level of stress to the ward environment that cannot have been helpful to either the patients or the staff. The trust did not believe that this was a helpful practice and told us it was no longer operating in this way. Ward staff told us that the practice continues.

Age and culturally specific care

3.28 MB was a week past his 20th birthday when he killed JC. He was only 18 years old when he first became a patient of Conolly ward. Conolly ward is a mixed adult ward which means that it caters for patients of both sexes from the age of 18 to 65. It is self evident that the needs of an 18-year-old are unlikely to be the same as those of a 50-year-old and yet there is no evidence that MB's age was ever explicitly taken into account in considering his treatment. (It may however have been taken into account implicitly – but unhelpfully – in seeing his threats of harm as male teenage 'mouthiness').

3.29 There were – and are - no age-specific services for young adults who are therefore expected to manage their illness and their lives as if they were fully mature. MB resisted the hospital's push for him to live independently. This was seen as MB becoming dependent on the ward. And yet it may simply have been that he was still young and insecure enough to want to live with his family.

3.30 The wider issue in relation to MB is that there is no reference in the files to his particular cultural needs and circumstances. His family is Kurdish. His parents (especially his mother) speak little English and there would have been expectations of the role he would have to fill as the older son which were noted but did not seem to be understood. His parents were consulted about his care by the ward in 2005 and by the home treatment team in January 2006, but there is little evidence that they were subsequently involved. This lack of reference to his cultural background means we do not know what part if any this played in the way he was treated. Did it for example explain why the medical staff agreed that he could go to Turkey in October 2005? Was his reluctance to live independently and desire to remain with his family part of his cultural background, as a young unmarried man of his age would not normally leave

home to live independently? We don't know the answers to these questions but it did not seem to occur to anyone involved in his care to ask them.

Post-incident support and learning

3.31 The final area we considered was in relation to the post-incident support and the learning that flowed from it. A meeting took place on the Monday morning after his arrest (which had happened on the Friday/Saturday night). Senior trust staff thought it was handled appropriately and sensitively. They said that some staff had been quite hostile and wanted to focus on their on their own needs and emphasised the particular difficulties they faced in Hackney of high rates of mental illness and risk. The senior trust staff wanted to counter that and get them to focus on MB's care. They denied that the doctors had been blamed in the meeting.

3.32 Some of the staff we interviewed told us the meeting was negative and that they were left with the impression that judgements about their practice had already been made even before an internal investigation had been conducted. The fact that two Connolly ward consultants went on leave immediately contributed to the feeling that staff were being blamed for something which – rightly or wrongly – they felt was not fair.

3.33 The absence of the two ward consultants created problems for the immediate management of the ward. Consultant cover was provided from other wards but the newly arrived registrar and the pre-registration house officer were mostly left to manage the ward with some consultant advice available but no consultant-led ward rounds until the two consultants returned.

3.34 We asked whether any reflective practice had taken place for the ward staff and the various teams who provided services. Regrettably this didn't happen. Following a serious untoward incident such opportunities can help individuals take personal responsibility for learning rather than it being imposed (for example by being sent on a course).

3.35 The trust developed a detailed action plan as a result of the internal investigation and it has already led to many improvements but some staff we interviewed knew little or nothing about it.

3.36 We were told by ward staff that the patients of the ward were informed about what happened to MB. We do not think this was part of a systematic way of letting patients and staff know about events, especially those staff who were away.

3.37 MB's parents told us that no one from the trust spoke to them about what had happened. There is evidence to suggest they were in fact invited to a meeting but it is not clear that anything more than this was done. This is unfortunate as families of perpetrators are also victims.

Recommendations

Medical care and management

R1 The current model of working between the consultants and specialist registrars should be further examined by the trust to ensure that there is an explicit, single line of consultant responsibility throughout a patient's inpatient stay and that responsibility is retained as an outpatient, with the SELT team and at subsequent admissions.

R2 Consultant psychiatrist B's specialist registrar should not make decisions on behalf of consultant psychiatrist A.

R3 Where one consultant takes over the care of a patient from another, such a handover must be documented in the medical records.

R4 Consultants can still provide second opinions but these should be identified clearly as such in the notes.

R5 Trainee doctors working in psychiatry in the trust should receive formal training in the role of CPA and risk assessment.

R6 If consultant psychiatrist A is not approved as a trainer for junior doctors, he should receive alternative ward-based medical support to help him manage his allocated inpatients.

Ward rounds

R7 Consideration should be given by the trust to having a non-medical individual with the requisite seniority, such as ward manager or senior occupational therapist chair the Monday management meeting, CPA reviews or ward rounds.

R8 The role and purpose of the Monday management round and Friday *"putting to bed"* round should be evaluated and clarified by the trust.

R9 Clinical decisions should not be made in the Monday management round.

R10 Each consultant should review only their own patients during their ward rounds (unless covering the leave of another consultant).

R11 Both consultant psychiatrist A and B should examine how the added value of one-to-one assessments would improve their clinical decision-making, the rationale for when such assessments would be appropriate in individual cases and how undertaking such assessments could be incorporated into their work schedule.

Record keeping

R12 Consultants should supervise what is recorded in the notes.

R13 Trainee doctors should receive structured training on how to record discussions in ward rounds in particular and what to write in the notes in general.

R14 An explicit management plan should be recorded in the notes at each ward round, including treatment and non-medical interventions proposed and risk management.

Discharge summary and risk

R15 The discharge summary should refer to and be accompanied by the risk assessment and management tools when sent to the GP, or include specific sections addressing the risk assessment and management for that individual.

R16 Doctors who have not been involved with a patient's care should not prepare that patient's discharge summaries.

Drug testing

R17 Drug screening must be systematically and routinely carried out on any patient suspected of using illicit drugs.

R18 The implications of a negative drug screen when a positive screen was expected should be noted.

Community teams

R19 The liaison between Conolly ward and the community teams must be examined and improved, with clear records of attendance of community team members at ward-based meetings, CPA reviews and ward rounds and their involvement in and contribution to such meetings being kept.

R20 Clinical and management decisions made by the SELT should be contributed to and endorsed by the relevant consultant.

R21 The trust should clarify the role of the home treatment team.

R22 The trust should ensure that the home treatment team is adequately resourced and able to operate to reduce or abolish over-occupancy, to provide a safer and more appropriate alternative to the use of unescorted leave and to provide a gate-keeping service for admissions to inpatient facilities.

R23 The relationship and communication between the home treatment team and inpatient service must be made more explicit so as to allow the home treatment team to undertake its roles as a psychiatric emergency community assessment and treatment service, an alternative to hospital admission and facilitator of early discharge.

Care programme approach

R24 The trust should review its CPA guidance in light of the new Department of Health guidance on CPA[1], the findings of the internal investigation report and this investigation. It should pay particular attention to ensuring care planning and risk assessments are at the heart of all CPA reviews and ward rounds.

R25 The trust should ensure a broad view of a patient's past history forms part of any risk assessment and that there should not be undue reliance on whether the person has been violent or has self-harmed as a predictor of risk.

R26 The trust should not rely solely on issuing new policies but provide opportunities for all senior clinicians and managers to understand fully and commit to the principles underpinning CPA. The objective of the training should be to avoid a superficial adherence to CPA procedures without a corresponding commitment to its principles.

R27 The trust should ensure that all staff comply with its policies on CPA, risk assessment and risk management regardless of their own personal views.

Transitions

R28 The trust should ensure that CPA policies and procedures stress the importance of planning for and managing transitions. Advocacy services should be available for all patients when major changes are introduced to their care to ensure that they understand what is likely to happen.

[1] Refocusing the Care Programme Approach, Policy and Positive Practice Guidance, DH, March 2008

Child protection procedures

R29 The trust should amend its existing child protection policies and procedures so that they explicitly cover circumstances in which someone with a mental illness is living in the same house as a child.

R30 The trust should ensure that all staff are familiar with child protection procedures and understand how to operate them. The trust should audit compliance.

Age, family and culture

R31 The trust should continue to review how they could develop a service for the 16 to 25 age group which would overlap with CAMHS and adult services rather than be separate from them.

R32 The trust should develop a process for ensuring a full family history is always taken and that assumptions are always checked in relation to the culture of the particular patient.

R33 The trust should ensure that interpreters are used when necessary, especially where there may be language difficulties for a primary carer.

Inpatient services

R34 The trust should undertake a review of the dependency needs of the clients on Conolly ward and the appropriate staffing to meet those needs. The review should be undertaken collaboratively with the staff on the ward and any changes made explained fully to them. The review should take account of the number of patients being actively cared for rather than just bed numbers because some of those on leave look to the ward for support.

R35 The trust should review the patient leave policy and procedures on Conolly ward as a matter of urgency to ensure that the current practice is safe and compliant with CPA.

Post-incident action and support

R36 The trust should ensure reflective practice/learning opportunities are always arranged and supported after a serious untoward incident so that individuals can take responsibility for their own learning.

R37 The trust's policy on management of incidents should be amended to include:

- in what circumstances staff may be relieved of their duties after a serious untoward incident; the status of their absence and their rights regarding representation;
- the need for staff to be offered opportunities for reflective practice as part of learning from a serious incident.

R38 The trust should amend its policy on managing incidents to ensure it clearly separates out policy, procedure and guidance and to improve its readability.

Details of the investigation

4. Narrative

4.1 We include a narrative chronology in the main body of the report for those who like to know the whole history before looking at the issues. Some of the narrative is repeated in the main sections of the report to give a context to our points.

4.2 A separate section of the narrative gives details of MB's medical care.

Early life 1986 – 2005

4.3 MB was born in Cyprus on 30 June 1986. His parents are Kurdish, originating in Turkey. MB spent some of his early childhood in both Cyprus and Turkey. He came to England with his parents and younger sister when he was three.

4.4 The family lived at first in hostels and then in council accommodation in east London (Hackney). MB's brother was born in 1996.

4.5 MB's early life seems to have been largely unremarkable. His GP records show usual childhood complaints. He did well at school and he thought he might go to university. However, when he was about 15 by his own account he *"headed in the wrong direction and I ended up in a bit of a mess"*.

4.6 MB said he started skipping school, and smoking cannabis and going clubbing with his friends. He also seems to have started gambling. He said he was expected to do well in his GCSEs but in fact never took them.

4.7 He said he was sexually abused when he was five by a 14-year-old cousin, though there are no other details of this. He said he had abused his brother, sister and a cousin several years ago. He reported these events, he said, because they troubled him and he could not stop thinking about them and why he had done it.

4.8 MB said his parents did not get on and often argued. His father would sometimes leave the family home as a result of these arguments. His father worked in a bakery and MB occasionally worked there as well after he left school. MB's mother was once admitted to Conolly ward in the Homerton Hospital.

4.9 MB said he asked for help with his gambling before he left school and saw a social worker a few times. He lost contact once he left school.

First contact with mental health services – 31 May 2005

4.10 On 31 May 2005, MB was in a pub after working in his father's bakery when he had what he has described as a panic attack. He thought he was dying. An ambulance took him to accident and emergency (A&E) at the North Middlesex Hospital. MB said he had suffered hallucinations before this but had not sought medical help. He thought people on the television in the pub were telling him he had a contagious disease and he was going to die. He found himself unable to breathe and was worried that his heart would stop. He also thought the birds were talking to him, calling him to heaven.

4.11 He was transferred to the Homerton Hospital and admitted overnight to Brett ward under section 4 of the Mental Health Act 1983.

4.12 On 1 June he was transferred to Conolly ward and agreed to stay voluntarily. He was described as having suffered an acute psychotic episode. He also reported that in the past he had tried to drown himself in the bath and suffocate himself. He made the first mention of the alleged sexual abuse of his brother but also said it might not have happened.

4.13 On 6 June 2005 he was allowed leave from the ward and was to return every day for his medication. Consultant psychiatrist B's specialist registrar, SPR 1 also referred him to the early intervention in psychosis service (EQUIP) which was not followed up until late September.

4.14 MB continued to attend the ward for his medication and stayed with his family. His medication was increased. His mental state improved. On 11 July he stayed on the ward overnight because he was agitated and aggressive but resumed his leave the next day.

4.15 This pattern continued until the beginning of August. He occasionally missed his medication but was essentially compliant. On one ward round (17 July) he was described as 'extremely confused' and was hearing voices but remained on leave. He began to spend longer on the ward. He did not have a care coordinator.

4.16 By 8 August the improvement in his mental state seemed to have halted and his medication was changed. He was also asked to stay on the ward for a week. Further reference was made to a referral to EQUIP. For the first time, he mentioned difficulties with his accommodation at home. He said he did not want to stay at home but had nowhere else to go.

4.17 He remained on the ward until 1 September. He was described as having increasingly florid psychoses and suicidal thoughts. He began talking about 'left-right thinking' and believed people's lips were telling him to do things. In the middle of August his mother wanted to take him home but was told that if she insisted, they would have to assess him for detention under the Mental Health Act. Towards the end of August his father asked if he was well enough to go to Istanbul but was told he was not and had schizophrenia.

4.18 On 30 August it was agreed that he could resume leave, returning every day for his medication but he was behaving erratically and stayed overnight on the ward several times. After little more than a week his leave was stopped and he stayed on the ward until 20 September when he was again allowed leave as part of a plan for discharge.

4.19 This lasted until 23 September when he said he had nowhere to live. He remained on the ward until 9 October when he resumed overnight leave. However, on the 11 October he came to the ward and was "*aroused*" and over-familiar. He was introduced to his care coordinator. He became angry and said he did not want one. It

was decided he should remain on the ward. He stayed on the ward until 19 October. He was discharged from the ward on 21 October as his father had told the hospital that he was taking him to Turkey. He was given a month's medication to take with him. The discharge summary refers to him as having schizophrenia.

4.20 On 25 October his care coordinator saw him at home. MB said he had a ticket to go to Turkey for 27 October. His care coordinator advised him to get a letter from the hospital to take with him to Turkey but he did not do so.

4.21 While he was away in Turkey EQUIP followed up the referral made on 23 September.

2006

4.22 It is not clear exactly when MB returned from Turkey (it was probably about 5 January) but on 19 January 2006, his GP referred him to the psychiatric emergency clinic where he was diagnosed as paranoid schizophrenic and referred to the home treatment team (HTT). His medication had been changed while he was in Turkey but there is no other information about the treatment he received there.

4.23 He felt suicidal and talked about the past sexual abuse of his brother.

4.24 He received visits twice daily and sometimes daily from the home treatment team for about a month. He was generally compliant with his medication.

4.25 MB began to talk more about the possibility of harming others. On the 25 January 2006 he also said he had been thinking about throwing himself under a train.

4.26 At the end of January the HTT decided to refer him to the London Borough of Hackney children and young people's service (child protection) as a result of his claims to have abused his brother. It is not clear what triggered the referral at this particular point. MB became agitated at this and threatened violence towards any social worker who came to the home.

4.27 SPR 1, (now promoted as locum consultant for the HTT) saw him on 1 February. He had suicidal thoughts and thoughts of harming others but showed no actual intention of doing this. He said he had been watching the film American Psycho as he was himself 'a psycho'. His diagnosis at that stage was of cannabis induced psychosis *"…or, more likely, a schizophrenic illness which is partially treated. There is an obsessional feature to it"*.

4.28 In the first week of February MB began saying that he felt he might need to be in hospital because of increased pressure. On 7 February he said that he felt he might die soon and talked about wanting to strip someone and bury them alive. The HTT felt that he was trying to shock them and test the boundaries rather than expressing a real intent. He asked several times what would happen if he killed someone and was told he would go through the criminal process.

4.29 On 8 February a clinical meeting decided that he should be transferred from the HTT to the south east locality team (SELT). MB was told of this plan. On 11 February he was told that visits from the HTT would reduce to every other day. On 15 February his case was formally transferred to SELT. MB told the HTT that he had fleeting suicidal thoughts and would probably act on them within two to three years. HTT felt he was being manipulative to prevent his discharge.

4.30 On 16 February MB received a joint home visit from the HTT and SELT where he was given a week's medication and was told they would drop off a further two weeks' medication later that day. He was told to go to his GP if he continued to have headaches and to go to the emergency clinic if he was in crisis.

4.31 On 23 February MB was admitted to Conolly ward following a self referral because he felt he might kill someone or himself. A staff grade doctor saw him in the emergency clinic. MB said he felt driven to throw himself under a tube train. He also said it would be 'thrilling' to kill someone after seeing a violent film. He had gone out recently with a short kitchen knife after smoking cannabis but then felt killing someone would be immoral. He thought he would kill someone soon unless he was contained in hospital and he did not feel his illness was being taken seriously. The

staff grade doctor thought his presentation suggested hebephrenic schizophrenia and his risk was difficult to assess because he had no history of violence or self harm.

4.32 MB's father appears by this time to have left the family home and to be living separately.

4.33 On 27 February, MB was allowed day leave at a management round pending a ward round the next day but was subsequently also granted home leave. He was to come to the ward for his medication twice a day. He failed to attend for his night medication in the evening and telephoned the next day to say he was not coming back as the medication was not good for him. He was discharged from the ward on 28 February with no medication.

4.34 The SELT contacted MB and visited him at home on 2 March because he had failed to attend their office as agreed. It was a difficult encounter because MB insisted he was ill but was recorded as refusing all forms of help. He failed to attend an EQUIP appointment on 6 March. MB's care coordinator followed up the referral to child protection the HTT had made in February.

4.35 On 15 March MB was seen by consultant psychiatrist B's new specialist registrar, SPR 2 at the SELT offices with the care coordinator. MB felt better for not taking medication. He talked about the sexual abuse and gave another version of his earlier story. On the same day, a representative from SELT attended an urgent meeting with the child protection team at Stoke Newington police station following the referral to child protection. They agreed to interview MB's brother at school that day to find out if MB's story was true. The brother did not disclose anything and the police decided to take no further action. If any further action was to be taken, it was agreed that this would be by child protection alone.

4.36 On 17 March MB failed to attend an outpatient appointment although he did go to his GP on 20 March. He missed another appointment with EQUIP on 21 March.

4.37 On 27 March the representative from SELT and a social worker from child protection visited MB at home, pursuing the allegation of sexual abuse. MB claimed it was a momentary impulse when his brother was seven months old. MB knew it was not right. It had happened only once, although there was a similar incident with his sister when she was seven. He also said that he had done something similar five or six times with a cousin who now lived in Cyprus. He said he had disclosed it as he felt he needed help with his thoughts. They were eating away at him because he did not understand why he had done it.

4.38 What happened after this meeting is not clear except that the child protection social worker phoned police for guidance. Despite the police position that they were not pursuing the case, the police officer seems to have advised the social worker that MB should leave the home pending further investigation because his brother (now aged 10) could be at risk. It was assumed that MB could stay with his father who at that point was not living with the family.

4.39 On 28 March MB was informally admitted to Conolly ward from A&E. MB said he was experiencing intense thoughts of self-harm (and of harming others) and was shocked as a result of the visit the day before. He could not stay with his father who had a one-bedroom flat. He initially refused medication. MB was admitted to Conolly ward but he had to sleep on Brett ward because there was a shortage of beds.

4.40 On 29 March, while watching television, MB said he was going to stalk and kill a well-known TV presenter. For the next few days he was intermittently compliant with medication. He continued to say he felt suicidal (though did not want to die) and said that he was likely to kill himself if he was discharged.

4.41 A management round on 3 April came to the conclusion that his primary need was housing and agreed that he should be discharged with a referral to the homeless persons unit (HPU). At the ward round the next day (4 April) MB continued to say that he was suicidal and wanted to stay on the ward. He could not live at home but could not live by himself. He was told that he would get support in the community. He said "*I am acute. I'm suicidal. What else do you want me to do? Are you going to take responsibility for that?*". He was told that if he got into trouble with the police the

hospital would say he had no mental illness. He became angry and said "*what do you want me to do? I don't want to have to do anything to make you think I'm not well*". He said if he was not ill then he would not take medication. He was told again that the hospital would not help him if he got into trouble with the police. MB wanted to know why they were threatening him. He was told that he needed to help himself. He said that "*if something happens to me I'm going to kill everyone. Just wait and see*". The ward round record notes his diagnosis as borderline personality disorder with some anti-social traits. He was discharged from the ward with a referral to HPU, to be followed up in the community in two to three weeks.

4.42 MB contacted the HPU, who became alarmed at his story that he was mentally ill but refusing to take medication; that he had thoughts of harming people and about sexually abusing his brother. They contacted SELT for clarification of his risk. After talking to consultant psychiatrist A, MB's care coordinator persuaded the HPU that he did not present much of a risk as he had more of a personality disorder than a well-defined psychotic illness. He had not carried out his ideas and thoughts and should not be excluded from housing as his level of risk could be managed in the community. On 7 April, the HPU agreed to recommend him for supported accommodation.

4.43 However, when they contacted MB to let him know he refused any offer of accommodation because he said his father had found somewhere for him and his family would never let him be homeless.

4.44 After this there was limited intermittent contact between MB, his GP, EQUIP and SELT. It is not clear whether he had a supply of medication. His father appears to have arranged for him to see a private psychoanalyst who offered him hypnosis. EQUIP maintained contact but said that they would need to transfer him if he continued to stay with his father. His care coordinator seems not to have made any contact with him.

4.45 On 15 May he failed to attend an outpatient appointment and the senior house officer taking the clinic discharged him from the clinic.

4.46 On 19 May MB went to the SELT office with his mother. He said that his father had beaten him up and thrown him out so he had nowhere to stay. He was advised to go to the HPU. He said that he had been told he was intentionally homeless. The duty worker at SELT both telephoned and wrote to the HPU explaining that MB really was homeless this time and urgently needed accommodation. On the same day, MB and his mother went to the children and young people's department who told him to go to housing and to see his care coordinator. MB said he was intentionally homeless and his mental health worker had told him to go to child protection. He wanted a letter from a doctor saying he could not go home. He was told that the investigation was a police matter and he should get his key back from his father.

4.47 No other contact with MB was noted until 1 June when he turned up at the psychiatric emergency clinic saying he was sleeping rough on buses. He was tortured by racing thoughts, including thoughts of sexual violence and suicide. He thought he might jump in front of a tube train, drown himself with weights in the river or poison himself. He talked about hearing voices and 'lip reading'. He was admitted to Conolly ward.

4.48 He generally settled on the ward although he continued to be agitated and paranoid. On 6 June he had an argument with consultant psychiatrist A at the ward round when consultant psychiatrist A told him that he liked the ward because he did not have a place to live and that the ward was not a hostel. Consultant psychiatrist A told him he was not hearing voices; he did not have a defined psychotic illness and the main treatment would be to find him somewhere to live.

4.49 He nonetheless remained on the ward. A management round on 9 June noted that he had drug induced psychosis and personality problems and was quite manipulative. He was later noted to be loud and pressured with an underlying threat. He began to spend more time off the ward during the day.

4.50 He continued to insist that he wanted only to go back home and did not want to live independently. At a ward round on 15 June the plan was for his care coordinator to pursue accommodation for MB and to undertake an assessment of daily living (ADL). MB had written something which tried to explain his 'left-right thinking'.

4.51 He was relatively calm and stable after this, although in a conversation with one of the nurses on 18 June he said that he believed that people were sending him messages through the television and when they were talking to each other. This made him angry and he felt like attacking someone. He thought that anger management might help him. He spent a lot of time watching the World Cup on television and gambling on it.

4.52 At the ward round of 22 June he said he needed more Lorazepam because of panic attacks. He said that he felt angry and frustrated because of his gambling. He had taken £100 from his father and gambled it. He had lost about £20,000 in total and about £1,500 since May. In the past he said he had sold his family's belongings to get money for gambling but denied doing it any longer. He said that when he was on the underground he had the urge to push people onto the track and that he had always had this urge. He stopped himself because he did not want to go to prison. He thought he might be violent soon and had been thinking about bringing poison onto the ward and putting it in the water. He said that his thoughts were genuine and he did not think he could contain himself.

4.53 He was told to spend more time on the ward and was to take no leave for a week. If he left he would be assessed for compulsory admission.

4.54 On about 23 June he had a long conversation with an occupational therapy assistant. He said he felt like killing people. He was agitated and wary of things around him. He thought that if he was let off the ward or out of the hospital he would buy a gun, pick a colour and then come back and shoot everyone wearing it. He said he felt like an animal. He seemed disturbed by what he was saying. On 23 June he complained that a doctor woke him up to give him a personality questionnaire to fill in. He was getting violent thoughts because of it and again talked about bringing poison onto the ward.

4.55 He was also upset about not being allowed off the ward but was generally compliant.

4.56 At an OT 'smoothie group'[2] on 26 June he suggested that the occupational therapist should stick his hand in the blender 'as a dare'. He had a first assessment session with EQUIP and agreed to eight more.

4.57 On 27 June he was reported to be anxious and had a thought-disordered rambling conversation. He said he was having auditory hallucinations telling him to kill as many people as he could. He said he was low because he had lost £50 betting on a football match.

4.58 On 28 June he said that he had recently forced a female patient to lie down and lay on top of her. There had been no penetration. He said he had done this for three days in a row and that the female patient had allowed it. She had not reported it. He was distressed and agitated about this and had asked to see the doctor as he felt like hitting her. He was worried about what would happen to him.

4.59 On 30 June (his 20th birthday) he said that thoughts about harming people had stopped. He was, however, worried that if he was discharged he would be all right for about a month and then the paranoia would start. He did, with some persuasion, complete the first part of the assessment for daily living (ADL).

4.60 On 3 July he said he felt well and if the doctor thought he should go home now he would be willing to go with his medication. He said that he recovered when he stayed in hospital but his suicidal and paranoid feelings came back as soon as he went into the community.

4.61 He attended an art and craft group on 4 July where he said that he had no intention of acting on the voices he heard and would not want to hurt anyone.

4.62 At the ward round on 6 July his mental state was seen to have improved but he was still paranoid about being out on the street. He was not expressing thoughts of harming people. Consultant psychiatrist A had assessed him for personality disorder by questionnaire and he fitted the criteria for borderline/anti-social.

[2] The smoothie group was an activity group run by occupational therapy during which patients made fruit smoothies.

4.63 MB said he was anxious about his responsibilities if he left and the impact of the anti-social diagnosis. He was worried this might mean he would hit his brother. It was agreed by his clinical team to pursue his accommodation with his mother again and that he could have two to three hours of unescorted leave.

4.64 On 7 July he left the ward at 9am but returned for his ADL assessment at midday. He cooked a meal and talked about needing to renew his passport. He acknowledged he needed an alternative plan if he could not return to his mother. He left the ward again in the afternoon and returned at about 7pm. He was quiet and subdued and went to bed.

4.65 At 1.40am on 8 July the police arrived with a CCTV photo which identified MB as the person who had killed someone by pushing them under a tube at Highbury and Islington station earlier the day before. He admitted having done this and was arrested.

After the incident

4.66 MB was remanded to Belmarsh prison. He pleaded guilty on 15 December 2006 to manslaughter by reason of diminished responsibility. The plea was accepted and he was remanded to Broadmoor Hospital pending an assessment for sentencing. He remained in Broadmoor until 3 May 2007 when he was returned to Belmarsh because he had been given a diagnosis of personality disorder. He was sentenced on 22 June 2007 to life imprisonment with a recommended tariff of four-and-a-half years. He was re-referred to Broadmoor and readmitted on 17 October 2007 where he remains at time of writing as a transferred sentenced prisoner detained under sections 47/49 of the Mental Health Act 1983.

4.67 He remains a patient in Broadmoor because his diagnosis has changed to schizophrenia which is predominantly hebephrenic.

5. Medical issues

5.1 This section is in two parts. The first provides a narrative chronology of the key medical issues involved in MB's care. It has been compiled after examination of all the medical notes related to inpatient, outpatient and community care and transcripts of interviews with some of the medical team. The chronology is not exhaustive but contains the key information that identifies the quality of care that MB received. It includes some commentary. The second part identifies a number of themes relating to his medical care and discusses their impact.

Part 1: medical chronology

First admission

5.2 At 7.58pm on Tuesday 31 May 2005 MB attended A&E at Homerton Hospital. The note relating to this presentation dated 1 June 2005 states:

> *"18 year old man Turkish presenting with an acute psychotic episode characterised by thought disorder, perplexity, auditory hallucinations and ideas of reference."*

5.3 MB's psychotic symptoms were also described:

> *"Said that when the psychiatrist saw him the first time she made a facial tick which confirmed to him that the psychiatrist knows everything. He hears voices – 2 voices – not sure male or female. They converse amongst themselves about him. They also comment on his activities and sometimes command him to do things. Said the voices give him good commands which he sometimes obeys. Has not smoked cannabis for about 7 weeks."*

5.4 On the 1 June 2005 he began taking Haloperidol 5mg bd[3].

[3] "bd" means twice a day

5.5 Notes for 3 June 2005 indicate he had formal thought disorder in the context of an acute psychotic episode. Staff discussed him with consultant psychiatrist B and the following plan was proposed:

- urine drug screen
- appetite, sleeping pattern and social interactions on ward to be monitored
- diazepam 5 mg tds[4]
- bloods

5.6 On 4 June 2005 he saw the ward SHO[5] and told him he wanted to go home and that he was willing to accept home treatment.

5.7 On 6 and 7 June 2005 his urine drug screen was negative.

5.8 On Monday 6 June 2005, at the management ward round held by SPR 1, MB was started on Quetiapine titrating[6] up to 300 mg daily over five days. SPR 1 referred him to EQUIP and he was given leave to return to the ward daily to receive his medication.

Comment

The working formulation appears to have been **"acute psychosis, treat with antipsychotics and it should settle down".** ***The drug screen was appropriate as was the referral to EQUIP, except that the latter was not done until some time later. Commencing Quetiapine and the dose regime (increasing to 300mg over five days) was appropriate. However, giving him leave so soon after admission meant that he would not be observed round the clock and it would have been more appropriate, if he was so keen to have leave, for him to have been referred to the home treatment team.***

The plan recorded at the ward round did not suggest any further one-to-one assessment to establish psychopathology and enquire into his personal history.

[4] "tds" means three times a day
[5] SHO – senior house officer
[6] To analyse the best end point (for dose) for a medication

It is not clear from the notes at what point consultant psychiatrist A became the responsible consultant for MB's care and treatment.

Care during first admission

5.9 From the 7 June 2005, MB attended the ward daily until a (management) ward round on 13 June 2005. By then, his dose of Quetiapine had been increased to 350mg twice daily. At the management ward round on 13 June 2005 the dose was increased to 400mg twice daily. He continued to attend the ward for his medication, being assessed on some occasions by nursing staff.

5.10 On 11 July 2005 he became agitated after he returned to the ward in the evening and he was given Haloperidol 5mg and Lorazepam 2mg. The duty doctor was contacted and MB provided a urine sample which was negative for illicit drugs. He was not specifically asked if he had used any illicit drugs. He agreed to remain on the ward overnight. *"No thoughts to harm self or others"* was noted.

Comment

This was significant in that it was the first time that MB's mental state was deemed to warrant an overnight stay in hospital. We question the advisability of giving leave to someone newly presenting with an acute psychosis within six days of admission to an inpatient ward. If they appear to be well enough only to attend the ward for medication, a referral to home treatment to continue assessment, treatment and monitoring would seem to be the most appropriate course of action.

5.11 There was no follow-up and he returned home the next day. On 12 July 2005 a member of the nursing staff noted that he *"was assessed by the doctor and he was sent home to continue his leave"*. There is no doctor's entry of this assessment in the notes.

5.12 Notes from the management round on 18 July 2005 (recorded as 17 July 2005, but this is a Sunday) state that MB had "*delusional beliefs about special powers. Has been treated for about two months*". The plan was to: "*continue the present medication (for about six to eight weeks); consider for a full needs assessment; try and get early intervention*".

5.13 On 24 July 2005, an entry comments on MB's rapid speech stating he was: "*jumping from one topic to another with unrelated statements during conversation, distractibility and difficulty concentrating*". The impression was that MB "*remains relatively unstable in mental state, thoughts quite muddled up*".

5.14 Notes from the management round on the 8 August 2005, say that MB:

> "*admits to taking some cannabis but recent UDS[7] negative…currently on Quetiapine 400 mg b.d., starting on 6/6/5. Does not appear to be working/helping. Therefore the pharmacist suggests we start Aripiprazole. Consultant psychiatrist A feels things aren't helping at present and so advise [MB] to stay on the Ward at present and to change his medication to Aripiprazole*".

5.15 Once again, in the plan after the ward round, a full needs assessment was suggested. It was also stated "*?referred to EQUIP*".

Comment

It was certainly appropriate to try a different antipsychotic drug at this stage and Aripiprazole was as good a choice as any. However, there should have been questions about why MB was not responding to the medication and what might happen to him. Once again there should have been a comment on the negative drug screen.

There was no care plan addressing MB's home circumstances, carer assessment, or social needs. There was still no needs assessment. There was no formal risk

[7] Urine drug screen

***assessment. The referral to EQUIP had not been followed up. Consultant psychiatrist A had advised MB to* "stay on the ward at present". *Thus, the overall treatment plan continued to be an extremely and seemingly unilaterally medical one:* "time to change antipsychotic medication and let's hope that does the trick".**

5.16 On the 9 August 2005, following the introduction of Aripiprazole the dose of Quetiapine was slowly reduced with the final dose of 100mg on 23 August 2005.

5.17 MB then remained on the ward until the end of the month. At the next ward round on 16 August 2005, it was noted that he had become more paranoid. It was also noted that: *"Needs UDS. Admits smoking Cannabis 2.5 weeks ago"*. The urine drug screen (UDS) was negative. MB continued to stay on the ward but was noted to be leaving it more frequently.

5.18 On Tuesday 23 August 2005, at the ward round with consultant psychiatrist A, it was explained to MB's father that his medication had been changed as: *"didn't notice very much improvement in mental illness with other medication. now we have to wait to see any effect from this new one"*.

Comment

This succinctly sums up the approach taken, i.e. the entire focus is on medication with a hope that MB would respond. However, he had now been an inpatient for nearly three months without any significant change in his mental state.

5.19 On Tuesday 30 August 2005 the ward round with consultant psychiatrist A noted that MB wanted to be discharged. It was explained that he could not be discharged but *"can start leave and overnight leave"*. The plan was for MB to have leave, attend the ward in the mornings to have his medication and *"review mental state every few days"*. Once again there was no consideration of using the home treatment team to support MB while the change in medication was instituted.

5.20 For the next week MB was confused about whether or not he wanted to stay on the ward. On 1 September 2005 he returned to the ward saying that he could not live outside:

> *"it is stressful for me. I think I am not ready. Sorry I challenge your intelligence. I should not have gone home."*

5.21 Later that night he decided he wanted to go home and he was assessed by the duty doctor who allowed him leave *"as per team care plan"*. He returned the following morning for his medication and told a staff nurse he was feeling depressed *"medicine are not helping me. I don't like medication"*. He refused to stay on the ward to see the doctor. He returned in the afternoon, said he was not feeling well and requested prn[8] medication.

5.22 On 4 September 2005 he requested Lorazepam because he felt *"high and agitated"* and his father rang the ward on 5 September 2005 saying that MB needed to come back to the ward. MB said he had smoked cannabis a few days before. This did not prompt a urine drug screen. He left the ward in the evening of 5 September 2005, returning the next day and staying overnight. He appears then to have remained on the ward from 6 September 2005 until 13 September 2005 when he went home to see his mother during the evening but returned within an hour.

5.23 On the 19 September 2005, after a comprehensive mental state review by the SHO it was noted that MB *"continues to express delusional ideation and paranoia"*. The review gives considerable detail of his psychotic symptoms and is clear evidence of unresolved psychotic symptomatology.

5.24 On Tuesday 20 September 2005 notes from consultant psychiatrist A's ward round once again say that MB "*requires a full needs assessment"*, that leave should be encouraged *"as much as possible"* and that there should be an *"aim for discharge in next few weeks"*. According to the SELT notes, the full needs assessment was carried out on 23 August 2005.

[8] "prn" medication to be taken as the occasion arises; when necessary.

Comment

***It is difficult to understand the rationale that there should be an aim for MB to be discharged* "in the next few weeks" *given his lack of improvement*.**

5.25 From 20 September 2005 MB was noted to be restless at times and intrusive with staff. He was noted on one occasion to have bizarre beliefs such as saying that when he was a young boy he always felt like *"biting African boys' heads"*. There was no note of other psychotic symptoms.

5.26 From 21 September to 25 September 2005 he attended the ward daily.

5.27 On 27 September he said he was beaten up by his father and had slept rough on a bus. He slept on Conolly ward on 28 and 29 September saying that his father had thrown him out of the house. He remained on the ward from 28 September until 3 October when he left the ward, returning in the evening saying that he *"could not stay at home tonight as he had promised"*.

5.28 There was no investigation or care plan relating to his home circumstances after these events. No formal care plan or risk assessment was carried out. There was no CPA review.

5.29 On 4 October 2005 the long awaited activities for daily living (ADL) assessment was scheduled for *"Wednesday 5/10/05 at 10 am"* but it did not take place.

5.30 On Tuesday 11 October 2005 it was noted at the ward round that there were *"some behavioural elements"*. It was stated that:

> *"in the last 2/52 has generally been calm and much more settled, only this a.m. much more aroused. Came back to ward these a.m. shouting ++, demanding medication, overfamiliar"*. His *"dependency on ward"* was noted.

5.31 During this ward round, MB was introduced to his care coordinator. MB's response was antagonistic. It was agreed to start him on Haloperidol 5mg tds with a view to then reducing the dose of Aripiprazole.

5.32 It seems that MB was generally more settled but his mental state was clearly subject to significant fluctuation. His behaviour was thought to indicate a dependency on the ward, even though he had been encouraged by consultant psychiatrist A to stay on the ward. Nevertheless, at this ward round it was the intention that MB should remain on the ward while his medication was changed for the third time, this time to Haloperidol. According to the drug chart, Haloperidol 5mg tds was written up and dispensed from 11 October 2005 in addition to Aripiprazole, but was crossed off on 24 October 2005. It is not clear why it was stopped on this date. Aripiprazole was not crossed off.

5.33 The discharge summary states:

> *"He became very angry and aroused [having been introduced to his care coordinator] and was therefore kept on the ward for a couple of days. However, he settled fairly quickly and it was decided at this point he could have some Haloperidol 5mg tds which he was given for a couple of weeks, and it was reduced to stop."*

5.34 This does not accurately reflect what happened - that the Haloperidol was suggested at the ward round and not afterwards. There was no plan to stop Haloperidol and it is not clear why it was stopped. The ward round of 11 October 2005 does not indicate that MB should stay on the ward for only a couple of days.

5.35 In fact, there are only three further entries for this admission; on 14 October 2005 when he attended the ward for his medication, on 19 October 2005 and on 21 October 2005. There is no entry relating to consultant psychiatrist B's ward round on Thursday 20 October 2005.

5.36 The last relevant entry dated 21 October 2005 and timed at 2.30pm perhaps sums up the approach staff were taking towards him:

> "*Attended the ward for his medication and took it. He appeared stable. But I asked him: How are you? He said feeling terrible, he could not explain to me why. I asked him if he took drug he said yes. Cannabis.*"

5.37 At this stage, MB's admission seems to have fizzled out as, even before his announcement that he was going to Turkey, there was no discharge care planning and no clear treatment plan. It is clear that at the time of his discharge he remained mentally ill and he had been changed on to a new antipsychotic drug.

5.38 Consultant psychiatrist A, in evidence to us recalled the circumstances around MB's 2005 admission and discharge:

> *"Late in 2005 I think he was on the ward for about five or six months, and that was the time he was discharged. That wasn't initiated by the ward or any member of the team; that happened because he wanted to go to Turkey; his father wanted him to go. I remember I called a CPA meeting then with the father in attendance and we discussed things, and I explained to the father the risks that were involved, because I felt he was still very psychotic, that he needed to have treatment, and the father said no, that was the plan of the family. We just advised them as to what to do. We gave him his medication and then he was supposed to be given a letter that he took to Turkey, and that was it. What we said was that, coming back to the UK he should get back to us."*

5.39 There is no record of the CPA meeting that MB's father attended. Consultant psychiatrist A told the investigation that if MB had not gone to Turkey, he would not have discharged him and would probably have considered another medication, perhaps Clozapine. He did not appear to consider the implications of MB travelling to Turkey in a mental state that required inpatient admission and consideration of further antipsychotic medication. Clinical staff provided no documentation or made any contact with psychiatric services in Turkey.

Summary comment on 2005 admission

The evidence from the notes suggests that MB presented to psychiatric services with symptoms of schizophrenia that never fully abated.

MB claimed to use cannabis but there is only one documented reference to a positive urine drug screen for cannabis and no objective evidence of a positive urine drug test. His alleged use of cannabis is not supported by drug testing. There is no systematic assessment of his illicit drug use. A referral to Addaction is mentioned during his later admission in June 2006 but this was probably for his gambling.

There was no comprehensive continuing assessment of his presentation, whether of psychotic symptoms, alleged sexual abuse against him, alleged sexual abuse of others, illicit drug use, gambling, personal history, social circumstances or risk.

We note:

- ***There was no systematic use of leave from the ward.***
- ***There was no referral to SELT until 14 June 2005. It is unclear what role the SELT team took in his inpatient admission. No care planning took place.***
- ***The referral to EQUIP was not made until 23 September 2005.***
- ***It is not clear why he could not have been referred for home treatment***
- ***There was little evidence of multidisciplinary decision-making or contribution to decisions.***

There was no discharge planning and his admission petered out at the end of October, after a further change of medication was suggested. He remained unwell. There was no assessment of his social needs or the needs of his primary carer, his mother.

It appears that his failure to improve resulted in a change of attitude from those caring for him. Rather than thinking that his failure to improve might be because

***of illness factors, his continuing symptoms and presentation began to be labelled as* "behavioural".**

Conclusions

C1 The evidence from the notes suggests that MB presented to psychiatric services for the first time on 31 May 2005 with symptoms of schizophrenia that never fully abated.

C2 The decision to initiate treatment with antipsychotic medication and the titration upwards of that medication (Quetiapine) was appropriate as was the decision to try another antipsychotic drug, Aripiprazole.

C3 The extent of MB's use of cannabis was never clear. From the evidence his use of cannabis was at best sporadic and the assumptions made of the association of his alleged use of cannabis and deterioration in his mental state were unfounded. Consultant psychiatrist B, in his evidence asserted that nearly all patients under his care smoked cannabis. He said:

> *"Have you walked the streets of Hackney? It's a bit like the dog that didn't bark in the night. The absence of cannabis is the unique thing."*

C4 An assumption seems to have been made that MB was smoking cannabis, despite the lack of evidence to support this view. MB's use of illicit drugs was not established. We conclude that cannabis did not play a significant part in his symptoms of psychosis or behaviour and it was wrong for the conclusions to be drawn that MB's use of cannabis had an impact on his mental state because the evidence was not there to support such a conclusion.

C5 There was no comprehensive continuing assessment of MB's presentation, whether of psychotic symptoms, alleged sexual abuse against him, alleged sexual abuse of others, illicit drug use, gambling, personal history, social circumstances or risk.

C6 It appears that MB's failure to improve resulted in a change of attitude from those caring for him. Rather than thinking that his failure to improve might be because of illness, his continuing symptoms and behaviour were labelled as *"behavioural"* and an alternative explanation was sought.

C7 MB should not have been discharged in October 2005. If he had insisted on going to Turkey and was deemed not detainable under the Mental Health Act, he should have been provided with a letter to take with him summarising his presentation, working diagnosis, response to treatment and treatment plan with contact details available addressed *"to whom it may concern"*.

Home treatment experience

5.40 On 20 January 2006 after a referral by his GP, MB was taken on by the home treatment team (HTT) (refer to section 7 of this report on transitions). Once again, the plan appears to have been to increase his antipsychotic medication, this time with the support of the HTT. However, there was no care plan and no risk assessment. The working formulation appears to be: *"Patient with Schizophrenia, relapsed, need to increase medication again"*. There was no plan to review MB's old notes. The HTT visited him at least daily and sometimes twice a day.

5.41 On 31 January 2006 MB was reviewed by the long term locum staff grade doctor (LSGD) with the HTT and emergency clinic who noted:

> *"Anxiety, restlessness. Patient wanting to isolate himself. Preoccupied with thoughts of self harm. No plan/intent at present. Occasional thoughts of wanting to murder people in order to get a "buzz" out of it but would never do it because he is a moral person…"*

5.42 As a result of her assessment, the LSGD increased the dose of Risperidone to 6mg nocte[9] and started MB on Chlorpromazine 25mg bd.

[9] Nocte – at night

5.43 The HTT consultant (previously SPR 1) saw MB on 1 February 2006. This was a long, detailed assessment:

> *"Current diagnosis is that of cannabis induced psychosis or more likely, a schizophrenic illness, which is currently partially treated. There is an obsessional feature to it. I do not feel there is currently any risk of abuse towards his younger brother on the basis of the history we have. He was open and clear about his past episode and his mother reports no concerns from school/behaviour.*
>
> *His violent thoughts seem to have started more recently (no record of these on his prior admission). Interestingly he equates his illness with that of American 'psycho' in view of the terms "psycho" → "psychosis". He has not acted any of these out, and he has shown capacity for emotional engagement in his childhood."*

5.44 The HTT consultant stated his view that there was no risk on the basis of the history available of abuse towards MB's younger brother. He noted the recent surfacing of violent thoughts (but was wrong to say that there was no record on MB's prior admission; there was). He commented that MB *"has shown capacity for emotional engagement in his childhood"* implying that he did not think that MB had an anti-social personality disorder.

5.45 The HTT consultant's plan was comprehensive and appropriate, assuming that MB's psychosis responded to the increase in medication. He suggested consideration of a forensic opinion. He also wanted MB discharged *"when CMHT linked in"*. The discharge appears to have happened rapidly and the CMHT linked in on the day of discharge.

5.46 There do not appear to have been any meetings equivalent to ward rounds to discuss his management while MB was under the care of the HTT. There were no illicit drug screens, no care plan and no risk assessment. The referral to the children and young people's department (see section 8) appears to have been made unilaterally without consultation and planning.

5.47 On 16 February 2006 MB was discharged from HTT to the SELT while still mentally unwell, shortly after an increase in his medication had been made and with elements of the management plan (such as referral to EQUIP, decision of a forensic assessment, referral to children and young people's department) outstanding. There appears to have been no consultant-to-consultant discussion or handover. There was no *"medical"* discharge summary.

5.48 Consultant psychiatrist A told us he was aware that MB was back in the country only when he was admitted on 23 February 2006. He had not been aware that he had gone to the emergency clinic or of his subsequent home treatment. He was not sure if he had been aware of the referral from home treatment to SELT. He told us:

> *"That's something that wasn't clear. My thinking would be that when the home treatment said they were going to hand him over to the SELT, most likely what they might have done, or what they could have done, will have been that – because the home treatment team are at the management meeting on Monday, they do attend the team meeting on Wednesday as well – they could have attended the team meeting and said, 'This patient is back, we've seen this patient and we are discharging this patient to your care.' Possibly that's what they did."*

Summary comment on HTT

The HTT visited MB every day and sometimes twice daily. In interview with us he described this period of care as:

> **"They were all right, they were okay. There's a difference from being admitted into hospital. They would come and ask me how I was every day, I'd evaluate my day to them, and I'd speak to them about how I felt and all that and whether I thought there was any improvement and things like that."**

From MB's perspective this was a positive period of care. Undoubtedly this level of intervention provided the degree of supervision and engagement that enabled

MB to remain at home as an alternative to inpatient care, as intended. Unfortunately he was discharged from the HTT not because he no longer needed this level of support but because he had reached the limit of the time that the team would provide a service (section 7, paragraph 21 refers). This led to an abrupt transition to the SELT community team which led to his rapid re-admission to hospital (see section 7 transitions).

If HTT is to be a real alternative to hospital, its delivery of care needs to be structured with effective care planning and care management. Unfortunately in MB's case it was not. The following list identifies shortfalls in care planning and care management:

- ***There is no evidence of multidisciplinary meetings leading to shared decision-making.***
- ***Plans were not followed through.***
- ***A narrow medical model was followed, with home treatment staff's role seemingly to assess mental state and provide medication.***
- ***An opportunity to obtain a forensic opinion was missed.***
- ***No urine drugs screening was undertaken.***
- ***There was no liaison with the SELT team except on the day before discharge.***
- ***MB was discharged to SELT while still mentally unwell.***
- ***There was no evidence of handover between doctors.***
- ***The HTT picked up on the potential for violent behaviour but did not follow this through by having a care plan or formal risk assessment. The discharge summary did not pick out key elements of his risk or history.***
- ***The HTT picked up MB's allegation that he had abused his brother and acted on this in a seemingly insensitive and uncoordinated way. [See chapter on child protection referral].***

Admission on 23 February 2006

5.49 On 23 February 2006, a week after his discharge from the HTT, MB attended the emergency clinic and saw the staff grade doctor who arranged for him to be readmitted to Conolly ward. This doctor had looked after MB in 2005.

5.50 The staff grade doctor recorded:

> *"Impression: 19 year old male with a history and presentation very suggestive of hebephrenic schizophrenia. Seems not to have been adequately treated by 3 different atypical antipsychotics. Risk is difficult to assess – certainly there is no history of violence or self harm but is clearly not managing in the community and would benefit from admission for r/v of management and consideration of Clozapine.*
>
> *D/W SPR 2, SELT: agrees with the above."*

5.51 The staff grade doctor succinctly summarised the situation with MB, identified the medical issues and formulated the correct plan. He seems to have decided that MB should be admitted (rather than re-referred to home treatment) both because he was not managing in the community and for consideration of starting Clozapine (which requires regular blood level analysis). He made a putative diagnosis of hebephrenic schizophrenia and suggested a possible treatment plan.

Comment

It is unfortunate that this plan was not communicated effectively to the ward. It raises the question as to how the staff grade doctor's intentions (confirmed with SPR 2) were communicated both to ward staff and the ward-based doctors. The management round paid no heed to the staff grade doctor's assessment.

5.52 MB was seen by the PRHO[10] in the morning of Monday 27 February 2006 (four days after admission) *"asking to go home"*. The PRHO noted:

> *"Due to his previous psychiatric history and dependence on ward I felt it would be good to encourage overnight leave…I have asked him to come to ward morning and night for his medication and quick chat with nurse."*

[10] PRHO – post registration house officer

5.53 There was no rationale for this decision. His previous assumed dependence on the ward was irrelevant in relation to this admission which was specifically to carry out the plan the staff grade doctor outlined.

5.54 The ward book for the management round of Monday 27 February 2006 states:

"Assess risk and can go on day/overnight leave
Team to come up with a plan of managing manipulative behaviour."

5.55 The entry made in the medical notes states:

"Known to services
Discharged from Home Treatment Team 2/52 ago
Has a forensic history
Presented to EC thinking he would kill someone.
To review on WR Thursday
Can go on day leave until then"

5.56 This is a flawed plan. There is no evidence of a forensic history. There is no acknowledgement of the plan discussed between the staff grade doctor and SPR 2 regarding MB's admission. MB was booked in for consultant psychiatrist B's ward round on 30 February 2006, so presumably, he was seen as the responsible consultant at this time otherwise MB would presumably have been booked into consultant psychiatrist A's ward round the day after the management round.

5.57 However, MB did not return for his medication on 27 February 2006, and after a telephone conversation the next morning in which: *"He said he is not going to come back to the ward…"* he was discharged during consultant psychiatrist A's ward round that day (which the staff grade doctor did not attend).

5.58 It is difficult to ascertain how much consultant psychiatrist A was aware of the staff grade doctor's comprehensive assessment and formulation and his admission plan which had not translated into an active management plan. He told us:

"Most likely that decision was taken in the management meeting as to being discharged from the ward in his absence. Looking back, what I would think is that often times this gentleman presented with different patterns or in different ways, and it is possible the case was discussed that Monday and the impression was that he wasn't as ill as he presented at the emergency clinic, and that most likely the community could follow him up. That would be my thinking about that. I wish I could recall the details of that meeting. Unfortunately what I notice, especially after this event, is that often the extensive discussions in that management meeting are not often conveyed into the notes."

Comment

The importance of the staff grade doctor's assessment was never acknowledged and the opportunity for this admission to have resulted in a comprehensive review of diagnosis, risk, aftercare and care plan, was lost. No discharge summary was provided after this brief admission.

5.59 On 15 March 2006, MB attended an appointment with SPR 2 and MB's care coordinator. This appointment had been made when MB's care transferred to the SELT on 16 February 2006. This resulted in the first detailed assessment of MB's history of alleged sexual abuse both as victim and self-confessed perpetrator. SPR 2 does not refer to the staff grade doctor's assessment which is surprising given that this had occurred only three weeks earlier and he had noted that he had discussed the case with SPR 2.

Comment

SPR 2 undertook a detailed, thorough and comprehensive assessment including a risk assessment, although he seems to have forgotten the conversation he had with the staff grade doctor regarding MB's possible diagnosis of hebephrenic schizophrenia and admission for trial of Clozapine. He makes suggestions regarding considering another change in medication but it is not clear whether or not MB is taking any medication. MB told SPR 2 that he had stopped taking

Risperidone three weeks earlier. No formal risk assessment form was completed by SPR 2.

Admission 28 March 2006

5.60 On 28 March 2006 MB was readmitted to Conolly ward after the children and young people's department intervened. The admission summary noted:

> *"Known? Paranoid Schizophrenic, non compliant with medication, nil clear psychotic or depressive symptoms, however has accommodation issues at the moment."*

5.61 However, the psychiatric liaison nurse who assessed MB gave a clear description of psychotic ideation and a reference to suicidal ideation.

5.62 On 30 March 2006 following advice from consultant psychiatrist B regarding MB's medication the plan stated:

> *"to encourage him to continue with Risperidone, if he refuses use prn medication over next few days before considering changing medication. To be reviewed at Management Meeting on Monday."*

5.63 On 31 March 2006 there was a mini-management round although the ward book refers to this meeting as a CPA. It recorded that the diagnosis was now personality disorder.

Comment

It therefore appears to have become the case that MB was diagnosed as having a personality disorder (PD), with much of his behaviour manipulative, only a month after he was admitted for consideration for Clozapine because of a putative diagnosis of hebephrenic schizophrenia. His claims of being unable to live by himself were not heeded. He became increasingly desperate to try to convince those managing him about how seriously unwell he felt. We do not know who

carried out this CPA (which took place on a Friday) and what a mini-management round[11] is unless it is part of the* "putting to bed" *function of a Friday that consultant psychiatrist B mentions in his evidence.

5.64 MB was seen by the PRHO on 3 April 2006 and it was noted:

> *"HPU[12] letter*
> *TTAs Chlorpromazine 100mg nocte*
> *Follow up on 5th May 11.30 am*
> *D/C[13] from the ward today"*

5.65 In fact, MB was not discharged immediately but attended consultant psychiatrist A's ward round on 4 April 2006. At this ward round the following is noted:

> *"Told we feel that being on the ward will not help his mental health – it is more personality issues. Told about HPU today. Says he doesn't want to live by himself… Told we will give him support in community but he needs to help himself…"*
>
> *"Diagnosis Borderline PD[14] with some Antisocial Traits."*

5.66 Justifying the decision to discharge MB, consultant psychiatrist A told us:

> *"At this point a lot of issues were coming up. To understand this gentleman we need to have a longitudinal picture of his problems. At the time we assessed him the most important thing that was paramount at that point in time was the problem of accommodation, and we realised at that point that the family was in a lot of distress. There were a lot of problems going on in the family and he needed a place to stay. However, his thinking was that he will continue to stay*

[11] See sec 6, paragraphs 11-13 for description of the various rounds and meetings.
[12] HPU refers to homeless persons unit
[13] D/C refers to discharge
[14] PD refers to personality disorder

on the ward. The problem we had then was that the ward was so highly pressured that you can't just give a bed to an individual because you feel that he has no other place to stay. Some of these things were discussed with him: that's okay, we understand that you have problems, which we discussed extensively in the team and in the management meeting as well. Okay, there are problems with his dad, and what is bringing out this issue is basically the issue of the fact that this gentleman was evicted from his house and he needed a place to stay. That's what we said we were going to work upon."

"He had some psychotic symptoms, but to my mind and to the way things were, and the way we saw him then, was the fact that he did not appear more ill than he was at the beginning when we were treating him. Reading through the notes or with the benefit of hindsight, it might look as if he was in a lot of crisis, but if you talk to virtually every member of the team that knows this guy well, they will say to you that the primary problem of this guy at that point was the difficulty that was going on at home at that time. He wanted to be on the ward or he wanted to have a place to stay, he wanted to have a place to feel comfortable in, and I said that's okay, we are going to work out things for you, but it cannot be on the ward because we needed to move patients on. That was the pressure."

"Our assessment of what we saw him as of that time is that he's such a person that we could manage in the community without him being on the ward.

Q. Using the community resources provided by the SELT.
A. Yes. That we could manage him in the community without him being on the ward."

Comment

There is no discharge summary relating to this admission. The nursing assessment dated 28 March 2006 is incomplete. A risk assessment tool in the notes, undated, but seemingly related to this admission repeats the inaccurate* "history of sexual abuse whereby he sexually abused his brother and sister".** ***There is a care plan 1

(signed by MB) and 2 (not signed by MB) dated 28 March 2006. The proposed urine drug screen was not carried out. His psychotic symptoms are assumed to be part of a borderline personality disorder. A longitudinal assessment[15] was appropriate (and should perhaps have been carried out some time before) but it is unclear exactly how it would be carried out if MB was discharged without a care plan. There is no discharge care plan.

5.67 On 7 April 2006 MB attended to see his care coordinator who noted "*Has been taking Quetiapine with good effect*". It is not clear who had prescribed Quetiapine and at what dose. The GP notes dated 19 April 2006 state "*Started on Quetiapine 100mg 2/52 ago*". After MB's GP spoke to SPR 2 it transpired that MB received Quetiapine from A&E.

5.68 On 5 May 2006 MB failed to attend an outpatients' appointment and was discharged from outpatients by the SHO who told the investigation that although primarily ward based, she did run one outpatient clinic a week on a Friday morning. She told us:

> "*I was generally following up discharged patients from the ward. There were a couple of long-term community patients who we were seeing for management of chronic depression and those sorts of issues, but again it was very much supported by the consultants and we would not be making decisions of our own accord.*"

5.69 The process of allocation of patients to post-discharge outpatients was unclear. The SHO told us:

> *"From what I can recall there was no discussion at the ward round as to who would follow these patients up. We would make a decision and I had to document notes to be followed up in outpatients, but I don't think we would have documented exactly who would see them."*

[15] An assessment covering the patient's history not just recent events

5.70 Consultant psychiatrist A commented on MB being discharged by the SHO:

> *"I wasn't aware of that. Again, this issue of being discharged, I don't fully understand what that meant, because when you look at the issue of ward discharge, as I said, this is a gentleman that is being managed by the team, has a care coordinator and effectively the team is still caring for him."*

5.71 The SHO said she had discharged him:

> *"It was on the advice of consultant psychiatrist A because I didn't know the patient very well. We ran our clinics parallel to each other, so I went in to discuss the case with him and he knew MB quite well from the previous year's admission. He said that as he hadn't turned up to two outpatient appointments, we needed to write to the GP and discharge him and if they had any concerns, to re-refer him back to us. Yes, I did that on the advice of consultant psychiatrist A."*

Comment

It was not appropriate for MB to have been discharged from outpatients. At the very least a CPA review should have been held before deciding discharge from outpatients.

Conclusions

C8 There is evidence that MB's psychosis was changing with clear evidence of ideas of reference and command hallucinations. He was assessed by the ward doctor, discussed with consultant psychiatrist B and seen by a further doctor who stated *"no psychotic or depressive symptoms"*.

C9 On the 31 March 2006 there is the first clear reference to personality disorder. The inpatient team felt that his admission was due to his having been made homeless and he was labelled as *"having a history of abusing his brother and sister"*. His protestations that he could not manage on his own were seen as manipulative, as were his voicing of homicidal thoughts.

C10 There was no urine drug screen.

C11 There was no assessment of his ability to live independently.

C12 His psychotic symptoms were ignored.

C13 There is insufficient evidence to support a diagnosis of *"borderline personality disorder with some antisocial traits"*. He was summarily discharged with no coherent discharge plan.

Admission 1 June 2006

5.72 MB went to A&E at 2.00am on Thursday 1 June 2006. The incomplete A&E notes states:

> "*… woman because she was provoking me by playing with her necklace and looking at me funny". Concrete plans to "smash her head in the wall and kill her". States was very difficult to stop himself."*
>
> *"Risks:*
> *Self: thoughts to harm self, nil plan, intent present. "Can't go on like this"*
> *Others: thoughts to harm others. Not walking around with weapon.*
> *Wants though to harm someone.*
> *Neglect: sleeping rough, non compliance*
> *Exploitation: nil"*

5.73 Other notes include the following description of his presentation and mental state:

"Tortured by racing thoughts, ++ content of sexual violence
Contemplating suicide - considered; jumping in front of a tube, drowning with weights in the river or self poisoning….

Describing being particularly affected by what may be ideas of reference and delusional perceptions…

Has taken 100mg Quetiapine almost (?) daily for 2.5 months"

5.74 MB described having "*spontaneous thoughts which he feels compelled to act upon but has so far resisted*". A ward-based urine drug screen was noted to have been positive for cannabis by the admitting SHO but there is no documentary proof of this in the notes. There was a ward round on the day of his admission and the following plan documented:

"Plan: ↑ Quetiapine - 100mg bd; full physical + bloods; MMSE/CAGE questionnaire; Monitor for alcohol withdrawal."

Comment

The symptoms and thoughts that MB was expressing and the manner in which he expressed them should have prompted a thorough review of his presentation. However, there is no assessment of his diagnostic formulation or risk at this ward round. The ward urine drug screen apparently tested positive for cannabis but this was not followed up with a laboratory test. The opportunity to suggest a thorough review of his history and current functioning was not taken.
The dose of Quetiapine was increased to 100mg bd it was not increased as it had been during his first admission (i.e. up to 300mg daily over five days).

The CAGE[16] questionnaire scored 0 for all questions and the MMSE[17] 30/30 for all questions.

[16] CAGE questionnaire: A four item screening questionnaire for alcohol dependence

5.75 On Tuesday 6 June 2006 MB attended consultant psychiatrist A's ward round, and the notes of that meeting state:

> *"Consultant psychiatrist A asks why he does not feel safe outside? MB says he does not feel comfortable & feels he might get panic attacks…consultant psychiatrist A says that as he does not have an appropriate place to live, that's why he likes the ward. Consultant psychiatrist A explains to him that the ward is an alternative place to live…consultant psychiatrist A says that the ward is not a hostel and he can't stay here forever….MB gets angry & says that he does not want to live with his father."*

> *"Consultant psychiatrist A says that whatever MB has described that shows that he is not hearing voices (that he is not hallucinating)….consultant psychiatrist A says that the main treatment is to get him a secure place to live & the care coordinator needs to look into this…consultant psychiatrist A says that according to him MB does not have any well defined psychotic illness… Consultant psychiatrist A says that in few days or weeks, he will like to carry out an assessment to reach to a diagnosis."*

Comment

Consultant psychiatrist A does not address the difference in MB's presentation and the significance of his reported symptoms and behaviour. He appears to have made up his mind that MB had a personality disorder and was being manipulative. He disregarded the possibility that MB might be psychotic.

5.76 It would appear that this was when consultant psychiatrist A decided to take a back seat in relation to his input into MB's care and treatment and handed responsibility to consultant psychiatrist B while he carried out a review of MB's notes and administered a personality questionnaire to try to clarify MB's diagnosis and make

[17] MMSE: stands for Mini Mental State Examination; a systematic objective test of cognitive function including attention, concentration, orientation and memory functions. The higher the score, the better the cognitive functioning.

sense of his behaviour. There is no record in the notes of consultant psychiatrist A's intention, but consultant psychiatrist B recalled what happened in his evidence to us:

"Because of [consultant psychiatrist A's] difficulties with managing him, he asked me to take a view of this man. This happened with other patients as well, so I thought that while the symptoms looked very schizophrenia like, he was in a real dilemma…He was getting concerned about the personality disorder and I remember him saying to me in an exasperated way that he couldn't get to grips with this person because of the evanescent nature of his symptoms… consultant psychiatrist A felt that because he was Nigerian, he couldn't get to grips with the particular London-Turkish culture of this guy and his comings and goings.

Q. But he was still involved obviously in terms of the assessment?
A. Yes, sure. He wanted to complete that and add it to the picture, so we could decide what to do next."

5.77 Consultant psychiatrist A told us that MB was aware that he was going to review his notes and diagnosis but it is not clear that MB knew of the shift in consultant responsibility from consultant psychiatrist A to consultant psychiatrist B. Consultant psychiatrist A said:

"A. When it comes to the issue of managing him, again you have to remember this issue of a team.

Q. Was he aware or not that you were going to shift and take a bit of a backseat?

A. One thing I know he was aware was that I was going to review his case, I was going to discuss his case and then I was going to ask him some questions, I was going to assess him. He was aware of that."

5.78 It is not clear why consultant psychiatrist A, having made this decision, waited until 23 June 2006 to administer the questionnaire to MB or why he had not begun his review of MB's notes by the time MB committed the offences on 7 July 2006.

5.79 Consultant psychiatrist A told us:

> *"What I planned to do was to read through his old case notes and be able to write out his presentation at each point in time, because as of this time there was a lot of information scattered all over the place. The home treatment team had their own thoughts of what was going on, the people at the emergency clinic, that we were going to get this thing, read through and then be able to come to some conclusion, and then be able to see if there was a particular pattern to his behaviour, that when do we say this guy is psychotic, what are the consistent symptoms that have been there. At each ward round, if you look at it, it's different symptoms coming up at different times, so what are the things that are consistent, what are the things that are there. Those are the things I was going to read through."*

5.80 Nevertheless, consultant psychiatrist A continued to contribute to discussions about MB's care. He told us:

> *"…one thing I know is that during those three weeks, when we discussed this case in the management round, consultant psychiatrist B continued to see him with his SpR. I know that, despite that I discussed this case – normally we discuss this case amongst ourselves –*
>
> *Q. Do you mean see him formally in ward rounds or just review him when he was on the ward?*
>
> *A. Formally in ward round, and I think during the course of these three weeks his medication was gradually increased. Then there was the issue of the management of his risk because I know that two weeks prior to the incident there was this management meeting when somebody said he was coming up again with these thoughts about wanting to kill people and things like that. At*

the management meeting we decided that he should stay on the ward. There was active management going on; nothing was really premised on the fact that I was going to do this and because of that the patients are to wait. It was eventually, go through the notes…"

5.81 Entries over the next few days describe MB's florid symptoms of psychosis yet this is not recorded in the management round on 12 June 2006. On 15 June 2006, at consultant psychiatrist B's ward round, the approach appears to have been to increase MB's medication and pay no heed to the possibility that his psychosis was making him increasingly dangerous.

5.82 On 22 June 2006 consultant psychiatrist B's specialist registrar (SPR 3) held a ward round. The notes state:

"Discussed gambling"

"thinking bad things – I think people can read my mind…On the underground, felt like pushing someone on to the track. Last had that thought 3/12 ago. Has always had urge to push people on to track but stops the urge as doesn't want to go to prison. Thinks he will become violent soon."

"I was thinking about bringing poison onto ward and putting it in the drink"
"I don't think I can contain myself"
"My thoughts are genuine and strong"
"I always talk to doctors and nurses"
"Wants to be detained therefore he can't go out and do bad things. Section sounds distressing"

5.83 It seems from this entry that SPR 3 took MB's risk seriously. However, there was no indication of what should be done about it and how it should be monitored, other than to consider detaining him on the ward if he wanted to leave. The dose of Quetiapine was increased to 600mg daily. He was asked to stay on the ward.

5.84 Subsequent notes misrepresent why MB's leave was suspended. They say variously that his leave was suspended because of his habit of staying away from the ward, or being violent towards his father or to monitor his mental state.

5.85 The management round on 26 June 2006 noted *"going on leave"*. This is unclear. There is no indication if this leave was due to his having absconded or having been granted leave by staff. An entry in the notes dated the same day states *"he is currently ward based to monitor mental state",* making his leave status confusing.

5.86 The next ward round took place on 6 July 2006, two weeks after the previous ward round, three days after a management round on 3 July 2006 and after the incidents when MB had lain on top of another patient[18] on 28 June 2006 and the entry made on 29 June by the OT assistant stating MB's threat to buy a gun, pick a colour and return to the hospital and shoot everyone wearing that colour. The ward round was taken by SPR 3. The entry in the notes described the assessment of MB's mental state during the ward round and, in particular, states:

> *"Mental state improved but still paranoid about being out on streets…Not expressing thoughts of harming people…Feels able to spend a few hours off the ward…*
>
> *…Care coordinator was going to d/w his mother whether he could go there on discharge (care coordinator not present)…*
>
> *…Quetiapine increased to 350mg bd...*
>
> *…Leave unescorted 2-3 hours (informal)…"*

5.87 There is no explicit reference to MB's risk or an interpretation of his increased use of Lorazepam. He had been given nine doses of 2mg from 23 June to 2 July 2006 - a high dose.

Comment

[18] See section 4, paragraph 58 of narrative.

SPR 3 appears to have based her decision to reinstate unescorted leave for MB on reports at the ward round of his apparently improved mental state and MB's own view that he was **"able to spend a few hours off the ward"**. ***The reference to him having*** **"informal"** ***status indicates that he was a voluntary, undertrained patient and, presumably, deemed not liable to be detained under the Mental Health Act. SPR's decision to allow leave is consistent with previous decision making regarding leave for MB. However, in the context of his fluctuating disturbed mental state we take the view that this decision may not have been made if SPR 3 had been aware of the full extent of MB's psychosis and risk at that time.***

There are no records of one-to-one assessments by senior medical staff throughout this admission, particularly at the time that MB expressed homicidal ideation. Consultant psychiatrist B in his response to the draft report states that:

> **"…both consultant psychiatrist A and myself see patients on a *"one-to-one"* basis *(however usually with an SHO or nurse in attendance, which is good practice in terms of for example writing notes or improving communication),…"***

We found no record of one-to-one meetings with MB. If such meetings had occurred, the extent of MB's psychosis and potential for acting on his aggressive thoughts might have been picked up. It seems bizarre that despite all the evidence of florid psychosis and threats of violence well documented in the notes, nobody raised any significant concerns and the notes continue to focus on his need for accommodation. Quetiapine was increased to 350mg twice a day.

Personality assessment

5.88 Consultant psychiatrist A decided to assess MB's personality using a questionnaire. He intended to give this personally to MB but he told the investigation that when he went to the ward to do so MB was asleep so he left it there to be given

to him when he woke up. According to the SHO, the questionnaire was administered by SPR 3. The notes refer to MB being given the questionnaire on 23 June 2006:

> *"Angry because he cannot go out. Complained that the doctor woke him up to give him personality questionnaire to fill so that he can work out his mind. Said 'Because of that I am having violent thoughts. If I go out I'm going to get a poison and come and put it in the patients' drink."*

5.89 The personality assessment undertaken is missing but according to consultant psychiatrist A, the assessment was in two parts. MB completed the first part and the second part was to be completed after discussion and clarification with him. Consultant psychiatrist A told the investigation that he saw the self assessment by MB and it indicated that MB had a borderline personality disorder. He told the SHO of his impression. He did not progress with the second part of the assessment. The SHO communicated consultant psychiatrist A's opinion to those attending the ward round on 7 July 2006, noting:

> *"Consultant psychiatrist A assessed him for ?personality disorder by questionnaire. Fits criteria for borderline antisocial."*

5.90 Consultant psychiatrist A agreed that he was not at that ward round. His intention was to complete the assessment but he had not done so before MB committed the offence.

5.91 Despite some difficulties in his relationship with MB, consultant psychiatrist A was in no doubt that he was the right person to evaluate his personality.

5.92 The internal investigation commented on consultant psychiatrist A's decision to carry out such an assessment as follows:

> *"The panel's view is that the material for such a review was readily to hand, and that the bulk of this would support the need to focus on the vigorous treatment of his mental illness, and management of his expressed dangerous*

ideas. The panel did not see the personality assessment that was undertaken, but took the view that the reliability of such an assessment, in someone as apparently actively symptomatic as MB, would be somewhat limited, and would require very careful interpretation, and that the reported findings should have reinforced the need to be more, rather than less, active in his management."

5.93 We asked consultant psychiatrist B what he thought about consultant psychiatrist A undertaking the personality assessment. He answered:

"A. I thought it was rather original. It was a good idea because when you are confronted with these difficult to manage people; one has to think sideways about what is going on.

Q. The internal inquiry came to the view that they didn't think it was appropriate, given his level of symptoms and disturbance.

A. That doesn't conform with my view."

5.94 We agree with and endorse the internal investigation's finding regarding the administration of a personality assessment. Consultant psychiatrist A was right to try to objectify his impression of MB's personality but any interpretation of the questionnaire was likely to have been misleading given MB's prevailing mental state. Furthermore, consultant psychiatrist A admitted that only part of the full assessment had been completed but he prematurely interpreted the assessment as indicating that MB had a personality disorder and said so to the SHO who reported it in the ward round.

Summary comment

MB seems to have obtained Quetiapine from A&E just before this admission to self-medicate. His mental state at this admission was qualitatively different from before and his psychosis much more florid.

The A&E assessment and admission summary give clear evidence of serious psychotic illness and warnings of risk to him and others. Given his presentation on 1 June 2006, we think MB could have committed homicide at any point.

Consultant psychiatrist A did not adequately review all the evidence relating to MB's mental state at his ward round at 6 June 2006. There appears to be no evidence that any member of staff was concerned at MB's presentation.

There appears to be disparity in consultant psychiatrist A's approach (PD and manipulative behaviour) and consultant psychiatrist B's approach (increase medication) but it is not clear what his diagnostic formulation was. Furthermore:

- ***It was not clear from the notes that consultant psychiatrist A was reducing his involvement.***
- ***There was no systematic risk assessment or clear acknowledgement of the potential risk that MB posed both to himself and others.***
- ***Leave arrangements were confused.***
- ***The plans made at ward rounds were not followed through.***

Significant medical themes

5.95 We turn now to identify significant medical themes and comment on their impact on MB's care. There are essentially three main categories: the first is the role of medical staff generally and the joint consultant model in particular; the second is the narrow medical model of care used in relation to MB and its effect and the third is the relationship of the hospital-based medical staff with the community teams.

Roles of medical staff

Joint consultant model

5.96 This was a model of working which appears to have been devised by consultant psychiatrist B and entered into by consultant psychiatrist A after he joined the trust in

2004. Essentially, patients were not specifically allocated to one of the two consultants but a form of shared care was adopted. This model seems to have applied to inpatient care. The internal investigation report comments on this arrangement:

> *"Whilst the value of joint management/referral meetings, involving both Consultant teams, is clear, the panel's view is that clear accountability and clinical leadership from a single Consultant in respect of each patient (in hospital and in the community) is necessary. This should not detract from the value of cross-cover nor prevent the identification of specific roles for each Consultant. The reliance on junior medical staff to record medical and MDT reviews detracted from the authority of these records and was stated by consultant psychiatrist A not to be an entirely accurate reflection of his comments."*

> *"The assumption of primary Consultant responsibility by consultant psychiatrist B from consultant psychiatrist A was not documented and was not clear to all (but was to some) members of the MDT. It is unclear whether the patient, MB, was aware of this."*

5.97 Part of its recommendation states:

> *"The caseload of patients cared for by the South East Locality should be reviewed and allocated to one or other of the two Consultants. Members of the MDT and Community team should be clear as to which Consultant is responsible for whom."*

5.98 We have reviewed this arrangement because we believe it had a greater impact on the care received by MB than appears in the internal investigation report. It was labelled a 'joint consultant model', but we think it did not in fact operate in that way and this further confused the situation. We are also not confident that the recommendation in the internal report was fully carried out.

5.99 Consultant psychiatrist B told us the joint consultant model was a pragmatic approach to the fair allocation of patients. He told us that all the patients were discussed in the Monday management meetings and the patients they were allocated to was agreed. He also said he believed:

> *"There was never any uncertainty in the nurses' minds as to who was the RMO…"*

5.100 He told us he did not think the internal inquiry was right to recommend that the joint consultant model should stop. He believed that the recommendation was included as:

> *"They wanted us to make it more overt as to who was who and in order to make it easier for the next inquiry."*

5.101 To comply with the recommendation of the internal inquiry consultant psychiatrist B told us they had now produced a document that set out the:

> *"(patient) names, ages and so on, CPA times, care coordinator and we have just added in the column behind the name a little bracket with "dr ?" or "Dr?", so it is more explicit. In that sense we have made it more explicit to those coming from the outside, but it has never been inexplicit to those working on the ward."*

5.102 Consultant psychiatrist A was not as enthusiastic as consultant psychiatrist B about the joint consultant model:

> *"Even when it comes to the patient in the community it was quite difficult, because in essence it appeared that [consultant psychiatrist B] had always been there, so he's had times of having locum consultants coming in and going, so virtually every patient was attached to him. Even on the file, every patient's*

consultant was consultant psychiatrist B, irrespective of who was there or left and things like that."

"I felt that the practice was not the ideal."

5.103 Consultant psychiatrist A told us it had now changed and that:

"…we have our patients now and they are properly labelled as this belonging to consultant psychiatrist B or to myself."

5.104 Consultant psychiatrist B thought that the nursing staff were clear but we found in our interviews that there was confusion about which consultant was responsible for which patient. Apart from the obvious difficulty of knowing which consultant had responsibility at any one time, the other problem with the joint consultant model was that there were more opportunities for responsibility for the care to be diluted rather than focused. This model of working may seem to have advantages but the care MB received highlights the disadvantages. The evidence suggests that consultant psychiatrist B was the *"default"* consultant because he had been in post longest and had had a number of other consultant colleagues before consultant psychiatrist A arrived.

5.105 Consultant psychiatrist B was responsible for training a specialist registrar and the two ward-based junior doctors. The specialist registrar in effect made decisions in his or her own right when they were involved, increasing the joint working to three. We understood that the joint consultant model applied only to inpatient care and that consultant psychiatrist A was responsible for patients in the community but in MB's case, he was not solely managed by consultant psychiatrist A as an outpatient either. In fact, there was no clarity about which consultant was responsible for outpatients. The HTT had a separate consultant but the consultant relationship with the SELT was not evident. The internal inquiry report said:

"Consultant psychiatrist A's job, by his own account, entails a greater proportion of his time involved in the Community team (SELT) than that of

consultant psychiatrist B, and more time devoted to this aspect of his work than to in-patient care."

5.106 We did not find this written down anywhere and it does not seem to have necessarily been the situation in relation to MB.

5.107 The communication between all three doctors leaves something to be desired. This is exemplified when MB was admitted by SPR 2 on 23 February 2006. SPR 2 was consulted by SGD (who seemingly could have contacted any of SPR, consultant psychiatrist B or A). SPR 2 agreed for MB to be admitted with a clear management intention to consider starting him on Clozapine and an acknowledgement that he was not coping in the community. After his admission it was agreed at the ward management round on Monday 27 February 2006 (which SPR 2 may or may not have attended) that MB would be discussed at consultant psychiatrist B's ward round on Thursday 2 March 2006. This did not occur as he was discharged *in absentia* by consultant psychiatrist A on Tuesday 28 February 2006.

5.108 There is no record that the SGD's reasons for suggesting admission (agreed by SPR 2) were passed on to either consultant psychiatrist or the inpatient team, and, if they were discussed at the Monday 27 February 2006 meeting, the decision for MB to be discharged next day would have been contrary to what was agreed the day before.

5.109 Similarly, after MB was admitted on 1 June 2006, initial decisions about his treatment appear to have been made by consultant psychiatrist B (at a ward round on Thursday 1 June 2006), his treatment was reviewed at a management round on Monday 5 June 2006 and then MB was reviewed in consultant psychiatrist A's ward round on Tuesday 6 June 2006. The next ward round he attended was consultant psychiatrist B's on Thursday 15 June 2006.

5.110 Consultant psychiatrist A commented on how the lack of clear medical continuity and consistency had resulted in an unclear picture of MB's needs and diagnosis and a lack of thorough review. He told us that several different doctors saw MB and that that:

"…pushed us to the point in June that somebody will need to sit down to put all these things together. ….the fact is you have different people doing these things and you have a gentleman that keeps on coming up with different presentations at different times, so different people had different pictures of who he was, and that was difficult."

5.111 The problem with the model was that it was difficult to know which consultant was responsible at a given moment for the overall care and treatment of MB. Consultant psychiatrist B told us:

"The responsible consultant would be as defined at the time by who was seeing him regularly on the ward. If consultant psychiatrist A was seeing him, he would be seen as the responsible consultant; if it was the home treatment team, the home treatment team consultant. That is how it was handled."

5.112 It would appear that, according to consultant psychiatrist A, when MB was first admitted, he was consultant psychiatrist B's responsibility because SPR 1 saw him in the early ward rounds. At some point during his admission in June 2005, consultant psychiatrist A took lead responsibility but his community involvement is not clear when MB returned from Turkey. For example, MB was reviewed in March 2006 at the SELT offices by SPR 2, who was consultant psychiatrist B's SPR. Consultant psychiatrist A seems not to have known this. He thought he was MB's consultant at that time, rather than consultant psychiatrist B.

5.113 The SHO told us that "*as far as I'm aware, the information I was given was that all the patients were under shared care*." She also felt that the arrangement worked well.

5.114 MB appears to have been under the care of consultant psychiatrist A after his admission in June 2006, although this is not obvious from the records. Indeed, if we had not been able to interview either consultant psychiatrist, it would not have been possible to find out which consultant was responsible for MB's care and treatment at any one time. Responsibility during this admission appears to have shifted to consultant psychiatrist B, although this is not clear. There was no formal handover.

Consultant psychiatrist A asked consultant psychiatrist B to become involved and it would seem that he then become the responsible consultant. If so, given that the ward round on 22 June 2006 was taken by SPR 3, it would mean that consultant psychiatrist B was the responsible consultant at the time MB committed the offence.

Conclusions

C14 The joint consultant model appears to have led to discontinuous and disjointed provision of medical care to MB. The lack of an identified consultant with continuing responsibility meant that ultimate responsibility for MB's care was blurred. It appears to have resulted in unrelated assessments that failed to convey important information between and to the consultants to inform care and treatment planning.

C15 The internal inquiry came to the same conclusion but consultant psychiatrist B does not accept it and he has paid little more than lip service to their recommendation of identifying clearly which consultant retains responsibility throughout an inpatient stay and beyond.

Recommendations

R1 The current model of working between the consultants and specialist registrars should be further examined to ensure that there is an explicit, single line of consultant responsibility throughout a patient's inpatient stay and that responsibility is retained as an outpatient, with the SELT team and at subsequent admissions.

R2 Consultant psychiatrist B's specialist registrar should not make decisions on behalf of consultant psychiatrist A.

R3 Where one consultant takes over the care of a patient from another, such a handover should be documented in the medical records.

R4 Consultants can still provide second opinions but these should be identified clearly as such within the notes.

Working relationship between the two consultant psychiatrists

5.115 The joint consultant model implies that both consultants carried equal seniority and responsibility. If this was the case, it would at least be possible to say that both consultant psychiatrists carried equal responsibility for MB's care. Our investigation suggests that this was not true.

5.116 Consultant psychiatrist A commented that the working relationship between himself and consultant psychiatrist B seemed at times to be one where he played a subordinate role. He appreciated consultant psychiatrist B's experience and help in orienting himself to working in the UK after he arrived from Nigeria but he told us he *"…felt like a glorified SpR."*

5.117 Consultant psychiatrist B accepted that he was the senior colleague as he told us *"I've simply been in the business longer…"* His response when asked whether consultant psychiatrist A viewed himself as on a par with consultant psychiatrist was:

> *"A. He's often asked me about things. Clearly I am his senior colleague because I've simply been in the business longer and got less hair and he often would ask my advice and discuss management of cases, but we've never had differences about things in general.*
>
> *Q. Do you think he had the same authority with the staff that you would have had, or do you think they viewed him more as a specialist registrar?*
>
> *A. I can't really say that. He preferred to let me lead the Monday meetings because I've been around longer and all that kind of thing, but we share it essentially. How the staff view him I couldn't say. Obviously I am the senior and he is more community based than ward based because there is a slight imbalance of how the jobs were set up, but we are both consultants and they ask both of us for advice."*

Comment

Our impression was that consultant psychiatrist A, although of equal standing to consultant psychiatrist B as consultant grade, viewed himself and was probably viewed by others as a "junior consultant" who felt ill-equipped to challenge the status quo of the joint consultant model and to establish his autonomy as a consultant in his own right. He perceived that patients were viewed as belonging to consultant psychiatrist B and it appears that his involvement both directly and through his specialist registrars was significant throughout MB's illness. If the recommendations in the previous section are implemented and there is greater clarity over consultant responsibility, this issue may be resolved.

Roles and supervision of non consultant grade doctors

5.118 Consultant psychiatrist B to us that "*The substantive medical team for Conolly ward are consultant psychiatrists A and B, the specialist registrar and the two juniors, the SHO and the PRHO.*" He was also the trainer for the specialist registrar and the two juniors.

5.119 Consultant psychiatrist A confirmed that one of the SHOs on the ward (the pre-registration house officer) would have been inexperienced as he/she was doing psychiatry as an alternative to medicine or surgery before registration with the General Medical Council. He also said he was not sure how the SHOs organised their work on the ward. He had little involvement with the work of the specialist registrar. He told us:

> *"Whatever they did had to be referenced to consultant psychiatrist B because essentially they were his SpRs. As I say, they held ward rounds as well on Thursday alongside him."*

5.120 MB saw a number of doctors over the 13 months as inpatient and outpatient. The ward doctors were junior doctors with little experience of psychiatry. There were three consultants and three specialist registrars and one staff grade. All were experienced in psychiatry. MB was assessed by a senior doctor (SpR, consultant or staff grade) on an individual basis (i.e. not in a ward round) on only three occasions.

5.121 There appears to have been little coordination or organisation in how these doctors worked. The failure of the various doctors to provide continuity of care for MB led to decisions about his care which were not informed by recent or previous assessments by colleagues. Assessments by individual doctors were generally thorough and provided useful information but it is difficult to tell whether this information was being used in the management meetings and ward rounds.

5.122 There appears to have been little appreciation of or input to care planning by medical staff as well as others and no incorporation of CPA and formal risk assessment into clinical practice.

Comment

We were told that a joint consultant model was practised but our impression is that consultant psychiatrist A had little influence over the working practices of the ward-based junior doctors and was not informed about decisions made by consultant psychiatrist B's specialist registrar. In reality, consultant psychiatrist B both behaved as and was viewed as the more senior consultant. We do not know whether the lack of clarity over consultant responsibility led to the lack of coordination between the more junior doctors. The combination of these factors led to fragmented and discontinuous care for MB.

Recommendations

R5 Trainee doctors working in psychiatry in the trust should receive formal training in the role of CPA and risk assessment.

R6 If consultant psychiatrist A is not approved as a trainer for junior doctors, he should be provided with alternative ward-based medical support to help him manage his allocated inpatients.

Model of care

5.123 During MB's period of care it is evident that the approach to care was a narrow medical model: *"patient has schizophrenia, treat with drugs, attend ward for medication and opportunity for mental state review, patient gets better, discharge, prepare discharge summary"*. The ward round arrangements give a superficial impression of multi-disciplinary care but truly multi-disciplinary planning or CPA planning for MB was rarely if ever achieved and a narrow medical approach prevailed. This was reflected in the structure of meetings on the ward.

Ward rounds and management round

5.124 The Monday management round was a notes review identifying patients who needed to be reviewed in person that week (either to assess their mental state or as part of a CPA review). The number of patients staying on the ward or on leave meant that not all patients could be reviewed every week. Consultant psychiatrist B described the Monday management round as: *"…the major organising meeting, defining the ward rounds for the next couple of weeks in part at least."*

5.125 Consultant psychiatrist A added:

> "*The management meeting covers all the patients and it's a general discussion with the multidisciplinary group. Then we just look at those ones that need review and they need to be seen, then we allocate them for those days."*

5.126 The SHO also told us that consultant psychiatrist B would chair the meeting and that:

> *"The community mental health team would also be present along with the nursing staff from the ward. We would go through recent updates, how things had been over the weekend and talk about any changes that needed to take place or things we needed to do before the ward round on the following day, Tuesday."*

5.127 She told us that the junior doctors would write up the notes in the patients case files and the nursing staff would also write up notes in a ward round book.

Comment

Although the purpose of the Monday management meeting was described to us as a largely administrative one, in fact the records show that clinical decisions regarding MB's care were made during that meeting and there was a blurring of the boundaries between the management round and the Tuesday and Thursday ward rounds.

5.128 Consultant psychiatrist A acknowledged that ward rounds would review only a about five or six of the total number of patients but that there was also consultant psychiatrist B's ward round on Thursdays and the SpR would also hold a ward round at the same time, so there were three ward rounds a week. This still meant that a maximum of about 18 patients would be reviewed each week out of a total of up to 35.

5.129 The SHO confirmed that during the ward round she was clear what type of review was being undertaken:

> "*It was pretty clear. At the start of the ward round we would set out which patients should be seen – although that would have been decided beforehand – and then the community mental health team would bring patients who they were also worried about. On the whole, it was clear.*"

5.130 Consultant psychiatrist B also described another Friday ward round whose purpose was principally to:

> "*…put the ward to bed for the weekend and go through all the patients with the nursing staff and exactly what was going to happen about them to catch up to Monday.*"

5.131 Consultant psychiatrist A noted that sometimes there was a loss of continuity soon after admission as patients would be transferred between doctors regularly. He told us:

> *"Quite often something that might have happened quite a lot is a situation where you have a particular patient on admission and then during the management meeting, if you say, 'I saw this patient last week, will you see this patient this week?' which again is not the best practice really, looking at it now. That happened quite a lot."*

Conclusion

C16 We were told by a number of interviewees that the management rounds identified which patients would be reviewed as part of the CPA process but there is little evidence from the notes that this was the case. The ward rounds generally operated as 'normal' medical rounds (see section 6, CPA).

Recommendations

R7 Consideration should be given by the trust to having a non-medical individual with the requisite seniority, such as ward manager or senior OT chair the Monday management meeting, CPA reviews or ward rounds.

R8 The role and purpose of the Monday management round and Friday *"putting to bed"* round should be evaluated and clarified by the trust.

R9 Clinical decisions should not be made within the Monday management round.

R10 Each consultant should only review their own patients during their ward rounds (unless covering the leave of another consultant).

One-to-one reviews by senior doctors

5.132 As we say above, the notes do not record that the consultants reviewed MB on a one-to-one basis. Consultant psychiatrist A said the pressure of work would not allow it, though he accepted it would have been good practice.

5.133 The lack of one-to-one assessment by the consultants meant that they relied on assessments by junior doctors and ward staff. However, the quality of information provided was variable. Consultant psychiatrist A said:

> *"You have a situation where you have ward rounds and you have the staff coming to talk about this patient, and they can't give any clue as to what was going on in the ward in the past week."*

> *"Sometimes you have some of the staff documenting and writing things down who are not really trained, and you read through what they've written and I say, 'What is this? When did this take place?' and they will start arguing among themselves."*

Conclusion

C17 The failure by senior medical staff to review MB on a one-to-one basis meant that his care was not effectively overseen by senior medical staff. There was no collective understanding of him and no one took responsibility to bring together the variety of different assessments to develop a suitable plan to be followed by all who cared for him. Consultant psychiatrist A suggested this during MB's final admission in June 2006 but there is little evidence that any progress had been made before MB killed JC.

Recommendation

R11 Both consultant psychiatrists should examine how the added value of one-to-one assessments would improve their clinical decision-making, the rationale for when

such assessments would be appropriate in individual cases and how undertaking such assessments could be incorporated into their work schedule.

Record-keeping

5.134 Both consultant psychiatrists relied on others to record in the patient notes details of what was discussed at ward rounds. Consultant psychiatrist A expressed surprise at the quality of what was recorded in the notes:

> *"Unfortunately, reading through the notes of that meeting, I was amazed at what was written down, because that's [not] what we discussed, not even in that meeting alone. The Monday before, which was the management meeting, we discussed part of this as well, so that's part of what we discussed, that this gentleman needs help. He needs help with accommodation, we know that.*
>
> *Some of this discussion took place within the meeting and outside the meeting, when he was there and even when he left. That's why I am surprised that these things were not documented."*

5.135 Consultant psychiatrist A admitted that he had not made a habit of reading through his patients' notes:

> *"To be very sincere, I wasn't doing that much before but now I do: okay, what has been written about this person, let me see…It's a bit of a problem. This was an eye-opener to me because now I take time to read through patients' case notes."*

5.136 Consultant psychiatrist B told us that it was part of the junior doctor's training to take notes of what was discussed and that they were well aware of what to include in the notes. Despite this, the SHO's recollection differed:

> *"Not guidance, no. I had a very brief induction period. I had a couple of sit down sessions with consultant psychiatrist B who said "These are the sort of things we would want you to document in the notes.", including mental state*

examinations, any discussion or telephone discussions we had with various team members. There was no formal education, but there was informal education."

"A lot of it was also going back in the notes and seeing what other people had done and what sort of things had been documented, so I was trying to follow that pattern. At the start I would check with my consultants whether I was entering things as I should be and the general feedback was that I was, so I felt fairly comfortable with that."

Comment

Accurate note-taking is important, especially in the context of a busy ward with high levels of risk and when a variety of different staff are caring for an individual. It is therefore important that clear guidance, training, and review of notes is undertaken, otherwise important decisions and judgements will be lost, to the detriment of effective care planning.

Recommendations

R12 Consultants should supervise what is recorded in the notes.

R13 Trainee doctors should receive structured training on how to record discussions in ward rounds in particular and what to write in the notes in general.

R14 At each ward round an explicit management plan should be recorded in the notes, including treatment and non-medical interventions proposed and risk management.

Discharge summaries and risk

5.137 The reliance on a narrow medical model is exemplified by the approach to discharge summaries and the identification of risk. Consultant psychiatrist B confirmed

that the discharge summaries prepared by the junior doctors did not contain a heading relating to risk or risk management. His view was that the discharge summary served its purpose in providing information to the GP or to an on-call doctor. The formal risk assessment and management plan should be adequately covered by the CRAM 1 and CRAM 2[19] documents.

5.138 Consultant psychiatrist B believed that medical discharge summaries covered risk by commenting on a patient's forensic history, an assessment of their mental state, recent history and older history. To comment on risk in the discharge summary would mean unnecessary duplication or be meaningless.[20] His view is summarised in the following from his interview with us:

> *"[The discharge summary] is meant to be a summary of the management plan and, as I've mentioned, you have the medication you think is appropriate, the level of CPA monitoring, 1 or 2, the follow up arrangements and who will be seeing him. What more are you meant to put there? Do you say "This person on a risk score of 1-10 is at 1.3 risk of self harm."? How will that actually help your practical management subsequently?"*

> *"I was trained to assess people in terms of their mental health and their past history and the key feature about risk in the future is what they have done in the past. That remains the single, core outstanding feature. That is built into the history you have there - forensic history, history of actions and so forth…"*

5.139 In fact, the discharge summary relating to MB's admission in 2005 carries no information on his risk at that time and the discharge summary part 1; dated 23 June 2006 relating to his admission from 1 June 2006 has a section under forensic history that says:

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[19] CRAM 1 is a risk assessment checklist and CRAM 2 is a risk management form which should be completed to set out a management plan to deal with the assessed risks.

[20] In consultant psychiatrist B's comments on the draft of this report he recommends that we review the Royal College of Psychiatrists report *"Rethinking risk to others in mental health services"* Extracts of this report are attached at appendix A and provide guidance on the content of discharge summaries. This guidance does not support consultant psychiatrist B's view of what they should contain.

"Denies carrying weapons. Has thoughts of harming others. History of possible sexual molestation of family members and strangers. Has attacked prostitutes with a knife. Has had no previous convictions. Currently an ongoing Social Services investigation with the alleged sexual assault on his brother."

5.140 This is not only factually incorrect (there was no record that MB had ever attacked anyone) but fails to make any comment on the likelihood of any repetition of these alleged offences.

5.141 The SHO told us she was given guidance on what to include in discharge summaries. This was to include how patients presented, how they were on presentation and what management plans were to be put in place. She told us she:

"…was always advised to mention the risk within the mental state examination. In this case I had put it in the forensic history on the part one summary, so I did talk about his risk and some of the previous investigations that had been going on, but it was probably not a formal risk assessment as to what the care coordinators would organise."

5.142 The SHO also had to complete discharge summaries for patients she had never met:

"When I started in February there must have been at least a month's backlog that I was catching up on and these were patients who I hadn't actually met myself, so I was having to start from scratch and go through the notes. That was something that both consultant psychiatrists were aware of and that I had flagged up with them on a number of occasions."

5.143 MB often made specific threats towards himself and others while he was in hospital. These are dealt with in the CPA section of this report. It is enough here to note that his statements ranged from serious self-harm to homicide, including pushing someone under a train.

5.144 These threats were never systematically assessed or addressed during ward reviews. It is significant that among his many threats, only what he said in 2005 about abusing his brother, sister and cousin when he was younger and fantasising about young girl's legs and thinking about having sex with his mother later became the focus of his mental state.

5.145 The discharge summary for this period of treatment states:

> *"He was quite preoccupied with themes of child abuse, and reported that he had abused his brother and sister and cousin and also reported that he was abused himself by his cousin. However, he is not sure whether these things really happened or not."*

5.146 There was no analysis of his statements about allegedly abusing others or being abused as to whether or not these thoughts formed part of his psychosis and/or whether it needed to be investigated. There was no formal risk assessment or opinion given about risk to himself or others and no indication of his level of CPA.

Comment

Consultant psychiatrist B's firm view was that the discharge summary should be a standardised summary of a patient's presentation and progress in hospital. Any information on risk could be gleaned from what was contained in their forensic history and the description of thoughts and behaviour contained in their presentation and background history. There was no need for a separate section on risk assessment or risk management.

This approach further identifies that during 2005/6 CPA and medical approaches to care management were operating in parallel and that ineffective risk assessment and risk management plans were the consequence. Furthermore in MB's case this led to a serious failure to assess and manage his risk.

Recommendations

R15 The discharge summary should refer to and be accompanied by the risk assessment and management tools when sent to the GP, or include specific sections addressing the risk assessment and management for that individual.

R16 Doctors who have not been involved with a patient's care should not prepare that patient's discharge summaries.

Alleged cannabis use

5.147 One of the issues relating to MB's behaviour and his diagnosis was his alleged use of cannabis (skunk). The only evidence that MB smoked cannabis was given by MB himself. The drug screens on 4 June 2005, 13 July 2005, 10 August 2005 and 15 August 2005 found no illicit drugs. The only drug screen positive for cannabis was after MB was admitted on 1 June 2006. No clear medical direction was recorded about how to interpret his drug-taking given these negative results.

5.148 Nevertheless, the discharge summary after his first admission states:

> *"MB also continued to cause problems on leave with smoking cannabis. He would often come back to the ward having taken cannabis and his mental state would obviously deteriorate following this and his urine screens were often positive."*

5.149 There is no evidence to support this comment. There may have been ward based drug screening but if so the results were not recorded.

Comment

None of MB's negative drug screens were commented on in the notes. He said on admission that he had not used cannabis for two days (and later said two weeks) before his admission. The fact that the drug screens were negative supports this

and is significant, particularly given later references to his alleged drug use (£10 per week for two years and four joints a week on skunk marijuana) and references to a diagnosis of* "drug induced psychosis". *The negative drug screens should have provoked comment and diverted diagnosis away from a drug- related cause. MB's drug use (if he did use drugs) may have had nothing to do with his psychotic symptoms. There should have been greater effort to establish his drug use.

Recommendations

R17 Drug screening must be systematically and routinely carried out on any patient suspected of using illicit drugs.

R18 The implications of a negative drug screen when a positive screen was expected should be noted.

Overall diagnosis and formulation

5.150 MB received a number of diagnoses or putative diagnoses following his admission in June 2005. These included psychotic episode; cannabis-induced psychosis; schizophrenia; hebephrenic schizophrenia; paranoid schizophrenia; and borderline anti-social personality disorder.

5.151 The psychiatrists agree that at his first presentation he had symptoms of psychosis compatible with a diagnosis of schizophrenia throughout his first admission. He claimed to be using cannabis but none of the urine drug screens undertaken during his first admission were positive for cannabis.

5.152 Nevertheless, an assumption was made by his clinical team that his mental state was influenced by illicit drug use. Indeed, the discharge summary after his first admission says:

"He would often come back to the ward having taken cannabis and his mental state would obviously deteriorate following this and his urine screens were often positive."

5.153 There is no evidence in the notes to support this comment but this assumption led to a diagnosis of cannabis-induced psychosis being considered.

5.154 It is only during his second admission in February 2006 that the possibility that some of MB's behaviour was attributable to personality disorder was raised. Thereafter, the diagnostic formulation seems to have drifted away from that of schizophrenia in favour of borderline and anti-social personality disorder with psychotic symptoms, gambling and use of cannabis.

5.155 Consultant psychiatrist A told us:

"When MB presented at first, in 2005, there was not a single doubt in our minds that he was very psychotic and that he needed treatment, and we started treatment. However, if you look through from June 2005 to October 2005 you will find that, although he was on admission, he spent more time out of the ward than being on the ward. Essentially he took the medication, he would appear stable… He might go for two weeks on medication and then, as soon as there was a problem at home either with his mother or with his father, or perhaps he had gambled and lost a lot of money, he will be back in crisis."

5.156 However, consultant psychiatrist A recalled how he did not believe that all of MB's behaviour could be explained by his psychosis. He told us:

"Our concern was that beyond the issue of psychosis there were issues that we needed to look at: the issue of drug use, issues of gambling. On top of that, before he went to Turkey there was the fact that there were some behaviours he started showing that each one of us started thinking that beyond this issue of psychosis there is something underlying this….he was testing boundaries, asking, if I did this what do you think would happen, and there were times that he was very aggressive even towards members of staff. To my mind, I had no doubt

that this guy was quite psychotic, and I believe that when he was on antipsychotics those things remitted….something that became more and more evident were his bad behaviours, but at no time did we as a team doubt that this guy has been psychotic, at no time…what I think we agreed on was most likely that this guy had both of them, that this guy was psychotic and had personality issues."

5.157 Consultant psychiatrist B thought MB's symptoms were consistent with a schizophrenic type illness:

"…so I thought that while the symptoms looked very schizophrenia like, [consultant psychiatrist A] *was in a real dilemma. He couldn't work out what this guy was on about because of his comings and goings to Turkey, his father, his drug taking or whatever it might be.*

He was coming round more and more to the idea that he had a personality disorder and what is interesting about this particular journey that we made is that when I went to the CPA meeting at Broadmoor, exactly the same things were happening there. No one could quite fathom out what was the matter with this guy.

My other point would be that he is very difficult. I have been a consultant for 21 years and there have been perhaps two or three people who are as difficult to fathom out as this guy."

Comment

Consultant psychiatrist B's view that MB had schizophrenia seems to have made no difference to the treatment he was given after he took over day-to-day responsibility for him from consultant psychiatrist A.

5.158 The SHO's memory of MB's presentation provides a helpful picture:

"Initially MB came across as very anxious when I first met him. He was very young as well. The impression I got on the first few occasions I met him was that

he had come from what seemed like a very disturbed childhood and had quite a disrupted upbringing as well. He wasn't quite sure where he was heading in life and he gave the impression of being still very much childlike. His interaction on the ward was fine; at times he got quite anxious, but he wasn't aggressive on the ward. When I asked to speak to him, he would happily come and talk to me. He spoke to nursing staff appropriately and seeing him on the ward with other patients I would say his behaviour was appropriate."

"It was during the June admission that I got to know MB quite well. There were questions over his diagnosis. I remember there being lots of discussions at ward rounds as to whether this was a borderline personality disorder, although he did exhibit psychotic symptoms as well. There was a lot of discussion around that and it seemed to me that he was unwell and there was a diagnosis, but I wouldn't be experienced enough to have made that diagnosis. To me, at that time I would say he was exhibiting psychotic symptoms."

"To me it seemed as if he was stuck in his adolescent years. He wanted attention; he hadn't had a very good upbringing from the sound of what he recalled to us. He was scared to go back home and he mentioned that on a few occasions. He didn't want to be discharged him [sic] and he didn't really have a home to go to because of the social services' investigation into what was going on at home with the alleged assault with his younger brother. There were a lot of issues there and he came across as a needy man."

5.159 Dr E, forensic psychiatrist at Broadmoor Hospital, view was that MB had hebephrenic schizophrenia. He told the investigation how the diagnosis had been arrived at:

"In very brief terms, speaking from where we stand at the moment, during his first admission to Broadmoor Hospital we had a lot of debate about his diagnosis and whether he had a schizophrenic illness or whether he had a personality disorder with a lot of histrionic borderline features. At the end of his first admission, and the reason that he was sent back to prison, was that we came down on the side of personality disorder initially. That was contrary to the

views of most other psychiatrists who had seen him….That was our initial view….He went back to Belmarsh, he was re-referred, I went to see him and he was readmitted and we reviewed the diagnosis and changed our mind. In essence, we were wrong the first time round."

5.160 He acknowledged the difficulty in diagnosing MB and the importance of deciding whether he had a personality disorder:

"…it was a reasonable thing to work through. There were lots of features of his presentation that were not typical of schizophrenic illness. For example, his willingness to take medication, his determination to stay in hospital, which is not typical for schizophrenic patients, his fleeting symptoms, the symptoms changing, the difficulty of pinning him down; he would lie and admit to lying, admit not telling the truth occasionally and all that sort of stuff, which muddied the waters. He would say things like, 'I'm having delusions', and if you're really having delusions you can't say you're having delusions because it doesn't make sense. All those aspects of his presentation, combined with the fact that he faced being sentenced for the serious offence, and combined with the fact that there was not a lot of evidence of mental illness around the time of the index offence. We struggled with the same issues, certainly initially."

5.161 Dr E said MB's improvement on antipsychotic medication and a diagnosis of hebephrenic rather than paranoid schizophrenia had dispelled any doubts about a possible diagnosis of personality disorder:

"Firstly, those aspects of his personality have improved with the depot medication, and with the recognition, with the benefit of hindsight, obviously, that his schizophrenia is predominantly hebephrenic and not paranoid, which makes a difference to how you view his mental state retrospectively."

5.162 He commented on the difficulty in diagnosing people with hebephrenic schizophrenia:

"…from my own experience of having had patients with hebephrenic schizophrenia, they are more difficult to diagnose because the predominant symptoms are abnormalities of affect and thought disorder. The more typical psychotic symptoms such as auditory hallucinations and delusions are much more fragmentary and fleeting and vary, and their behaviour is often quite variable and seen as devious or manipulative or difficult. It is more difficult to reach a firm diagnosis."

Comment

It is clear that MB became a difficult patient to diagnose and that this caused problems in formulating a treatment plan. There is universal agreement that during his first admission he had well-defined symptoms compatible with a diagnosis of schizophrenia and he was treated for this condition. Consultant psychiatrist A acknowledged that MB remained symptomatic when he went to Turkey in October 2005.

There are clear similarities between the symptoms MB was describing in 2006 and those he had in 2005. Furthermore, elements of his behaviour led to uncertainty in the minds of the various psychiatrists about his definitive diagnosis. We accept that MB became difficult to diagnose and that his presentation, particularly in 2006, was not straightforward.

We are not critical of the fact that no conclusive diagnosis was made while MB was a patient of the Homerton Hospital. In fact, a number of possible diagnoses were considered, including a tentative diagnosis in February 2006 of hebephrenic schizophrenia (the current diagnosis). We do criticise the fact that this diagnosis (like others) played little part in his subsequent treatment and was ignored or overlooked in further considerations of his medical care. This shows clearly that however comprehensive assessments are and however accurate the consequential diagnosis, without effective communication and care planning arrangements they are of little value.

Liaison with the community teams

5.163 We were told by a number of interviewees that members of the SELT team and home treatment team routinely attended ward round but, this is not reflected in the records of these meetings. Indeed, there is little evidence of any meaningful input to or liaison between Conolly ward and SELT and home treatment.

Recommendation

R19 The liaison between Conolly ward and the community teams must be examined and improved, with clear records of attendance of community team members at ward-based meetings, CPA reviews and ward rounds and their involvement in and contribution to such meetings.

SELT meetings and working with SELT

5.164 Consultant psychiatrist A confirmed that he attended the meetings held by the SELT team on Wednesday afternoons. He told us that in these meetings they would:

> *"…discuss what we call clinical issues, in the sense that if there are problem patients that the team need to know about. Such cases are raised up and then we will discuss them, offer advice or plan as to what we should do."*

5.165 He also told us that he could not recall ever talking about MB in one of those meetings and we have also found no record of his having been discussed.

Comment

Given this level of communication it is difficult to understand how consultant psychiatrist A was so unaware of the SELT team's involvement with MB at the time of the transfer to SELT from home treatment in February 2006 and the decision to involve the children and young people's department and subsequently undertake a visit on 27 March 2006. It is also unclear why SPR 2 and not consultant psychiatrist A saw MB at outpatients on 15 March 2006.

Recommendation

R20 Clinical and management decisions made by the SELT should be contributed to and endorsed by the relevant consultant.

Role of home treatment team

5.166 The home treatment team played an important role in MB's care in 2006 (and could have played a bigger one both in 2005 and 2006). However, there was little clarity about its role, which led to decisions being taken in relation to patients which were not related to the needs of the patient. Consultant psychiatrist A told the investigation that he saw home treatment as an alternative to hospital admission but that at the time the home treatment team functioned more as a crisis intervention team: *"It will be very unlikely for home treatment team to continue seeing a patient beyond a month"*.

5.167 Consultant psychiatrist A acknowledged that facilitating early discharge was part of the remit of the home treatment team. They would accept a patient only after their own assessment and then *"…may only stay with that patient for a couple of weeks before wanting to hand them to the SELT"*.

5.168 Consultant psychiatrist B described his understanding of the roles of the home treatment team:

> *"There are two. The first is to improve the quality of care we can offer to people outside of hospital and the second is to minimise the need for the length of stay in hospital, either by avoiding admission or by hastening discharge."*

5.169 We asked him if he thought they were fulfilling those objectives during 2005/6. He thought not because they were under-resourced but:

> *"They have started to be more successful now we have two consultants involved in running them, north and south. They are better staffed now, but it is still too*

early to judge in the context of somewhere like Hackney where 30-40% of admissions don't have a home, so you can't home treat them and 70-80% are under sections. We'll see."

5.170 Consultant psychiatrist B also agreed with consultant psychiatrist A that the HTT was functioning at that time as a crisis intervention team. He told us:

"I think that they saw themselves as a crisis intervention team in the standard way of a format as outlined in the NHS plan. Obviously delivering treatment at home was one of their roles. It is a good question as to when a crisis intervention team is a crisis intervention team and when it is a home treatment team. In a sense it points out some of the anomalies of trying to define treatment by where you do it or the context in which you do it as opposed to whatever the patient might need."

5.171 At the time of writing this report there is still confusion about the role of the HTT. The current manager said:

"The basic objective of home treatment teams or crisis resolution teams, as they are sometimes called, is to prevent hospital admissions, is to reduce the number of hospital admissions. The thing being that if we can treat someone in the community, they can get as better or better as quickly as if they were on a ward. We would take people with acute mental health crises that would normally necessitate admission, or we will also take people for early discharge, so people, that were our team not in existence, would still be on a mental health ward. In essence that is the purpose of the team."

Comment

Consultant psychiatrist B's analysis misses the point. These teams were set up precisely to meet the needs of patients who either did not wish to be or did not warrant being in-patients. The same team can provide both functions depending

on the needs of the patient. The thing that, if true, was not compatible with a home treatment team was the defined length of stay – because someone like MB whose psychosis might take weeks or months to respond to treatment would need an open ended opportunity to receive home treatment. But if he would otherwise have had to receive such treatment as a hospital inpatient, then there is no philosophical reason why the home treatment team should not deliver that treatment, for as long as the alternative to inpatient admission was required.

According to the two consultant psychiatrists the home treatment team was set up to provide an alternative to hospital admission, facilitate early discharge and provide crisis intervention. Staff attended ward round meetings so it is difficult to understand why the home treatment option was not used more as an alternative to granting periods of leave, particularly with someone like MB whose inpatient occupancy was extremely variable.

The home treatment team has a valuable, indeed essential role in managing patients who present with psychosis.

If home treatment is used as envisaged by the NHS plan most if not all patients granted leave from the ward should be referred to the home treatment team to take over the day-to-day management of their illness. Thus, a fully functioning home treatment service in practice would end the use of leave like that provided to MB, thereby significantly reducing bed over-occupancy. Only patients needing 24-hour care and supervision until they are deemed well enough to be referred to home treatment for assessment in the community would remain on the ward. When patients were ready the home treatment team should liaise with the ward and participate in taking them on supervised leave until they take over responsibility for their care (usually at the point patients are ready for overnight leave) before or at the time of discharge.
Furthermore, the home treatment team can act as the "gatekeepers" *to inpatient care by screening any potential admissions and assessing their suitability for home treatment as an alternative to inpatient admission. This can lead to an immediate reduction in inpatient admissions.*

Recommendations

R21 The trust should clarify the role of the home treatment team.

R22 The trust should ensure that the home treatment team is adequately resourced and able to operate to reduce or abolish over-occupancy, to provide a safer and more appropriate alternative to the use of unescorted leave and to provide a gate keeping service for admissions to inpatient facilities.

R23 The relationship and communication between the home treatment team and inpatient service must be made more explicit so as to allow the home treatment team to undertake its roles as a psychiatric emergency community assessment and treatment service, an alternative to hospital admission and facilitator of early discharge.

6. Care programme approach - risk assessment and risk management

6.1 This section summarises the use of the care programme approach (CPA) in the care of MB.

Background to the care programme approach

6.2 The care programme approach (CPA) was implemented in mental health services in England in April 1991. There were four key components:

- systematic arrangements to be put in place for assessing the health and social needs of people accepted by the specialist mental health services
- the formation of a care plan to address the identified health and social care needs
- the appointment of a key worker to keep in touch with the service user and monitor the care plan
- undertaking regular reviews and implementing agreed changes to the care plan, if required.

6.3 In 1999 the Department of Health undertook a review to revise and modernise the CPA. It also confirmed that the CPA would continue to be the key systematic approach to assessing and delivering mental health services to people of working age in contact with specialist mental health services.

6.4 The key changes set out below were introduced in 1999:

- The integration of the CPA and care management. This was to address the issue of lead roles between health services and social services being somewhat blurred.
- Health and social services would appoint a lead officer to work across both agencies.
- The term care coordinator would replace the previous title of key worker.
- There would be two levels of CPA - standard and enhanced.
- Reviews of care plans would be ongoing with meetings being set as required (replacing fixed six monthly meetings).
- Risk assessment/management to be part of the CPA. Service users on enhanced levels to have a crisis and contingency plan.
- The supervision register to be abolished from 2001 - subject to robust CPA arrangements being in place.

- Systematic audit to be established in respect of the implementation of CPA.

6.5 Subsequently, CPA has featured as part of performance management in trusts, as well as in Healthcare Commission reviews.

6.6 The following are the key principles that underpin CPA procedures.

- A multi-disciplinary approach to a patient's care, particularly if they have been in a psychiatric hospital.
- The appointment of a care coordinator who has overall responsibility for overseeing and monitoring the services provided for a patient under their care plan.
- A detailed and systematic assessment of a patient's health and social care needs, together with regular reviewing and recording of their care and support.
- A detailed written care plan of a patient's needs, produced following involvement and agreement of all those involved in a patient's care.
- The involvement of a patient in their care plan.
- The involvement of any carers.
- Regular reviews of you and your care, so any changes needed, can be made.

6.7 The trust's internal report makes a clear statement about how the staff failed to implement CPA properly for MB. Page five of the report states:

> *"At no point in MB's care was a planned, coordinated care plan and risk management meeting convened. Information already available and contributions from key staff, involved services and MB's family, and from MB himself could, and should have been expected to result in a care and risk plan clearly setting out the component elements, and their management. In the absence of such a forum, the services and component parts of them functioned in a fragmented manner which undermined the valuable work that was being done."*

6.8 We endorse this view. We set out in this section why we believe this failure occurred. Understanding the reasons for the failure effectively to implement CPA is necessary to ensure a more effective operation of CPA.

Comment

We believe that the principal reason for failing to operate CPA procedure and policy effectively was a failure to embrace the principles underlying it. This led to an over-reliance on a narrow medical approach without adequate multi-disciplinary or multi-agency involvement. It also led to the risk statements made by MB not being properly assessed and to the lack of any crisis or contingency plans for him.

6.9 We do not include here a chronology of the use of CPA because it appears in the internal trust report which also provides commentary on the way trust staff implemented CPA in the care of MB.

Care context

6.10 It is important when considering how staff cared for MB and how they undertook to comply with the national requirements of the CPA process to understand the context in which they were working. The internal inquiry panel commissioned a desk-top review of the clinical needs of Conolly ward patients and those of the SELT community team. The internal inquiry report states (page 4, paragraph 5.1):

> *"The report supports the recognition that Conolly ward, and the CMHT, deal with a population of patients which includes a high proportion of individuals with offending and in some cases dangerous behaviours, substance misuse, poor compliance and engagement with services and poor insight. About half of the case notes of inpatients reviewed showed significant histories of violence and a quarter were thought to warrant a forensic referral, particularly with a view to low secure rehabilitation."*

6.11 We have taken this context into account in arriving at our conclusions and judgements.

CPA procedures in operation at the time

6.12 Nursing and medical staff told us in interviews that arrangements for CPA planning were well integrated into the operation of Conolly ward. Indeed the procedures used (which we describe below) were on the surface well thought out, though closer examination reveals that the operation of CPA was effectively a modified system of ward rounds purporting to be CPA meetings. As seen in section five of this report which deals with the medical management of MB's care, an effective multi-disciplinary approach to his care supported by a robust CPA process was not evident. MB's case reveals a service functioning predominately on a narrow medical model without effective multi-disciplinary involvement which is at the heart of the CPA process (i.e. seeking contributions to decisions about care that take account of his medical, social, and family perspectives).

Ward rounds

6.13 The arrangements for discussions of patient care during 2005 and 2006 were that on Monday mornings a ward management meeting was held which briefly reviewed the patients. Decisions were made about who was to be reviewed in the Tuesday and Thursday ward rounds. The meeting would also determine which of the patients would need a CPA review that week (on Tuesday or Thursday) or the week after. There were also mini-ward rounds on Fridays to deal with issues which might arise over the weekend.

6.14 Ward rounds were held on Tuesdays and Thursdays when the patients identified during the Monday meeting were reviewed. Some of the reviews were led by a consultant or specialist registrar. Others were designated as CPA meetings and the care coordinator and nursing staff and other involved professionals were invited. Families of the patient were also invited, though it must have been difficult for some family members to attend at such short notice if the meeting was to be held that week (or even the next day). Representatives of the community team attended because they reserved the times of the meeting as part of their regular liaison commitment with the ward. This meant that it would not necessarily be the patient's care coordinator who attended but a duty worker from the service.

6.15 Consultant psychiatrist B described the purpose of the arrangements and their operation:

> *"Because of it being an acute ward in a busy area with 20 or 30 admissions a month, we made sure that there was plenty of senior review, without trying to impose too much on the ward, but also trying to get away from the multiple consultant dilemmas. I've been involved in inquiries where there are eight consultants milling around in one ward, which is a disaster. The Monday meeting was the major organising meeting, defining the ward rounds for the next couple of weeks in part at least. On Tuesday consultant psychiatrist A would lead with the team, I would lead on Thursday with the SpR as well and there was another ward round on Friday afternoons to put the ward to bed for the weekend and go through all the patients with the nursing staff and exactly what was going to happen."*

CPA reviews

6.16 CPA review meetings took about 30 minutes each with the patient present as well as other involved professionals and possibly family members. The notes were not usually made on CPA forms at the meeting. A junior doctor made a note of the discussion for the record. The nurses sometimes wrote up their notes in their ward round book. The information from the ward round book was later transferred to the CPA documentation. The care coordinator sometimes completed the CPA form at the meeting. There were therefore perhaps three different records of the same meeting.

6.17 This approach to recording the discussions and decisions at the CPA meeting illustrates our view that the CPA at that time was a modified form of ward round. In our review of the records and ward round book we found considerable variance about whether entries in MB's notes or the ward round book identified the review as a CPA review or an ordinary ward round review. In our view this haphazard approach to record-keeping is rooted not just in poor administration but also in the lack of clarity about whether the review was a CPA or a ward round. We believe this lack of clarity illustrates a failure to embrace the principles of CPA.

6.18 The modern matron, made the point to us succinctly:

"So I suppose about three years ago, CPA was not incredibly high profile, it was coming around, so it was about putting systems and things in place for CPA to be happening regularly, and also some of the medical team didn't value CPA. The process was basically ward reviews. Ward reviews and discharge. So I think over that period of time there was a lot of effort on actually getting CPA functioning the way it should do."

6.19 We asked about how CPA meeting dates were planned:

"…the idea is that a date would be set based on the individual presentation of people. But at that time, when we were still formulating the systems for CPA it was being used well, but it still had some developmental aspect to go. So planning meetings, I am quite sure were not that well organised. It would intend to be initial CPA, wait until somebody is quite well, then discharge CPA."

Comment

CPA was introduced in 1991 and substantially revised in 1999 and has been part of the NHS mental health service performance criteria since 1991, so it is not new. The implementation of CPA should be part of everyday working in mental health services so the admission that the trust was still implementing CPA procedures in 2005/6 is a matter of note and concern.

6.20 We asked consultant psychiatrist B about the poor compliance in completing CPA documentation in MB's case and whether better recording of the discussions taking place would have helped to understand the thought processes and considered opinion of MB's care team. He told us:

"It would have been in the CPA form stuck in front of the notes and given to the patient and their family. What they would have done with them, I don't know. The CPA so far as I am concerned is just what good doctors do anyway."

"I have been involved in a number of inquiries and not filling out the CPA form is an absolutely standard problem in every single one. What no one has done alongside those inquiries is to say, "Let's take the 20 patients before and after this admission and see how well the CPA forms were done there. The answer is that there would be no difference at all." (our emphasis)

6.21 Consultant psychiatrist B was clearly not convinced that the completion of CPA documentation made any difference to whether a patient is well managed by his care team. This is borne out by the following responses he made to us:

"So the idea that not filling out the CPA form has any relevance to whether or not this person was well managed, no one knows."

"The requirements of CPA, as you know, mimic all the other things we routinely do."

Comment

Consultant psychiatrist B is a consultant psychiatrist of many years' standing and is experienced in dealing with the wide range of needs in a busy psychiatric general admission ward. Our interview with him left us with the clear impression that he saw little value in CPA. Differing views amongst professionals about the effectiveness of CPA (or other approaches to care) is understandable, but failure to comply with trust policies which are based on nationally agreed guidance is unacceptable.

6.22 The desktop review of Conolly ward patients' clinical records report comments on the completion of care plans and states:

"…I draw attention to the fact that most service users had appropriate care plans (85%) despite the fact that they presented with highly complex problems." (page 8)

"…there was satisfactory evidence of plans being carried out in at least 73% of notes examined, but this may well be an under-estimate because of the reasons above-mentioned."(page 8)

Comment

Despite the findings of the review, it is evident that MB's CPA care plans were inadequate. We recognise that completion of forms in themselves is not a conclusive indicator of whether a patient is being* "well managed" *but the completion of CPA documentation does provide an indication of the commitment by a clinical team to manage care in a way that complies with CPA.

6.23 Consultant psychiatrist A helped us understand how the CPA process operated in practice on the ward. We asked how time was allocated in the meetings between ward reviews and CPA reviews:

"The way the ward rounds were scheduled is such that normally when we meet on Monday we look through the whole list – we have a nominal list of all the patients on the ward. Prior to this event the patients were not allocated, we just discussed all the patients, and by the time the ward rounds are outlined normally we start around ten, so you give a 30-minute slot to each patient on Tuesday or Thursday, and that goes until about 12.30 or 1.00. So each patient often would get a 30-minute slot, either a review or CPA."

6.24 We asked about the apparent occasional confusion on the ward where a review meeting was sometimes recorded in the ward round book as a normal review while the patient notes sometimes referred to it as a CPA review.

"The way it was is such that when it comes to care planning, and sometimes especially the CPA, which would take some time, that's where sometimes there are problems with keeping to this timing, going beyond 30 minutes and things like that. It puts a lot of pressure on you as a doctor, or even on the group or the team, to say that you are managing or seeing this patient and you want to cover every ground… So you see the list and in front of each name you see what we're supposed to do, either you put a review or a CPA meeting, an initial CPA

or discuss CPA. That's the way it is done, although quite often the question is will you be able to contain the whole CPA in a 30-minute meeting. It's not often the case. Often you go beyond such time and then you see the time spilling over to about one, two or three in the afternoon sometimes. Other times, when you think the patient is quite a complicated case, we set out may be an hour to do that, so between nine and ten we are going to have the CPA and that's just it."

Comment

There were clearly arrangements for reviews which could have ensured that individuals were reviewed systematically and regularly. It is also clear to us that these reviews were principally medically led. In MB's case, this led to an over-emphasis on the medical and pharmacological management of his case without an overview of all his needs. Some clinical decisions about his care were made during the Monday management meetings and the boundaries between the management round and the Tuesday and Thursday ward rounds were blurred.[see medical issues] It is evident that while the staff sought to ensure that ward round/CPA processes were manageable, the solution of renaming a ward round as a CPA and inviting a representative from the SELT team to attend was not an answer and shows that the clinical team did not fully embrace the principles of CPA.

Conclusions

C18 We endorse the view of the internal inquiry report that the care given to MB by his clinical team was undermined by their failure to produce a care plan to involve the whole team as well as the patient and family.

C19 We believe that the CPA reviews that took place for MB and probably for other patients were a modified system of ward rounds purporting to be CPA reviews.

C20 We believe that the service during 2005/6 was functioning predominately on a narrow medical model without effective multi-disciplinary involvement.

C21 The approach to record-keeping during 2005/6 was haphazard and symptomatic of the ineffective approach to CPA.

C22 We believe the whole clinical team failed to fully embrace the principles of CPA but the evidence we received from consultant psychiatrist B indicates that he still at best approaches CPA as an add on to his work and an unwelcome one at that.

Risk assessment/management

6.25 The summary of CPA at the beginning of this section says:

> *"Risk assessment/management to be part of the CPA. Service users on enhanced levels to have a crisis and contingency plan."*

6.26 Consequently risk assessment and risk management are an integral part of effective care planning. We now review the effectiveness of this element of CPA.

MB's presentation

6.27 MB was admitted to Homerton Hospital on 1June 2005 under the Mental Health Act but he agreed to stay informally so this was soon lifted. At various other times in his inpatient stays consideration was also given to assessing him for admission under a section of the 1983 Mental Health Act but as he was always willing to stay he was not detained. This matter is raised here because it is important to understand that although he was an informal patient during all his inpatient stays (except for the first 24 hours of his first admission), he was clearly unwell and needed to be in hospital. The fact that there were occasions when consideration was given to assessing him for a section indicates that at some level staff did see him as a risk. However, at the same time as presenting as a person who needed admission he was also generally friendly and easy-going. It was partly because of this that he was not seen as a risk.

6.28 The charge nurse[21] described MB's presentation on the ward:

[21] The charge nurse on Conolly ward during 2005 and 2006 having worked there since 1999

"His case was very unclear. Normally when people come in, straightforward you can diagnose, this person has this problem or that problem. With him, it was so difficult, from doctors to nurses, because one minute he's fine, talking fine, having sensible conversations, no problem, another time, he's talking about hearing voices – I think there was a situation where he mentioned about going home, wanting to have sex with his mum, so his mental state was difficult to assess."

6.29 Consultant psychiatrist B described him as follows:

"It is, though, most important to understand that his behaviour on the ward at all times was by and large very friendly, easy going and relaxed."

"Yes, a very nice guy. I got on with him very well. He'd never harmed a fly in his life before this."

"You must understand that. When you are surrounded by robbers, drug dealers, people with established forensic histories, etc, he is charming."

6.30 We met with a group of nurses who were involved in MB's care and they told us that the staff generally liked him and responded to him. They said he had fluctuating moods and looked on himself as an intellectual. He liked football and gambling and was betting on the World Cup in the summer of 2006. His reactions to winning and losing were extreme. He became upset when he lost and excited when he won. One of the groups did not think he was psychotic; one nurse said that MB at times felt like a teenager *'just pranking.'* Another said it was *"very difficult to think of him as a proper mental patient from the way he presented himself"*. They did not see any obvious psychotic behaviour. He was chatty and sociable and seemed to feel quite at home on the ward. He would laugh and joke with staff although he also lost his temper and was overly intrusive at times. However, when he behaved badly, he apologised afterwards, which was not a common experience for them. He was also helpful to the

staff and ran errands for some of the patients. He was generally compliant. Compared to most of their patients, MB was easy to manage.

6.31 At the same time as generally presenting as a likeable young man, MB expressed a number of serious risk statements.

Risk statements

6.32 During his first admission which lasted almost five months the records show that he talked about: self-harm such as attempting to drown himself, stopping himself breathing with a pillow, cutting himself; thoughts that people were trying to push him to suicide; homicidal ideation such as killing his sister's ex-partner, setting fire to a beggar, killing others; when he was young he felt like biting African boys' heads; fantasising about young girls' legs and having sex with his mother.

6.33 Before and during the next two admissions (in February and March 2006) he is recorded as talking about self-harm and harm to others; being suicidal; and jumping in front of a train.

6.34 During his last admission before killing JC he talks about hearing voices; threatening to push someone under a train; poisoning the ward water; choosing a colour, buying a gun and shooting everyone in the hospital wearing that colour; killing someone; having auditory hallucinations to kill as many people as he can and suggesting that the occupational therapist stuck his hand in the blender, for a joke.

Risk assessments

6.35 From MB's first contact on 31 May 2005 until his arrest on 8 July 2006 he is recorded as having some CPA risk assessments. These were helpfully set out in appendix 4 of the internal inquiry report. Extracts from the appendix are included here:

First admission 1 June 2005 –October 2005

6.36 1 June 2005 CRAM 1 initial risk assessment completed and CRAM 2 was completed on 14 August 2005. Care plans arising from the assessments were also completed on this date. The internal inquiry report states:

> *"The care plan was written 14 days after admission. Both plans remained unchanged throughout."*

Second admission 23 February 2006 – 28 February 2006

6.37 A CRAM 1 was completed but not a CRAM 2. There was an undated care plan. The internal inquiry report states:

> *"No risk assessment documents completed. Both plans remained unchanged throughout."*

Third admission 28 March 2006 - 4 April 2006

6.38 No formal risk assessment completed. The internal inquiry report states:

> *"No risk assessment documents were completed. The care plans were not based on a full risk assessment. Both plans remained unchanged throughout."*

Fourth admission 1 June 2006 – 8 July 2006

6.39 We have included the section from appendix 4 of the internal inquiry report in full to provide a fuller picture of the assessments carried out in this period as MB committed the homicide during this admission:

> *"Admission 4. 1st June 2006*
>
> *CRAM 1*
> *Threats to kill/harm others (current)*
> *Other (current – homicidal thoughts)*
> *Suicidal plans (current)*
> *Self – harm /injury (previous history)*
> *CRAM 2*
> *Dangerousness to others*

Self harm

RISK CHECKLIST

Aggression/Violence to others (Current/previous history)
Threats to kill/harm others (current)
Substance misuse (current and previous history)
Sexual abuse/other abuse (current)
Suicidal ideation (current)
Poor nutrition (current)
Non – compliance with medication (current)
Disengagement from mental health services (current)
Recent discharge (current)

The care plans based on the issues arising from the risk assessment was completed on the 1.6.06 on Brett ward.

Care Plan (Presentation/mental state)
Dated 1.6.06. Reviewed 18.6.06,25.6.06,3.6.06
Relapse of mental state due to non-compliance. Experiencing drug induced psychosis.

Care Plan (Safety/Risk)
Dated 1.6.06. Reviewed on 18.6.06,25.6.06,3.7.06

Risk of unprovoked attack on others as he is paranoid and suspicious. Abuse of illicit substances on ward.

Comments

Both care plans remained unchanged. A clinical risk assessment audit was carried out on 21.6.06"

6.40 None of the risk assessments was used to formulate a clear management plan. The internal inquiry report comments on this on page nine:

"In the case of MB, his day-to-day behaviour and his past history were such that his expressed preoccupations with violent and distressing themes often did not raise a high level of concern in staff involved with his care. The impression was that of a service coping with consistently high levels of manifest serious mental illness, agitation and disturbance in which the specific and vivid statements made by MB were, to an extent, not distinguished from this general pattern."

6.41 We say earlier in this report that we have taken account of the context of the morbidity of the population served by the Homerton Hospital and Conolly ward in

particular. The desktop author states in the findings and conclusion section of his report:

> *"The service user profiles of those admitted to Conolly ward are characterised by high levels of risk. Most display frank psychotic features, accompanied by poor or absent insight." (page 4)*
>
> *"As can be seen, this is a particularly risk-laden group, with nearly 80% of in-patients having a history of violence and or aggression, most of it against people and sometimes of a serious nature. A history of carrying weapons is not uncommon. To add to this picture, nearly 80% of in-patients have a history of drug abuse, most of it recent, and many of the service users are unmotivated to discontinue this practice…" (page 6)*

6.42 This assessment of the type of risks posed by clients on Conolly ward at the time of MB's inpatient stays is helpful as it provides a clue to why, despite the vivid risk statements he made, the staff were not more inquisitive about his risk. It may also explain why they were not more thorough in ensuring risk-assessments were translated into a risk management and contingency plan. Staff evidently considered him at the lower end of risk compared to many of the other clients on the ward.

6.43 The manager of the community team at the time, told us:

> "*…increasingly it was obvious to me that we were allocating the cases based on risk management rather than on disability, if you see what I mean. You have people who are disabled by their mental illness and impossible to help with motivation and relearning things, and you also have this difficult thing about allocating cases based on risk. Risk is not necessarily an absolute notion; the risk is always relative.*
>
> *So you have a team of however many care coordinators, say ten, and you give them 25 cases each, each of those cases by and large will have some kind of risk element to it, whether it's a previous forensic history, a history of violence, a history of drug abuse, co-morbidity, all those kind of things. You are managing*

an increasingly volatile group of individuals; you're not just managing someone with an illness, you're managing the whole caboodle that comes with that. When you are dealing with that on a daily basis, for no intention or reason, you may be desensitised. I don't want to use this word but I can't think of another one, it's not a bravado but we're managing quite a volatile group of people here, so in each case are you truly cognisant of the risks that person poses."

6.44 The internal inquiry report illustrates the inadequate approach taken to assess and manage MB's risk which seems to indicate that they viewed him as a lower risk than others. The report states on page five:

"At the time that MB was discharged in April, the care plan and risk plans developed by the care coordinator following discussion by telephone with consultant psychiatrist A were incomplete, were not based on a CPA meeting, and did not sufficiently reflect his known history, current presentation or circumstances. These included conflicts with his father, not being allowed to stay at his home with his mother and brother, and concerns about the investigations arising from his disclosures and expressed and plausible suicidal and violent ideation."

6.45 The records indicate that at various times the clinical team did assess MB's risk and as a result he was asked not to go on leave or to leave the ward. For example on 25 June 2006 during his last admission his threats of harming others increased and he was not allowed off the ward. Nevertheless, our review of the records and those of the internal inquiry show that these decisions to stop him from going on leave or having time off the ward were decisions made on the day in the light of immediately recent events and were not part of a considered risk management strategy arising from a longitudinal assessment of his presentation.

Medical discharge summaries

6.46 It is clear to us from our interviews, that during 2005 and 2006 the prevailing approach to the processes around risk assessment and management by the medical staff was that these were not their responsibility but that of the care coordinators. This ran alongside the medical approach which was to complete medical discharge summaries. Consultant psychiatrist B was asked about discharge summaries completed by junior doctors and the fact that they did not contain a risk assessment or risk management plan. He said:

> *"Yes. The CRAM things are filled out by the care coordinator as a formal risk document; that is part of their job. Within the discharge summary there should be a forensic history as one of the topics that is regularly covered and that is part of the full history."*

6.47 This creates a parallel approach to care management with a system of medical discharge summaries and separate CPA discharge summaries (although in MB's case, there were few of the latter).

6.48 In respect of medical discharge summaries consultant psychiatrist B said:

> *"This discharge summary is designed to summarise the nature of the admission and the after care plan. It is designed to provide an accessible document to the poor old doctor called to see the patient at three in the morning if they relapse or get ill again. It's there so that they can get the mental state sorted out and help assessments subsequently. It is also to help the GP to continue to provide, if the GP is going to be part of prescribing or supporting."*

6.49 Consultant psychiatrist B's view, as we set out in the chapter on medical care, was that the discharge summary should be a standardised summary of a patient's presentation and progress in hospital. Any information on risk could be gleaned from what was contained in their medical history and the description of thoughts and behaviour contained in their presentation and background history. There was no need for a separate section on risk assessment or risk management in the medical discharge summaries as any risk would be clear in the history. This leaves it open to each

succeeding doctor to make their own interpretation of the level of risk and how to manage it.

6.50 The purpose of undertaking a risk assessment as part of CPA is to formulate a risk management plan. In MB's case it is clear that the CPA risk assessment and management plans were inadequate or absent. As an alternative to a CPA risk management plan medical discharge summaries were also inadequate as they relied on the reader making their own assessment of risk based on the history set out in the discharge summary.

6.51 Medical discharge summaries were also delayed in their completion as they relied on the junior doctors to write them and have them typed up. Their value as a resource in case the patient relapsed was compromised.

6.52 We asked the SHO about the completion of the discharge summaries. She told us:

> *"... they were stacking up. When I started in February there must have been at least a month's backlog that I was catching up on and these were patients who I hadn't actually met myself, so I was having to start from scratch and go through the notes. That was something that the two consultant psychiatrists were aware of and that I had flagged up with them on a number of occasions."*

6.53 In MB's case there were two medical discharge summaries. The first related to his first admission dated 23 November 2005 (part one and two). This summary is comprehensive in most respects but says little about his level of risk, despite the quite clear risk statements he made during this inpatient stay. It is also dated a month after he left the country. The other (a part one discharge summary completed as part of his June 2006 admission) was dated 23 June 2006 which related to his last admission contained a little more information but was still sparse.

Comment

As the purpose of these discharge summaries is to help the GP or other doctors who may subsequently need to attend the patient, the absence of a reasonable summary of risk and risk management strategies is of concern. The delay in completion and sending them out to GPs seriously undermines their value.

MB's level of risk

6.54 MB was expressing serious risk statements but he had no known history of violence and was a generally cooperative and likeable young man. As a consequence he did not reach the threshold that put staff on alert. Consultant psychiatrist B told us:

> *"It's a very busy ward with many acutely psychotic people on it, as we pointed out to the medical director when he came to review things. I showed him the list of patients on the ward at the time when MB committed the murder – or manslaughter or whatever you want to call it. He was bottom of the list of people at risk. He had never harmed anyone in his life and was not under the Mental Health Act. Eighteen out of the 20 were under Section 2 or Section 3 of the Mental Health Act and half of them had forensic histories."*

6.55 We asked Dr E, MB's first consultant at Broadmoor about whether a forensic assessment would have been helpful. He told us:

> *"I think a forensic assessment would have been very difficult because he has no history of any significant offending or any significant violence, so there is no pattern of behaviour that would have led you to conclude that he would do what he did. That also makes his risk assessment now extremely difficult because there still is no pattern of behaviour; this is a one-off serious event in someone who doesn't normally behave in an antisocial way. It is much easier to predict or to manage someone's risk if they are hitting people once every two weeks, for example, because you have a pattern of behaviour that you can assess and manage. With MB it's very difficult because it's a one-off very*

serious event. Even now, predicting his risk is going to be very difficult because there is no established pattern of behaviour."

6.56 We understand that it is not always possible to predict risk and there is a prevailing, if unrealistic, view that as a society we must reduce risk in relation to mental health patients to a minimum. We have some sympathy for consultant psychiatrist B view that:

"*Society asks us to reduce levels of risk to below what it accepts for its other activities. If you wanted to reduce the risks in society you would ban cars, cigarette smoking and the use of ladders in the home because 80 people a year die from falling off ladders. How far do you go? Shall we say that for every patient in hospital we will keep 100 people in because of various risks they present. That becomes a nightmare."*

6.57 However, this is not a good reason for failing to undertake risk assessments compliant with CPA requirements. The procedures and processes integral to CPA which require an overview of a person's care are most valuable in managing the care of individuals who appear to have contradictory presentations. This was definitely the case with MB. The irony is that someone who has already carried out an act of violence is most likely to have an effective risk assessment. They are already self-evidently a risk. It is precisely patients like MB, who was making quite serious risk statements, where diagnosis was uncertain and who had contradictory presentations, who need the more comprehensive risk assessments.

Comment

We think that if a patient with a clear history of violence was admitted to Conolly ward at that time the clinical team would probably have completed the relevant assessments and have in place a risk management plan and be on notice that here was a risk that needed to be managed. In contrast MB, without a history of violence but making serious risk statements, was not appropriately assessed nor was there a risk management plan for him.

Knowing MB

6.58 CPA (including risk assessment and management procedures) provides an opportunity to build up a picture of an individual over time. This cannot be achieved if:

- record-keeping is inadequate
- the same information is recorded in different places
- the records fail to provide a summary of a patient's current presentation, needs and risks that have been properly informed by their history.

6.59 This was the case in respect of MB's care. As we say earlier, records of ward rounds or CPA meetings were variously kept in medical notes, the ward round book and sometimes on CPA forms.

6.60 The following exchange with the ward charge nurse is helpful in illustrating the lack of curiosity and wider consideration of what should be done for MB. He was asked whether the reviews of MB (whether CPA or ordinary reviews) sought to take a broader view of his care to understand his needs holistically:

> *"Were there any CPAs, or were there any, what I might call, rather broader meetings that sat down and said, not just 'What plan are we going to follow ', because sometimes CPA can be very mechanistic, can't it? What's his diagnosis? What's his medication? How long should he stay? When will we discharge him? Who's going to look after him?... What are his problems? We're getting different views about him – maybe he's PD, maybe he's psychotic. What's happening at home? Was there ever a meeting that said, let's stand back and have a look at this situation?"*

6.61 He replied:

> *"Not on the ward, no – I don't think there was. He had a care coordinator. I don't know whether anything similar like this happened in the community."*

6.62 In response he was asked whether such a review occurred on the ward:

> *"Not on the ward, no. His main reviews were either the ward doctor or in the ward round."*

Conclusions

C23 Staff evidently considered MB at the lower end of risk compared to many other clients on the ward and his general demeanour was compliant and friendly. This led to his vivid risk statements not being evaluated properly.

C24 None of the various risk assessments undertaken on MB was used to formulate a clear risk management plan.

C25 The reliance on using past behaviour as the key factor in determining the level of risk of a patient is understandable and appropriate. However, where there appear to be contradictory presentations, where the diagnosis is uncertain and where the risk is uncertain (because the patient does not yet have a forensic history) not properly assessing individuals is a serious danger. This was a major contributory factor in not identifying the possibility that MB might carry out one or a number of the threats he had made.

C26 We have taken account of the level of needs in Conolly ward as described in the internal inquiry report and do not underestimate the challenges presented to staff. This was:

> *"… a service coping with consistently high levels of manifest serious mental illness, agitation…"*

C27 We received no evidence that the difficulties posed by these challenges had been dealt with at a trust-wide level. On the contrary, we were left with the impression that the service had learnt to manage the various demands as best as it could.

C28 Consultant psychiatrist B's attitude seemed to us to be that risk assessment and risk management documentation were part of CPA which was not his responsibility but that of the care coordinator. In a letter to us consultant psychiatrist B questions whether such processes are proven by research to have value. He states:

> *"…evidence based recommendations (for example as to the use of CPA, risk assessment) should in my view be the basis for assessments and as far as I am aware there has been no substantial research as to whether these particular processes lead to better quality care in inpatient units."*

Consultant psychiatrist B was *de facto* the senior consultant of the ward his attitude to CPA is likely to have influenced significantly the clinical team's approach to the completion of CPA assessments and plans and medical discharge summaries. The Royal College of Psychiatrists report (see paragraph 5.138 and footnote 26) endorses a set of principles regards risk. These are set out in appendix A and contrast markedly with the views of consultant psychiatrist B and the care that was given to MB.

Comment

Consultant psychiatrist B's views as to the value or otherwise of risk assessments may be interesting but as an employee of the trust he was required to follow the trust's policies, regardless of his personal views.

Care coordinator

6.63 The following extracts from our interviews summarises the understanding of the role of the care coordinator in relation to the CPA. Consultant psychiatrist B told us:

> *"The CRAM things are filled out by the care coordinator as a formal risk document; that is part of their job. Clearly the level of CPA in itself defines how much continuing support and review is going to be used. That is the care coordinator's job. Continuing support at the local level is that of the care coordinators."*

6.64 *We were told:*

[On admission] they may not have a care coordinator. I think it happens automatically now, that when you come into hospital that you will have your initial CPA. But it will be between the primary nurse and the care coordinator to ensure that a CPA happens."

6.65 Consultant psychiatrist A said CPA was a nursing responsibility*:*

"The way it was then was such that for initial CPA we often said that the nurses on the ward would do that, so when we held a CPA the nurses would be documenting that.

For discharge CPA it's often done either by the care coordinator or by a representative of the locality.

…If there is a discharge CPA the care coordinator would do the documentation, and if the care coordinator is not there the duty [sic] would do the documentation.

When it's a review CPA I think it was still the responsibility of the nurses on the ward to do the review CPA. The only responsibility as far as CPA was concerned on the ward had to do with the locality at discharge, not when a patient is on admission."

6.66 The care coordinator's manager told us that one of the principal roles of the care coordinator was to engage:

"…an individual who has a mental illness in a way that forces some element of trust with them, and you can only do that if you're with them and working for them.

"That relationship is based… on a thorough assessment of need, and that assessment is only thorough if it's with the client participating in it where you can identify those needs."

6.67 MB was not allocated a care coordinator until 11 October 2005 just before he was discharged and went to Turkey. This is despite the fact that he was in effect 'in the community' for much of his time as an inpatient. We do not know why he was not allocated a care coordinator until this late stage in his first admission. A CPN was involved in August 2005 and (partly) completed a full needs assessment.

The consultant psychiatrist B said:

"Our ability to provide care coordinators is quite limited by the numbers we have. I don't know what the team have said about the provision of a care coordinator, because that is part of the community mental health team's remit. We had a lot of people stacked up at that time who didn't have care coordinators assigned because we didn't have enough staff. They had all gone off to the home treatment team."

6.68 We asked the care coordinator's manager whether someone who was more on leave than staying on the ward should have community team help and involvement. He replied:

"There are two ways of looking at it. One is, if you're quite cynical and you're protective of what's going on, you might say, if we're not being asked to see this person, let's not create problems for ourselves, he's being reviewed, he's being seen. Sometimes I do take that line; whether it's right or wrong, I do that. Or the reality is that there wasn't any real substance or need for our involvement, if it wasn't being suggested that this person needs CMHT involvement."

Comment

Not only did the ward have a haphazard approach to CPA documentation but there was also evident confusion at that time about the role of the care coordinator. In particular there was a clear failure to understand the responsibility of the care coordinator to manage the planning of care assertively and to ensure reviews are conducted effectively and actions are followed up. The responsibility of the care coordinator was not carried out well in the case of MB.

6.69 MB's had the same care coordinator for the whole period he was in contact with services. He described his role to us:

> *"I would have picked up the file and read through the file. The first point of contact was at his next available ward round review or CPA meeting, where I attended the ward round to introduce myself to him and took things on from there. I always make it a point, if somebody is an inpatient on the ward, to attend their ward rounds so I'm familiar with them and I have a good introduction to the patient.*
>
> *As I would be care coordinating patients in hospital. I might have facilitated their admission so I'd still be with them to their discharge, I'd still be going to their ward rounds and CPA meetings, so if they were going on leave I'd also check them at home. If they decided to leave the ward, I would be responsible to see if they were okay at home. If I'm not available, they might send somebody else from the community. It's a close working relationship we have with the wards, and there would always be an onus on me if they weren't at hospital. Even though they're considered an inpatient, I'd still be seeing how well they're coping at home, and I'd have to field that back to the consultants in the ward rounds as well."*

6.70 The care coordinator's involvement with MB can be divided into two periods:

- From 11 October 2005 until 27 October 2005 (when MB went to Turkey)

- From February 2006 after his handover from the home treatment team until MB's arrest.

6.71 The care coordinator first met MB when he attended a ward round on 20 October 2005 to introduce himself. He then saw him at home on 25 October and was made aware that MB's father had arranged for him to go to Turkey to stay with relatives. He advised him to get a doctor's letter setting out his medical history. The notes of that meeting state:

> *"25 October: Contacted MB, arranged to see him at home. Appeared much more settled. Discussed symptoms. Taking regular medication but experiences side effects. Need to discuss medication with consultants."*
>
> *"MB and his father have agreed for him to return to Turkey and spend time with his uncle and to receive treatment in Turkey. He would then be less tempted to gamble and smoke drugs. Has bought plane ticket for Thursday 27/10. I advised MB to inform the ward and request a doctor's letter to take with him for medical history when he's in Turkey.*
>
> *Plans: File is to be presented in allocation meeting. Consider closing as I'll be unable to provide necessary documentation to reassess case when MB returns to the country in approximately six months."*

6.72 The care coordinator told us:

> *"…I did mention at the time it would be more beneficial for him to stay here but he was very adamant that he wanted to get on the plane, and I think his family were supporting his decision in that."*

Comment

Despite the fact that we were assured that there was good communication between the ward and the care coordinator did not appear to know that MB had been discharged from the ward because he (MB) was going to Turkey. Nor did he seem to think it was any part of his responsibility to get a letter from the ward

or do anything about the fact he thought it would be more beneficial for MB to stay in England. Most of the staff quoted above seemed to think that the preparation of a discharge CPA was the care coordinator's responsibility. If this was the case, the care coordinator did not carry out this responsibility as there was no discharge CPA meeting.

6.73 The care coordinator's next contact with MB was not until after his discharge from the HTT in mid February 2006. It is entirely unclear who had responsibility for CPA during MB's period with HTT. There was no initial CPA when he was referred to the HTT in January and no suggestion that there should have been. Despite some confusion, everyone thought it was the responsibility of either the hospital or the care coordinator to undertake CPA, but it is not clear what the expectation was when someone was referred to the HTT.

6.74 MB's care coordinator does not appear to have had any contact with MB between his transfer from the HTT to the SELT on 16 February 2006 and his discharge after his admission to Conolly ward on 23 February 2006. He telephoned MB the day he was discharged and arranged to see him the next day. The care coordinator's priorities seem at this point to have been the referral to child protection rather than progressing MB's care. There was no discharge CPA for this admittedly brief admission.

6.75 The care coordinator's next contact with MB was at a review by the SHO on 15 March 2006. His manager from the SELT then visited with a social worker from child protection. This resulted in MB having to leave the family home. We discuss elsewhere the devastating impact this had on MB but the key point in this section is that despite the fact that SELT were involved in the referral and in the meeting at MB's home, no one from that team, including his care coordinator assessed the risks this referral presented for him.

6.76 The day after the joint visit with the social worker on 28 March 2006, MB was re-admitted as an emergency to Conolly ward. This short admission was again characterised by there being no risk assessment or CPA documentation. He was discharged (without a discharge CPA or effective care plan) on 4 April 2006. The only 'plan' was for him to find accommodation. The care coordinator helped with this and

completed a risk assessment for the homeless persons' unit (HPU) who were concerned about MB's risk. However, his subsequent risk assessment seems to have been based entirely on a telephone call with consultant psychiatrist A and was in effect no more than a clinical assessment. The care coordinator had asked for the ward round notes to confirm what consultant psychiatrist A told him which, since they were notes of his ward round, they would inevitably do. He was told that no notes were yet available. He also asked for the discharge summary from 2005 admission but again this was not available.

6.77 The care coordinator persuaded the HPU to offer MB supported accommodation:

> *"I tried phoning MB on his mobile and I tried phoning his father and chasing up this address, and I just met a dead end…"*

6.78 MB's last admission was on 1 June 2006. There is evidence that his care coordinator attended ward rounds (e.g. on 6 June 2006) but no evidence that the care coordinator was ever engaged in convening CPA meetings or completing the CPA documentation.

Conclusions

C29 The role of the care coordinator was generally unclear. Some of the clinical team told us that the care coordinator was responsible for review and discharge CPAs but if this was the case he did not do it.

C30 Our view is that the ward was essentially undertaking ward rounds, some of which were called CPA reviews. It is hardly surprising therefore that the care coordinator did not see himself as having a role in this, other than to attend if he was available. The lack of any effective planning for CPA meetings meant that the attendance of the patient's care coordinator could not be guaranteed.

C31 The relationship of the HTT to the CPA process is unclear. SELT do not seem to have been informed of MB's reappearance and his referral to the HTT so were

obviously not in a position to do anything. If the HTT are seen as an alternative to hospital admission – which is the role they carried out in MB's case - then an arrangement should have been reached which linked the HTT either to the ward or to the SELT, especially as they were under a separate consultant.

C32 The SELT at the time seemed to have a passive view of their involvement when in reality (and in the absence of any advocacy services) they should have been asserting themselves on behalf of their patient. They did not see it as their responsibility in 2005 to intervene and suggest that a care coordinator should have been appointed earlier or that some sort of framework should be put around MB's leave. Neither did they take responsibility for what happened to MB as a consequence of the child protection referral (which they had pursued) other than to pursue accommodation for him which he did not want.

Recommendations

R24 The trust should review its guidance in the light of the new Department of Health guidance on CPA[22], the findings of the internal inquiry report and this investigation. It should pay particular attention to ensuring care planning and risk assessments are at the heart of all CPA reviews and ward rounds.

R25 The trust should ensure a broad view of a patient's past history forms part of any risk assessment, and that there should not be undue reliance on whether the person has been violent or has self harmed in the past as a predictor of future risk.

R26 The trust should not rely solely on the issue of new policies but provide opportunities for all senior clinicians and managers to understand fully and commit to the principles underpinning CPA. The objective of the training should be to avoid a superficial adherence to CPA procedures without a corresponding commitment to its principles.

[22] Refocusing the Care Programme Approach, Policy and Positive Practice Guidance, DH, March 2008

R27 The trust should ensure that all staff comply with its policies on CPA, risk assessment and risk management regardless of their own personal views

7. Transitions of care

7.1 In this part of the report we look at some of what we have called the key transition points in MB's care and how they were handled. We recognise that these points are part of a continuum of care and therefore they also form part of the wider consideration of care planning. Nonetheless in relation to MB, these points highlight particular issues that need a more detailed examination.

7.2 The general failure of care planning and risk assessment meant that changes to care for MB happened abruptly and without much forethought. The reasons for the transitions in care were often unclear. The transitions were unrelated to any real assessment of what his care plans were intended to achieve. On at least one occasion (the transfer from the HTT to the SELT) it seems to have arisen because of an organisational view that care by the HTT could only last for a month, regardless of the patient's needs. Some were effected by MB himself (e.g. his visit to Turkey) but others were not. The absence of effective documentation setting out the rationale behind decisions meant that we have not always been able to understand why some of them were made and then carried out in the way they were. It was not always clear to us that decisions about transferring a patient from one service to another were made with the patient's interests in the forefront. All were characterised by their abruptness and a failure either to manage MB's expectations or to understand what the impact on him might be.

7.3 There are times during the care of all patients when the nature or location of the care changes. This can be as a result of a changing diagnosis, an improvement or deterioration in the patient's condition or the impact of an external life event. Transitions can be generated by the patient or by the medical team. In many instances change can present a risk to someone who may be vulnerable.

7.4 MB (like most other patients) went through a number of these transitions during his contact with mental health services. The four key ones were:

- his discharge to Turkey in October 2005

- the transfer of his care from the home treatment team to the south east locality team in February 2006
- his subsequent discharge from hospital in the same month
- his discharge into the community in April 2006.

These all show a failure of planning with too much reliance on MB to manage his own care.

7.5 The internal report commented on some of the individual transitions but did not consider it as a general issue. In this part of our report therefore we take a closer look at the four key transitions to highlight and draw out some general issues.

Turkey

7.6 MB left for Turkey on 27 October 2005. At this point he had been an inpatient on Conolly ward for nearly five months, although he had spent much of the time on leave. We understand that his father thought he would receive better care in Turkey and, crucially, from his father's point of view, he would be away from Hackney, drugs and gambling.

7.7 MB's father first raised the possibility of his going to Turkey towards the end of August 2005 but was told that MB was too unwell. He had been on leave from the ward from one week after his admission until the end of July but his mental state had deteriorated. His medication was changed and he was asked to stay on the ward for a week. He remained on the ward until 1 September 2005. During September he spent short periods on leave but an increasing amount of time on the ward. There was no significant improvement in his mental state. On 9 October 2005 a decision was made at the ward round to change his medication and on 11 October he was again asked to stay on the ward, which he did until 19 October. Two days later on the 21 October he was discharged from the ward as he was going to Turkey. There is no record of an assessment being made of his fitness to be discharged and if not fit whether he could be detained under the Mental Health Act. He was given a month's supply of medication. On 25 October 2005 he was seen by his care coordinator who advised him to get a letter of referral to take to Turkey. There is no evidence that he did this.

7.8 It was evident that MB was still unwell while he was on the ward in the week before his discharge. His medication had been changed but no consideration seems to have been given to how he would manage it or how the change might be monitored. There was no care plan and there is no record of consideration being given to whether he should be detained rather than being allowed to leave the country. The medical discharge summary was sent to his GP at the end of November. The absence of documentation and the fact that the hospital notes fade away at this point mean that it has been difficult to assess the rationale behind the decision to let him go.

7.9 Consultant psychiatrist A said at interview:

> "*That* [discharge*] wasn't initiated by the ward or any member of the team that happened because he wanted to go to Turkey; his father wanted him to go. I remember I called a CPA meeting then with the father in attendance and we discussed things, and I explained to the father the risks that were involved, because I felt he was still very psychotic, that he needed to have treatment, and the father said no, that was the plan of the family. We just advised them as to what to do. We gave him his medication and then he was supposed to be given a letter that he took to Turkey, and that was it. What we said was that, coming back to the UK he should get back to us.*
>
> *…There wasn't any plan at that time to discharge him."*

7.10 Despite consultant psychiatrist A's recollection we can find no record of a CPA meeting before MB's discharge or record of any clinical team discussion of discharge arrangements. No letter was written.

7.11 It is unclear why he was allowed to leave for Turkey. The hospital had no idea what care he would receive there and they did not try to find out or to provide MB or his father with a discharge summary or referral. To discharge him at all and then to do so without a summary or to know what circumstances he was going to was risky and yet there is no evidence that any risk assessment was attempted. This is despite the fact that MB's mental state had worsened rather than improved since his admission in June and that during this period he had made several threats of harm either to himself

or others. There is no evidence that any thought was given to a keeping him on the ward on a Mental Health Act section.

7.12 The internal inquiry report also commented on this transition:

> *"…the care he received [*following his first admission*], and the planning that went into this were to an extent undermined by the lack of organised pre-discharge CPA planning. During this admission there was a consistent view that MB was suffering from serious mental illness for which he was treated with Aripiprazole. Maintaining the therapeutic value of this anti-psychotic medication would require compliance, prescribing and assertive reviews and monitoring of his condition.* This would not be possible to ensure when he left for Turkey unless, at the least, he took with him a letter from the doctors or, better, some liaison with services in Turkey."(our emphasis)

7.13 Even from a medical management perspective therefore, the manner of his discharge to Turkey was at best unhelpful.

7.14 The manner of the discharge also demonstrates the almost complete lack of curiosity about MB as a person. The hospital had no idea where he was going, who he was going with (if anyone), whether he could cope with, let alone manage, a serious mental illness at his age, how long he was staying or whether he would receive any treatment.

7.15 So far as we can tell MB did receive treatment in Turkey. He told us that he saw a psychiatrist five or six times because he was suffering from severe headaches and his medication was changed. He also told us that he suffered psychotic symptoms while he was there:

> *"Yes. I was going through a lot of hallucinations, I was seeing a lot of things. I kept on thinking people were saying things when they weren't; it looked like they were talking to me when they were talking to each other."*

Conclusion

C33 MB was 19 when he went to Turkey. He had been diagnosed with schizophrenia and his mental state had worsened over the preceding month. His medication had recently been changed. Consultant psychiatrist A said that he was not contemplating discharge when MB was in fact discharged. Despite this, the discharge that took place was unmanaged and unplanned. No risk assessment was ever done or even contemplated. No consideration was given to keeping him on the ward.

Transfer from HTT to SELT

7.16 Shortly after MB returned from Turkey his GP referred him to psychiatric A&E where he was referred to the home treatment team. This leads to the second key transition – his transfer from the HTT to the south east locality team.

7.17 MB was referred to the emergency psychiatric clinic on 19 January 2006, probably some two weeks after his return from Turkey. There, he received an initial diagnosis of paranoid schizophrenia and was referred to the home treatment team. His medication had been changed to Risperidone while he was in Turkey but there is no other information on the hospital files about the treatment he received there.

7.18 He was looked after by the HTT for about a month, receiving up to two visits a day, largely to ensure he took his medication and to assess his mental state. During this period his medication was increased. There was no care plan however so it is not easy to see what outcomes the HTT were seeking from his treatment.

7.19 The remit of the HTT was described to us in various ways but was summarised succinctly by consultant psychiatrist A as "to *prevent unnecessary admission and to facilitate discharge from hospital*". The then manager of the HTT described their role as:

> "*…try and treat people using all the social systems and the medications and whatever interventions were to hand to try and maintain people at home, get*

them well, keep them with their families. It's the least restrictive alternative to treat them. That was their brief."

7.20 Unlike the SELT, the HTT was not part of the medical responsibility of the ward consultants and it had its own consultant. MB received one full medical assessment by the consultant while he was the responsibility of the HTT (1 February 2006). On 7 February he told the HTT that he felt he was going to die soon and he also talked about wanting to strip someone and bury them alive. The HTT saw this as an attempt to shock them. He asked several times what would happen to him if he killed someone and was told that he would go through the criminal process. The HTT's view was that he was testing the boundaries.

7.21 Instead of triggering a risk assessment, the next day a decision was taken to transfer his case to the SELT. MB was told of this but it is not clear whether he was told or understood the implications of this transfer. We can find no reason why the transfer was agreed. There was a general policy that the HTT would only work with someone for up to a month. It seems to us therefore that this is likely to have been the driver for the transfer to the SELT (given that the transfer did in fact take place almost exactly a month after he was referred to the HTT).

7.22 The HTT's input in terms of numbers of home visits was intense – often twice a day and MB perceived their support as positive. The team visited MB at home so they had close contact with his family. In contrast, MB's care coordinator (from the SELT) told us he usually had one meeting a week, reducing to one a fortnight and not usually in the patient's home. MB would also be expected to manage his own medication and there would be no frequent oversight of whether he was doing so or not.

7.23 This was a dramatic change of pace for MB which should have been carefully planned and managed. This transfer meant a transfer of consultant responsibility but there seems to have been no consultant-to-consultant discussion or consideration. There is nothing to indicate why the decision was taken to discharge him from the HTT at this moment and there was no risk assessment.

7.24 MB's care coordinator said that this sort of transition of care meant that:

> *"You have to give a lot of reassurance, a lot of support, acknowledging those feelings and emotions, but also helping them dealing with it as well. You could do it in a psychological way by offering that support, but doing it in an hour's contact at home with somebody who has all these emotions is very draining, and if you have that number of people it could be quite difficult."*

7.25 His supervisor said:

> "*As I remember it, I don't think we did acknowledge we're not going to see you every day, I don't think it was as clear as that, but the fact that he was living with his mum, and we met her at the time, and she was quite agreeable, if not happy, for him to be there, and I felt he was reasonably well, and therefore it was a question of allocating him for him to be reviewed by our team. We didn't specify how frequently he would be seen."*

7.26 Despite this, MB's care was transferred to the SELT on 16 February 2006 when the HTT and the SELT made a joint visit to his home. He was given a week's worth of medication and an appointment was made for him to see SPR 2 on 15 March 2006.

Conclusions

C34 This transition was again characterised by a lack of planning or risk assessment. MB was still mentally unwell; his medication had recently been increased and elements of the current management plan were outstanding. No attempt appears to have been made to manage MB's expectations or his understanding of what this change might mean and what he might have to do. It was abruptly carried out and no arrangements seem to have been made to monitor how he was managing. The decision to transfer his care appears to have been prompted more by an arbitrary time limit to HTT involvement rather than any real assessment of MB's needs.

C35 The transfer took place in the context of a referral to Hackney Council's children and young people's department which was to have dramatic consequences for

MB but which was given no consideration in managing the consequences of the care transfer (see section 4).

C36 On 23 February 2006, a week after the transfer, MB was admitted to Conolly ward on an emergency basis. He had self-referred because he felt he might kill someone. The SGD saw him in the emergency clinic. It is likely that the abrupt transfer from HTT to SELT played a major part in his deterioration.

February discharge

7.27 The third significant transition took place almost immediately after this emergency admission. MB was clearly ill when he was admitted on 23 February 2006 (after the discharge from HTT to SELT). He said that he felt he might kill someone or himself. He felt driven to throw himself under a tube train. He said that he felt he would kill someone soon unless he was contained in hospital. Yet within four days he was discharged from the hospital without any medication.

7.28 Despite receiving a comprehensive assessment from the SGD on his admission and despite his having a clear treatment plan, this was not followed through (see section 5, medical issues). He was almost immediately allowed day leave because of his assumed dependence on the ward despite the SGD's recommendation that he should stay on the ward for a review of his management. He was discharged immediately when he refused to come back to take his medication.

7.29 During his 2005 admission the records show that the staff had started to hold the view that MB was becoming dependent on the ward. This may have prompted his early discharge. It is unclear to us where this idea came from because he was largely compliant during his 2005 admission. His admission in 2005 was characterised by the hospital's decision that he should remain a patient of the ward with home or day leave. The lack of direction about leave makes it difficult to understand how a service-user was supposed to use their inpatient stay. The pressures on the ward mean there may have been a preference for service-users to go on leave. However, when they did not, they could be accused of *"dependency"* on the ward. On MB's return

from Turkey, he seems to have been willing to receive treatment from the HTT and this admission was his first since he left for Turkey in October 2005.

7.30 As with his discharge to Turkey, no one seems to have considered whether he should be detained compulsorily and no planning or risk assessment took place. He had been on medication continuously since 1 June 2005 and yet no attempt was made to ensure that he was managing without it.

7.31 His care coordinator saw him on 1 March 2006 after he left hospital. He was not an easy patient in the community. He said he wanted help but his care coordinator notes say that he refused to engage. The notes do not record any discussion about his recent admission and discharge. In fact, during this period, the SELT appeared to be more preoccupied with following up the referral to child protection than with whether MB was receiving appropriate care.

Conclusions

C37 This was MB's first admission to hospital since he had gone to Turkey and seems to have been triggered by the transfer of his care from the intensive HTT to the much less intensive SELT. This may have suggested to the hospital that MB was struggling to cope in the community, as in fact the SGD identified on his admission when he noted '*is clearly not managing in the community*'. This view appears to have gone unnoticed by the rest of the medical team.

C38 MB's refusal to return to the ward after his leave was uncharacteristic and together with his lack of medication should have prompted some concern on the part of either the hospital or the SELT, but it did not appear to have done so and led instead to his discharge.

C39 We can only speculate about why he was discharged given the absence of information. However, one of the conclusions we have drawn from the absence of care planning is that this led to views being taken about MB based on immediate observation rather than on any longitudinal study. In this instance, it does not appear as if anyone looked further than his refusal to return to the ward.

April discharge

7.32 The fourth and final transition we look at in this report follows little more than a month later.

7.33 MB had essentially been on his own in the community for a month. His care coordinator saw him on 2 March 2006. He missed an appointment with EQUIP on 6 March 2006 but they persuaded him to arrange another appointment even though he had initially said that he was not interested. SPR 2 saw him on 15 March 2006 (which appears to have been his follow up appointment to the transfer from the HTT to the SELT). MB then referred himself to the psychiatric emergency clinic for admission again on 28 March 2006.

7.34 This admission was triggered by the child protection referral and the impact it had on MB's life. A social worker and the manager from the SELT visited him and his family the day before. He was shocked that they were pursuing an investigation and had been effectively made homeless by it. He said he felt suicidal or might harm someone else. He said he could not live by himself and thought that being discharged would make him more suicidal (see section 8 for more detail).

7.35 Within two days of this admission the ward round notes indicate that a decision was reached to discharge him with a referral to the homeless person's unit (HPU) with an outpatient appointment to be made in four to six weeks.

7.36 Again, it is not clear why this decision was made except that it appears to have become the case that the diagnosis had shifted to one of borderline personality disorder with some anti-social traits and that much of his behaviour was now seen by his clinical team to be manipulative. No account was taken by the clinical staff of the impact of the children and young people's investigation (except to include a referral to the HPU) on MB's mental state, his ability to cope in the community and his relationship to his family. His threats were seen to be prompted by a desire to stay on the ward rather than as a consequence of his mental illness. He had managed to maintain himself in the community for a month with virtually no support or indeed medication and certainly without recourse to the ward, so again, the view that he had

become dependent on the ward is hard to sustain. His return to the ward seems more likely to have been a cry for help and a marker of how ill he was.

7.37 It is not clear when MB was told that he would be referred to the HPU or whether he understood what support might be offered to him. There was a particularly difficult ward round on the day of his discharge (on 4 April 2006). He and consultant psychiatrist A argued about his future care. MB wanted to stay on the ward but was told he would get support in the community. As there is no discharge care plan it is not clear what this support would consist of other than a referral to the HPU and an outpatient appointment.

7.38 In the event, the relevant services more or less lost contact with MB after he left hospital. He had one or two contacts with the SELT, largely at his instigation and about his housing. He failed to attend his outpatient appointment (15 May 2006) and was discharged from the clinic.

Conclusion

C40 This discharge was again characterised by an absence of any real consideration of MB as a whole person. He was a 19-year-old who was showing consistent signs of serious mental illness. He was known not to want to live independently and yet the impact of the children and young people's investigation had exactly that effect. There is no evidence that anyone involved in MB's care undertook any risk assessment of this intervention. Yet it is likely to have triggered this admission. There is no discharge plan so it is not clear what the intentions were about his support in the community or how this would be monitored.

Comment

This report has looked at the February and April discharges as moments of transition. The internal report did not look at the situation in this way but did consider the impact of the two admissions that led to the discharges. It said:

"There is no consideration of use of the mental health act, and his care needs and risk profile are not systematically considered. Rather, the emphasis is on his being held accountable for any actions he might take. It is apparent, particularly from the accounts of the ward round in March, that the patient's own concerns about his illness and risks were met with some scepticism. Although his behaviour does not pose major management problems, and his social circumstances have undergone a major change (as a result of his disclosures during assessments and the investigations by social services), there is clear pressure upon him to accept discharge at a time when he is unwell, with limited external support and concerned about his symptoms and his ability to manage his dangerous ideas. His perceived diagnostic profile shifts from that of a schizophrenic illness to one of personality disorder(s) and social and housing issues. MB's attempts to express his wishes regarding his future and discharge arrangements in a way that were given due weight by the clinical team, were not successful. The support of advocacy services at such times cannot be underestimated and yet there was no mention of such services being made available to MB."

Transitions in types and locations of care happen to all patients and present moments of vulnerability. This would suggest that to be effective, such transitions need to managed and planned carefully, allowing the patient the maximum time to adjust to the change and to understand what is happening and why. The internal report's mention of advocacy services is particularly apposite here.

In this case it is difficult to understand both why any of these transitions happened and the way they happened. They did not seem to be related to MB's care but more to other events. These were MB's trip to Turkey; a four-week limit to the HTT involvement; his refusal of medication and a belief that he was dependent on the ward. Other than the transfer from the HTT to the SELT, they arose largely because of immediate events rather than from anything relating to a planned care programme. The transfer to SELT seems to have happened because of an organisational parameter on the HTT involvement.

Recommendations

R28 The trust should ensure that CPA policies and procedures stress the importance of planning for and managing transitions. Advocacy services should be available for all patients when major changes are introduced to their care to ensure that they understand what is likely to happen.

8. Child protection investigation

Condensed chronology

8.1 MB made disclosures about sexual abuse during his first admission in 2005 but this led to no action by the staff. He repeated these disclosures when he was referred to the emergency clinic by his GP in early January 2006, and at the end of the month when his care was reviewed. He continued to live at home being cared for by the home treatment team (HTT) and visited once or twice a day. His allegations did not trigger any action at this point, though a discussion with his mother about these matters did take place.

8.2 For reasons that are unclear, at some point the HTT decided to refer the alleged abuse to the London Borough of Hackney children and young people's department. It is evident from the file that staff from the HTT discussed his future care with the emergency clinic doctor but there is no evidence that there was any discussion of the intention to make this referral. There is no record of the HTT having called a CPA review meeting or having held any other form of review that sought to plan what might be the implications of making such a referral.

8.3 The referral was also made by the HTT team without consultation with the HTT consultant who had recorded on 1 February 2006:

> *"I do not feel there is currently any risk of abuse … on the basis of the history we have."*

8.4 We asked MB's care coordinator whether he had believed MB's allegations of sexual abuse, He said:

> "*Did I believe what he said? No. When I further talked to him about him I asked searching questions with him, and how he was describing it wasn't sexual abuse, it was as if he was saying this to fabricate things, I thought to get more care or to get something. I thought, you don't need to do this because we're able to provide you with the care and support, we're offering you this."*

8.5 Initially the child protection team decided to take no further action. However after a second referral, again for reasons that are unclear, the child protection team launched an investigation in March 2006. But at the time of our investigations the child protection investigation had not been concluded and was not an active case.

8.6 The referral had a serious effect on MB's mental health. He was told to leave the family home with the expectation he would go and live with his father. Within 24 hours, MB was again admitted to Conolly ward saying he felt intensely suicidal and that he could not stay with his father (who had a one bedroom flat). He was discharged within a week. These events seem to have contributed to a fundamental shift in MB's medical care as it coincided with a change in diagnosis (from schizophrenia to personality disorder and a view that he was being manipulative). Following his discharge he became homeless and was lost to the service for a number of weeks before being readmitted in June 2006. It was during this admission the homicide took place.

Comment

In general, staff did not believe MB when he said he would harm himself or others and yet they acted as if they believed what he said about abuse even though they did not. It is obviously important that child protection issues are identified but mental health staff must take advice from professionals before making a formal referral. This includes obtaining a view from the consultant. Mental health staff must also remember that they have a dual primary duty – one to protect children and one to their own patient. This means that referrals should be made when appropriate, but that their patient also needs help and support in these circumstances. There appears to have been no liaison with any consultant about this referral and its impact or any consideration of calling a professionals meeting.

Policy framework

8.7 In 2005/6 mental health staff were required to follow the London child protection procedures 2003 (LCCP). There was also a joint protocol between mental

health services and children's social care dated 2002. The trust safeguarding policy was under development at the time and was ratified by the trust board in May 2006.

8.8 The LCCP and the joint protocol are more concerned about the impact on children of adult carers with mental health problems. However, the principles on which these documents are based are relevant for situations such as MB's.

8.9 The LCCP states that all health services staff have a duty to protect children and these procedures applied to staff in all NHS and private and voluntary services, all trusts, acute hospital trusts, PCTs and mental health trusts (MHTs). It goes on to say:

> *"All mental health staff and GPs must be aware of the possibility of child abuse in parent/ carers with personality disorder, mental illness, problems with aggression or violent behaviour and substance misuse or through misuse of drugs or alcohol. The needs and protection of the child (including the unborn child) of these patients are a priority in the assessment of parents and should be undertaken in partnership with PCT staff and the SSD."*

8.10 The LCCP requires each trust to have a designated professional to take the lead on child protection matters. The joint protocol reinforces this by also requiring designated liaison people in the community teams. One of the reasons for these requirements is so that there is someone with professional expertise to consult in the event of a child protection concern as well as someone to provide effective liaison with the relevant children and young people's services. There is no evidence that these professionals were involved in MB's case.

8.11 The LCCP states that care programme meetings about users of mental health services must include consideration of any needs or risk factors with respect to any children concerned including arrangements for contact and discharge. Children and young people's departments must be included in these meetings. Insofar as there were care programme meetings in MB's case there was no discussion of this at any point even though MB reported his alleged abuse on his first admission.

8.12 There are a number of requirements when a service identifies what it believes to be a child protection concern. Among these is a requirement to consult with the parents (and to use interpreters where English is not their first language) unless that would put the child at risk. A decision not to consult has to be recorded in the file. In MB's case, the referral was made to child protection without consultation with his parents. There was one recorded discussion with his mother but it is unclear that this constituted sufficient consultation especially as there was no interpreter. There is nothing in any file to indicate whether his parents formally agreed.

Conclusions

C41 There should have been a proper assessment by those charged with MB's care about the likelihood of any abuse in future; the impact on his mental state and the impact on his domestic situation. This did not take place. The HTT did not seem to think that they had any responsibility to provide him with support through whatever process might emerge. Indeed, they appear to have assured him that he would get support from the child protection team, which was unlikely to say the least. No thought was given to the impact on MB by any of the services which were responsible for his care. The consultants with responsibility were not even told.

C42 There should have been consultation with his parents through an interpreter.

C43 The referral to child protection is evidence of the flawed decision-making which dogged MB. It was unplanned; it showed little understanding or concern about MB; it was not based on any understanding of the risks he might have posed and even his care coordinator did not really believe his claims.

C44 Both the LCCP and the joint protocol stress the need for multi-disciplinary discussions at all stages where there are concerns. It is evident that this did not happen in this case.

C45 Hospital and community staff did not seem to be alert to the appropriate way to deal with child protection issues, including their identification. The procedures in force at the time were not followed.

Comment

This report is concerned with issues arising for the trust in respect of MB's care and so the investigation has not looked in detail at the practice of the children and young persons service or the police in relation to this referral. The narrative however indicates that issues may arise for those services as well about the way this case was handled – not least the fact that the investigation has never been concluded. However, as this was not formally part of our investigation, we have not interviewed either of these agencies about this and our thoughts are based solely on the documentary evidence we have seen and the interviews we have held.

Recommendations

R29 The trust should amend the existing policies and procedures so that they explicitly cover circumstances in which someone with a mental illness is living in the same house as a child.

R30 The trust should ensure that all staff are familiar with the child protection procedures and understand how to operate them. The trust should audit compliance.

9. Age, family and culture

9.1 In this section, we look at whether and if so how, factors such as MB's age and background were taken into account. This is not dealt with in the internal trust report.

Age

9.2 MB was a week past his 20th birthday when he killed JC. He was 18 when he first became a patient of Conolly ward. He was effectively an adolescent the entire time. Conolly ward is a mixed adult ward catering for patients of both sexes from the age of 18 to 65. The needs of an 18-year-old are self-evidently unlikely to be the same as those of a 50-year-old and yet there is no evidence that MB's age was ever explicitly taken into account in considering his treatment. (It may however have been taken into account implicitly – but unhelpfully – in seeing his threats of harm as male teenage '*mouthiness*').

9.3 There were – and are - no age-specific services for young adults who are therefore expected to manage their illness and their lives as if they were fully mature. The Conolly ward team sought to get MB to live independently because they thought he was becoming dependent on the ward. And yet it may simply have been that he was still young and insecure enough to want to live with his family.

9.4 The only service which might have been more appropriate to his needs as a young man was EQUIP – the early intervention in psychosis team. That was not designed as an age specific service, but its function meant that it did generally deal with younger adults. EQUIP was at an early stage when MB was a patient.

9.5 During his first admission there was mention of a referral to EQUIP on the 1 June 2005 but no referral letter was written until September 2005 and EQUIP did not attempt to make contact until after MB had gone to Turkey in October. Despite several subsequent attempts to make contact, MB's first assessment with EQUIP did not take place until 26 June 2006.

9.6 Several people we interviewed thought it was not right for someone of MB's age to be on a ward with older disturbed people. In relation to being an adolescent on an adult ward, one nurse said:

> *"It can be very terrifying. I would suggest it should be possible to raise the age limit as to patients who come to the ward to 22 or 23 or something."*

9.7 Consultant psychiatrist A's view was:

> "*It might not be the ideal situation. I know that when this thing happened one of the suggestions I made – because you have people like this, not just the issue of mental illness but they are in serious crisis and not only that they need treatment, they need respite – for such individuals it will have been good to have a facility that caters for them, especially for the young persons of his kind. If I had my way, that's something I would have loved to do, that there's a place for such individuals to come that will not mix with the general adult ward."*

9.8 Others thought staff were well equipped to deal with the age range on the ward and that it was not unique to have someone so young. It may be true that staff should be able to address the needs of all ages but it seemed to us as if little actual consideration was given to MB's age. It is not mentioned as a factor in any of the documents we have seen.

9.9 Many of those we interviewed said MB behaved as if he were young for his age. He talked about being worried about having to take on the responsibilities of the eldest adult son but this was not noted as an issue that might need to be dealt with if he was really going to become independent. MB's reluctance to consider independent living was seen to be evidence of his dependence on the ward and not the natural reaction of a young male who was not ready to leave his family.

9.10 And of course, the decision to ban him from the family home as a result of the referral to the local authority children and young people's service took no account of his dependence on his family.

9.11 Finally, if effective risk assessments had been carried out it might have led to curiosity about why a 19-year-old youth from Hackney believed that the place he felt safest in was an acute adult admission ward. This seemed strange to us and possibly evidence of how ill he felt. To the ward it was seen as evidence of his dependence on it.

Comment

We recognise that providing services for young people like MB is not simple. There are services for children and adolescents up to the age of 18 (the children and adolescents mental health service teams, CAMHS) but there can be issues of continuity of care from CAMHS to adult services. It would be possible to extend the age range of the CAMHS teams – but the needs of a 25-year-old are not like the needs of a 10-year-old. It would be possible to create a separate service for the 18 to 25s but that also increases the potential for fragmentation and lack of continuity.

The trust agree it was not optimal for someone of MB's age to be cared for in a general ward. They have started looking at how they could develop a service for 16-25's which would overlap with CAMHS and adults rather than be separate from it. We would support this while recognising that it could create different issues.

However, some of the issues arising from MB's youth should have been picked up by good quality medical and nursing practice and the effective operation of CPA. We hope that improvements in the operation of CPA may help resolve these issues.

Family and culture

9.12 We know little about MB's family and cultural background. There is virtually no information in any of the documents and it was not evident to us that any of the staff concerned in his care had looked closely (or at all) at this and the impact it may have had.

9.13 We know that MB was born in Cyprus to Kurdish parents who left for England when he was about 2½. We understand from MB that he also spent some of these 2½ years in Turkey. He joined his parents in England some six months later. MB is the oldest sibling. He has a sister who is about two years younger than him and a brother some 10 years younger.

9.14 The family initially lived in hostels and apparently in homeless families' accommodation before being housed by Hackney Council. His father ran a bakery where MB worked occasionally. Neither of his parents speaks much English.

9.15 MB says he was bright at school and could have gone to university. However, for reasons that are not clear (but which MB attributes essentially to associating with the wrong people) he left school without taking his GCSEs. He says that he began smoking a lot of cannabis which badly affected his ability to cope socially. His psychotic episodes were at times attributed to his use of cannabis but despite his claims, his drug screens in hospital were mostly negative.

9.16 MB's parents seem to have had a stormy relationship, with his father moving out of the family home from time to time. His sister is married and his younger brother (who is 12) lives with his mother.

9.17 His parents still have family in Turkey and MB stayed with an uncle when he went there in October 2005.

9.18 There is so little information that we are not able to say what difference knowledge of his background might have made. When the care programme approach (CPA) was implemented in 1991 two of the four key components were:

- systematic arrangements to be put in place for assessing the health and social needs of people accepted by the specialist mental health services
- the formation of a care plan to address the identified health and social care needs.

9.19 We can find no evidence that, staff made any real effort in their operation of CPA to identify or understand MB's family and cultural background. Without this, his social needs could not be identified. The only social need which was ever pursued to any extent was his need for housing – and this arose only because of his referral to the children and young people's service.

9.20 His parents regularly visited him in hospital (and still visit him in Broadmoor) but it is not clear how involved they were with his care planning. There are certainly more references to contact with his mother in particular during 2005 and while he was being cared for by the HTT. It is not clear how often an interpreter was used and without that our view after meeting MB's mother is that her understanding and contribution were probably limited. Engagement with the family was much more limited after the transfer of MB's care to the SELT and became problematic after the children and families referral.

9.21 His mother was effectively his carer when he was in the community, but the efforts to involve her in discussions about his care were minimal. She was thought by his clinical team to have an unrealistic view of his mental state and this seems to have led to her being treated in a dismissive way rather than triggering a concern about how best to help her.

Comment

We believe that assumptions were made about MB which might not have been made if there had been a better understanding of who he was and of his family culture. His resistance to independent living was seen to be symptomatic of a growing dependence on the ward. In fact it seems to us that it could equally demonstrate his dependence on his mother. It may be that young men in his community might be expected to stay at home for longer. MB was clearly concerned at time about the responsibilities he would have to take on and clearly did not feel mature enough to do so. Nursing staff told us he seemed young for his age. Yet he was expected to behave as if he were fully mature.

The apparent absence of curiosity about MB beyond his symptoms led to unfortunate assumptions about him which had a negative impact on his care. Hackney is an area with a large number of different cultures and it would be difficult for mental health staff to have a detailed understanding of them all. However, a full family history should be taken and there needs to be some means of checking assumptions against the culture of the particular patient.

Conclusion

C46 The medical and nursing staff failed to take sufficient account of MB's age, culture and family background and to consider these as part of their assessments of his needs. Consequently decisions made about his care were compromised and not always in his best interest.

Recommendations

R31 The trust should continue to review how they could develop a service for the 16 to 25 age group which would overlap with CAMHS and adult services rather than be separate from it.

R32 The trust should develop a process for ensuring a full family history is always taken and that assumptions are always checked in relation to the culture of the particular patient.

R33 The trust should ensure that interpreters are used when necessary, especially where there may be language difficulties for a primary carer.

10. Connolly ward occupancy rates

10.1 The level of bed occupancy is as an aspect of our investigation which was also identified in the internal inquiry report, which includes this table:

Bed occupancy rates	**Feb 06**	**April 06**	**June 06**
Occupancy (including home leave)	142%	128%	129%
Occupancy (excluding home leave)	91%	96%	92%
Section	3	6	4

10.2 The internal inquiry report makes no comment on the levels of occupancy of Connolly ward. The ward had and still has 20 beds. Nursing and medical staff repeatedly told us there were often higher numbers of patients who although on leave were still the responsibility of the ward. The documentation supplied to us included statistical returns to the primary care trust which show that the bed occupancy for Connolly ward including leave for July to December 2007 was 159%.

Leave arrangements

10.3 In our discussion with a group of nursing staff working on Conolly ward in 2005/6 we were told that there had always been high levels of bed occupancy; high levels on section – c17/20 (though the figures on numbers of sections included in the table in 10.1 do not support this) and high levels of patients on leave. They said the numbers of patients on leave started as a response to managing patients approaching discharge. The original intention was to let them go on leave but have a bed available when they came back. They told us that the original intention has changed as managing the number of referrals depended on maintaining high levels of patients on leave.

10.4 The patients on leave remain the ward's responsibility. Care coordinators, if allocated, were informed with the intention that they would visit. The ward nursing staff told us that even when a care coordinator is involved, patients on leave contact the ward at all times – day and night - because they see the ward as a safe place.

10.5 We asked the charge nurse of Conolly ward about the bed occupancy. He said:

"I can't remember the exact number we had on the book, but when we say 'on the book' that means we have some patients in the community, but we're still responsible for their care, so on a day-to-day basis they will come and visit us. So, given we have 20 on the ward, plus the others coming in, it becomes quite a lot for staff to take in."

10.6 We also asked him if they had many patients with high risks and high needs:

"Yes. Most likely, yes. That's why they were not discharged straightaway – we sent them on leave, and at the same time let them come in, so that we can monitor them, sometimes on a daily basis, sometimes maybe a couple of days, and see how they are going. Then again, different consultants work differently. Some consultants will say the patient is ready to be discharged, off you go; some consultants say, no, keep them on leave for a while and then we'll reassess."

10.7 Another nurse we interviewed had been a student on Connolly ward then joined the ward as a staff nurse and was still working there at the time of our interview. She confirmed that while they have 20 beds, they might have five or ten people on leave and that a bed would be used for another patient unless it was empty only for one night's overnight leave. She described the impact:

"Twenty sleeping, but if the patient comes – some patients go and they come daily for their medication – if they come and we have any concern, we detain them and then make a bed available for them, if we need to see them, on another ward, and also we do that. We don't just neglect them because there's a new patient."

10.8 She was asked how often a patient who returned would have to be found a bed on another ward or a patient who is more settled on the ward moved:

> *"Nowadays I would say it's rare, but some time ago we did have a big turnover and we tried to manage."*

10.9 It happened to MB on his March 2006 admission when he initially slept on Brett ward but was a patient of Conolly ward. The trust's bed management policy has guidance on how to handle these circumstances.

10.10 In our interview with consultant psychiatrist A we explored the impact of the levels of bed occupancy and how decisions were made about leave and what arrangements were in place to support patients who were on leave from the ward:

> *"Before this event sometimes you find that you are forced to make decisions because of the issue of beds, that there are no beds, which was not particularly helpful. Looking at where we work and the kind of clientele we deal with, sometimes it borders on the absurd as to what you are going to do when there is this sort of crisis. Oftentimes you find us forcing patients going on leave and things like that, and perhaps needing close monitoring by the home treatment team or by the care coordinator. Nevertheless that still exposes us to risk because sometimes you never know what these patients are going to do, even though you've tried everything you think you can do. So it's an ongoing problem, but in a way, after this event, personally it's like pushing it back to the Trust because I will just say my beds are full, and then the Trust should look for a bed. It's not an issue of taking decisions because of the pressure of beds, but it's an issue of the Trust making available beds for patients to be seen. There is a lot of pressure: you see managers coming in, 'How come that you still have 20 patients on your ward? How many do you want to discharge today?' blah, blah. There was a lot of pressure on beds."*

10.11 We also asked him how patients who had no care coordinator were supported when they were on leave, as was the case for most of MB's first admission when he was at home on leave and no one was aware of what he was doing:

"That has changed; the structure is a bit different now. Now in the community, instead of having just a whole community, within the community we have two teams: we have what we call the assessment and brief treatment team and then we have the continuing care team. Every patient that has come newly into the team is taken on by the ABT team, and often they have a key worker, somebody working with such person. The idea is that they work with such person for about three to six months before making a decision as to is this person going to, the continuing care team or discharged back to the GP, or the patient should be discharged to the ordinary psychiatric outpatient clinic. The system is quite different now."

10.12 We asked him if there were still patients in a similar position to MB's in 2005.

"There are still some arrangements like that. Some of these patients are care coordinated, some are not. There is that sort of set up of patients being on leave."

10.13 In response to another related question he told us:

"The fact is not all of them could be care coordinated. Some patients need an allocated care coordinator, some patients we will often say that the doctor is the care coordinator, and when they use that term it means the patient is more or less an outpatient. The consultant or the doctor seeing the patient is regarded as the "care coordinator" by the trust."

Comment

It is clear from our interviews and the evidence of the internal inquiry report that during 2005/6 there were high levels of bed occupancy on Conolly ward. This feature is not uncommon for psychiatric admission wards all over the country and particularly in inner-city catchment areas.

High occupancy levels combined with high dependency levels and high levels of patients on MHA section require clear procedures and processes to manage care and risk. These procedures and processes should ensure that decisions being made about leave are based on the best possible assessment and that support arrangements are in place with crisis and contingency plans. These procedures and processes are the essence of the care programme approach which in MB's case was complied with inadequately. In 2005 there were no support arrangements for him while he was on leave until just before he left for Turkey and throughout his care there were no crisis or contingency plans other than to return to the ward when he needed help.

10.14 We asked consultant psychiatrist B how the clinical team knew what MB was doing when he was on leave during 2005 because he had no care coordinator and they had no idea of the environment in which he was living:

> *"Absolutely and that is normal for many of our patients. If we wish to define the exact environment into which we could discharge our patients, we couldn't discharge anybody."*

Comment

As we indicate earlier in this report, we understand the environment in which the ward is working and we are not of the view that patients can only be discharged into a controlled environment. We say the service had a responsibility for MB's care which they could not fulfil when they had no idea what he was doing or how he was behaving when he was away from the hospital.

10.15 In response to a question about the lack of a care coordinator for most of 2005 consultant psychiatrist B stated:

> *"I'm not trying to defend that at all. Our ability to provide care coordinators is quite limited by the numbers we have. I don't know what the team have said about the provision of a care coordinator, because that is part of the community mental health team's remit. We had a lot of people stacked up at*

that time who didn't have care coordinators assigned because we didn't have enough staff. They had all gone off to the home treatment team."

10.16 Consultant psychiatrist A was asked how improved support from the HTT might help support those on leave from the ward:

"My thinking, which I've expressed, is that the home treatment team needs to be restructured and that if it was properly restructured it would serve better. My thinking is that each ward should have its own home treatment team. The home treatment team should be part of each ward, so when we have patients on leave or when we have a patient coming to the ward that we do know, we know that we have patients out there that a part of our ward is going out to see, and they can always feedback on a daily basis and who could take the patient out, who could bring the patient in. That's my thinking and I've always expressed that, and I think that's the best way to work, because at the moment you have an independent body, they have a barrier to break."

"Before coming in this afternoon I referred a patient from my clinic. I just listened to my phone message and they left a message on my phone saying that we've seen your patient, we need to discuss this patient with you before we can take that over. That means if I can't get there before five they are not going to do anything for that patient."

10.17 We met with senior managers including those at trust board level to discuss a range of issues. They were surprised that there was an issue of the high levels of bed occupancy and felt that the problem was better described as effective management of discharge rather than bed occupancy. They were concerned if this practice of allowing leave with no referral to CMHT was continuing (as staff told us it was) because it meant no proper follow-up or care coordination or planning and it had a profoundly negative impact on the service-user. They also accepted that staffing was organised on the basis of the number of beds and the system would be under pressure if this was still the approach. They agreed to review the figures to check on the current position regards leave and to review the current practice.

Low secure facilities

10.18 One of the recommendations of the internal inquiry report arising from the review undertaken was that the trust *"…considers what options there are for the development of low secure services as an integral part of the trust's range of facilities"*.

10.19 As a consequence of the inquiry recommendation and with the support of the City and Hackney PCT, the trust has developed a low secure ward in Tower Hamlets. We asked consultant psychiatrist B what he thought had been the effect of opening the unit:

> *"It has reduced our acute bed numbers."*
>
> *"A person has been appointed just to run the low secure unit. It isn't on site; it's at Tower Hamlets and it's full up all the time."*
>
> *"There was a review by the trust of all the patients on the ward and a number of transfers were made as well as the low secure unit to try to get some of the forensicity off the acute ward. Unfortunately, in order to do that by setting up a low secure unit we had to close a dozen acute beds, giving us less flexibility in our ability to manage people."*

10.20 The senior trust managers told us it was untrue that the low secure ward had been funded by closing one acute ward. One ward had closed since 2006 but there had only been an overall reduction of four beds. They also said that they were allocated as Hackney beds although they were in Tower Hamlets; that Hackney was the highest user of the low secure unit and of the forensic service and had most psychiatric intensive care unit (PICU) beds.

10.21 We asked the modern matron for inpatient service 2005/06, Mr P, if the impact of the new low secure beds had reduced the level of disturbance, difficulty, or risk on Conolly ward because we had heard evidence from nurses we interviewed that the position was not significantly different from that in 2005/6.

"I think the amount of aggression and violence on the wards is not significantly reduced, basically because the people who are generally aggressive or violent are people who have relapsed and come in."

Mr P commented on the value of the low secure facilities:

"…an extended period of resourced inpatient care with psychology and in a stable environment, maybe not using illicit drugs and things like that, will have a significant impact on that person's recovery and the understanding of their illness."

10.22 We asked him about the impact on the dependency of the patients now coming to the ward after the removal of the low secure patients to a separate unit:

"I think the inpatient services have shrunk and the community services have expanded, so the system has changed and reshaped."

"So the role of the inpatient services has been to develop practice, but it has also been there for crisis management. So hopefully people don't stay with us as long as they used to but when people come in they do come in acutely unwell, and, I have no evidence for it, but a higher usage of a higher percentage of people detained under the Mental Health Act."

Comment

We commend the trust for responding to the internal inquiry report and in consultation with City and Hackney PCT opening new low secure facilities. The new low secure ward based in Tower Hamlets was made possible by a reconfiguration that included the closure of an acute admission ward. We saw evidence that people welcome the development of this new service but there is also considerable concern that the impact on Conolly ward is that its percentage of acutely ill patients and patients on MHA sections has increased. The internal inquiry report sets out one of the objectives of opening such a service was to remove those patients needing low secure services so that they would not:

"…detract from the ability of staff to adequately monitor and respond to risk indicators exhibited by less disturbed and informal (not detained) patients."

One of the unintended consequences of transferring needs to the new service patients with low security is an increase in the numbers of patients in an acute phase being cared for in Conolly ward in the spaces thus created. This is because patients needing low secure services are usually no longer in an acute disturbed phase. This was confirmed by staff who told us that their perception of Conolly ward was that it now contained more not fewer disturbed patients and more not fewer patients on MHA sections.

Nursing staff numbers

10.23 Nursing staff told us at interview that the nursing numbers for the ward used to be three qualified nurses to one unqualified (in 2005/6). Now it is two and two and they thought this made the ward harder to manage. We asked Mr P (in general conversation, not in interview) whether any assessments had been done on the best level of nursing staff for Connolly ward. He said there had been no assessment of appropriate staff to patient ratios. He did not think enough work had been done on the optimum level of staff and that there was scope for using staff better, though this had not been researched properly. He also said the trust was now using different types of staff and there was more emphasis on what someone could do rather than on whether they were a registered nurse, as well as on improving the skill levels of unregistered nurses. Senior trust staff confirmed to us this approach of employing individuals for what they can do rather than whether they are registered nurses.

Comment

Acute admission wards have long been recognised as some of the most challenging areas in psychiatry because they serve as the A&E service and have to accept almost anyone, however acutely ill. It was evident in our investigation that the perception of staff working in Conolly ward was that there had been an increase in the dependency of the patients who were now more acutely ill. There may be a number of reasons for this:

- ***the reduction in acute beds***
- ***the less acutely ill being dealt with by the HTT***
- ***the patients with low security needs being transferred to the new unit.***

There have also been changes to the ratio of qualified to unqualified nursing staff and new types of staff employed based on competency rather than on qualifications. It is beyond the scope of this investigation to determine the staffing needs of Conolly ward but it would be appropriate for the trust to develop such an approach with the staff. This would help to gain the support of the nursing and other clinical staff.

Conclusions

C47 During 2005/6 the arrangements for sending patients on leave were not properly managed in that we found little evidence of any assessments that were undertaken before the decision to grant leave.

C48 We found no evidence of crisis and contingency plans for MB while he was on leave other than his contacting or returning to the ward or the emergency clinic.

C49 MB should have been referred to the community teams for support when he was sent on leave for extended periods.

C50 Our discussion with staff leads us to the view that the current practice in relation to leave arrangements is not vastly different.

C51 We welcome the development of the new low secure facilities. We also believe an unintended consequence has been an increase in the numbers of patients on Conolly ward who are in the acute and sometimes disturbed phase of their illness.

Recommendation

R34 The trust should undertake a review of the dependency needs of the clients on Conolly ward and the consequent staffing needed to meet those needs. The review

should be undertaken collaboratively with the staff on the ward and any changes explained fully to them. Any review should take account of the number of patients being actively cared for rather than just bed numbers because some of those on leave look to the ward for support.

R35 The trust should review the patient leave policy and procedures operating on Conolly ward as a matter of urgency to ensure that the current practice is safe and compliant with CPA.

11. Post-incident support and learning

11.1 MB was arrested on 8 July 2006 for the alleged homicide of JC by pushing him under a tube train at Highbury and Islington station earlier the day before. The police arrived with a CCTV photo which identified MB and he admitted what he had done.

11.2 A brief summary of the immediate events following his arrest is included in section 9 of the internal investigation report. In this section we look at the actions taken on the Monday after the arrest of MB. We received evidence in our interviews from a wide range of people that there was still considerable resentment about how this aspect of post-incident support was handled.

11.3 A meeting was held on the Monday after MB's arrest as the internal investigation report describes:

> *"Following the incident (Friday 7th July) and MB's arrest (Saturday 8th July), the MDT records were reviewed by the medical director on Sunday 9th July and a chronology compiled, including reference to key entries in the MDT notes. On Monday 10th July the Medical Director and Director of Nursing, met with consultant psychiatrists A and B, the Service Director, Senior Nurse Manager and a number of other members of the MDT at Hackney Centre for Mental Health, and they went through the circumstances of the incident, and the notes that the medical director had made the previous day."*

11.4 Convening a meeting immediately after a review of the MDT notes was appropriate. This provided an initial assessment of the care given to MB and whether it was generally acceptable. We are sure that the medical director came quickly to the view that there were matters of considerable professional concern and that these would need to be examined through an internal serious untoward incident investigation.

11.5 Meetings held immediately after a homicide or other such serious incidents obviously need to be handled with care. Those present who were directly involved may be in shock. If staff are to be encouraged to be open and not defensive, they need to

be given the assurance that judgements have not been made before the facts have been tested. A number of those present at the meeting felt that this was not the case and that the meeting was intimidating. We include a sample of the views of the staff who felt this way:

The Monday meeting

11.6 One member of staff involved in the meeting on the Monday said they were told:

> *"What sticky ground we were on, based on their reading of the locality file and the ward file. They had gone through it that weekend and we were summoned on Monday morning, because it happened on a Friday. I remember it was quite ludicrous, it wasn't supportive. We were given an opportunity to say various things, but 'listening to the hand' was very visible about certain things when we would try and make a point. We weren't listened to that sympathetically and I don't think it was supportive. Presumptions were made, conclusions were jumped to, based on a reading of files. I know we do that, but I don't think it was helpful, and I hope I never do that to anybody. I don't think it was right, and certainly people were badly affected by that."*

11.7 Another told us:

> *"On the Monday morning we were summoned to City and Hackney Centre for Mental Health…the medical director had looked through the notes on that Sunday and basically dealt with the situation pretty insensitively, removed consultant psychiatrist A from his duties and suggested that consultant psychiatrist B didn't come back to work until he needed to, which left the whole ward in a total mess. A senior registrar was asked to run the show, and she did so very well. You can imagine when this happens, a big disaster, all the normal systems like the consultants, they were all taken out, so the ward was jittery and all that stuff. …it felt pretty fragile and pretty vulnerable, and some of the people involved were pretty upset by it."*

11.8 Senior members of the trust told us they thought the meeting had been handled appropriately and sensitively. They said that some of the staff (including consultant psychiatrist B) had been hostile and wanted to focus on their own needs and emphasised the particular difficulties they faced in Hackney of high rates of mental illness and risk. The senior trust staff had wanted to counter that and get them to focus on MB's care. They denied that the doctors had been blamed in the meeting itself.

11.9 We include here the section of the internal investigation report which set out what the trust did in respect of the Conolly ward consultants:

> *"Subsequently, following discussions with the Chief Executive and after a further conversation with consultant psychiatrist B it was agreed that both consultants psychiatrists would both take a period of leave from 14th July to allow preliminary investigation under the SUI policy, to take place. Consultant staff at C&H, including staff from the MHOP service and from the Specialist Addictions Unit provided Clinical Director cover and Consultant support to SpR staff who 'acted up' into the Consultant roles, until consultant psychiatrist B's return to work initially on 24th July and fully on 28th July, and consultant psychiatrist A's return to work on 1st August. In each case this followed discussion with the Acting Medical Director. A series of mentoring sessions, beginning immediately, was put in place for consultant psychiatrist A."*

11.10 In respect of the removal of the consultants one of the staff told us:

> *"Because of the tragic events, I'm not sure that people should be relieved of their duties in this case. I think people should be removed from their duties if it's warranted, if it's malicious, if there is evidence of gross neglect, gross unprofessional conduct and behaviour. That's fine, I don't have a problem with that. In a high risk occupation like this when something goes very wrong in terms of the outcome, the corporate message is that you remove people as a neutral act while things are looked into, but behind all that you know what it's about. Frankly, I thought it was inappropriate and unnecessary, and it devastated certainly one of the individuals involved. I feel he was terribly hard*

done by and clinically undermined, because even the greatest experts in the country can't work out what the hell is the matter with this man, let alone what we try and do on a busy acute ward. I think that was inappropriate."

11.11 Consultant psychiatrist B's view of how consultant psychiatrist A was dealt with at that meeting is robust:

"At that meeting the medical director was extremely critical of consultant psychiatrist A's diagnosis of personality disorder because of his reading of the notes. He was extremely critical of him in public and I thought it was disgraceful."

11.12 Consultant psychiatrist B told us:

"I had this conversation (as I recall) with the medical director saying "If you are going to make consultant psychiatrist A go on leave, you have to make me go on leave, so you've got to announce that we've both been asked to go on leave", even though I was going on leave anyway."

11.13 Consultant psychiatrist A who was told to go on leave told us:

"I wouldn't know how to describe it. I should say that period was quite a traumatic time. What I can recollect is that the medical director came in and had a meeting and he said a few things that were quite uncomfortable, and afterwards consultant psychiatrist B came to me in the evening and said that Dr so-and-so said that I have to go away for a while. I asked him what did that mean and he couldn't really say what that meant. I said to him, 'Is that supposed to mean that I'm being sacked or being held responsible for this or what?' He said that that's what he said-that I have to go away for a while."

"He conveyed that message to me in the evening. I found that strange and, to be very sincere, I was weeping because I couldn't understand what was going on. I said to consultant psychiatrist B that it's okay that I will go, that's no problem, but I don't know what it's all about. Apart from what was said to me

in the morning, I couldn't understand what it was, so I left. Then consultant psychiatrist B called me later in the evening to say that the medical director wanted to see me the following day and would I like to go and see him. I said no problem, that I will go and see him. I went to the office and he made some explanation that he was trying to protect me, and I said I couldn't understand what that meant. It was at that point he said may be I should consider it as leave, so it was sort of leave, and I said okay, then I left. About two or three days later I got a letter from the trust saying that I was on leave, and today I don't know what that meant."

Comment

Handling such meetings after such a tragic incident is always difficult. It is compounded when an initial review of the documentation about the care of a patient identifies what appear to be failures. Nevertheless, it is important for staff to be left with the clear understanding that firm judgements will not be made until the matter has been properly investigated and the facts tested.

It is always a difficult judgement whether individuals should be removed from the work place in the interest of undertaking a thorough investigation. If necessary, this should be done formally by way of suspension, which is a legally neutral act. In this case the status of consultant psychiatrist A's leave (or indeed that of consultant psychiatrist) was not made clear and is still not clear. The danger of such a lack of clarity is that it can give the impression of victimisation because the individual is not certain of their rights in such a situation. For example, someone who has been suspended has a right to seek representation and the reason for that suspension would be stated.

Conclusions

C52 We accept that an initial reading of the documentation by the medical director would lead him to take the view that the care given to MB was seriously inadequate. It is evident that the attitude of consultant psychiatrist B/some staff made handling this meeting very difficult. Despite this, we believe the meeting could have been handled

more sensitively and it is clear that it has left a lasting negative impression with some of those who attended.

C53 The lack of clarity regards the status of the leave arrangements for the two consultants was unhelpful.

Managing the ward after the homicide

11.14 The ward was left without its regular consultant cover and with reduced consultant involvement when the two consultants went on leave. The trust tried to recruit a locum consultant to cover the ward but was unsuccessful. As an alternative the medical director arranged for the recently appointed specialist registrar to cover the ward, supported by consultants from other areas. This was a pragmatic response but it left the ward at a sensitive time without regular senior medical involvement. We were told in response to a series of questions:

> *"I think immediate support wasn't there, because once this happened, two consultants were taken away, and the ward was left one SpR."*

> *"I think the SpR was the one who did the last assessment, prior to MB leaving the ward."*

> *"So, given what happened, it had quite a bad effect on her, and people were not getting leave at all. So, I would say, once situations like this arise - I did raise that issue with the senior management when we had the meeting the week after - that once consultants are taken away, there is nothing put back in to support the team."*

11.15 We interviewed the senior house officer working on the ward before and after the incident. We asked her about the support available to her and the specialist registrar:

> *"It felt as though at a time when the junior staff needed support, both senior consultants were taken away and to me that felt a little unfair. There was a*

new Registrar, an SHO and the house officer was away. We felt very pressurised."

"We didn't have consultant led ward rounds for the time that bvoth consultants were away. A consultant would come in and we would discuss the patients that we'd reviewed with them. It was a difficult time, but I was only there for another three weeks before I left to move on to another job."

11.16 The internal investigation report addressed the issue of post-incident support and it recommended that:

"The trust should consider how, in the event of a serious untoward incident, the individual practitioners and the service involved can be practically supported in their continued function whilst the process of investigation is taking place."

11.17 We have reviewed the trust's current policy on managing incidents[23] to find out whether lessons from the internal inquiry had been incorporated into this document. This is a comprehensive policy but it is too long (69 pages). It is difficult to distinguish between policy, procedure and advice, it is poorly set out and hard to read.

11.18 Appendix 12 of the policy deals with post-incident support and sets out what needs to happen in supporting service-users, carers, family, friends and staff.

11.19 Appendix 3b of the policy deals with managing an incident and sets out the immediate and further steps that need to be taken. It deals with the need to put in place appropriate arrangements to ensure the work of the service can continue and says:

"Consider the service needs in the aftermath of a serious incident. This may include the temporary closure of a ward to new admissions, redeploying staff from other areas."

[23] A trust-wide policy for the management of incidents" (approved by the trust board November 2007)

11.20 This section should be expanded to address more fully the concerns raised by the internal inquiry, which we endorse.

11.21 We found no guidance in the policy on the procedure for removing staff from work. Since this may be necessary it should be made explicit and should be framed in light of section 2 of the policy, which quotes the trust's risk management strategy and says:

> *"To support staff, the Trust provides a fair, open and consistent environment and does not seek to apportion blame. In turn, this encourages a culture and willingness to be open and honest to report any situation where things have, or could go wrong."*

11.22 The quote from the risk management strategy also acknowledges that:

> *"Exceptional cases may arise where there is clear evidence of wilful or gross neglect contravening the Trust's Policies and Procedures and/or gross breaches of professional codes of conduct."*

Conclusions

C54 Arrangements were put in place for staff support but they were not sensitive enough to the emotional shock those involved felt. The specialist registrar who had only recently been appointed to the ward was left to manage the medical cover for the ward in the absence of the regular consultants. She was the doctor who had granted the leave in which MB had committed his offence, so this must have been a difficult situation for her.

C55 Sending the consultants on leave left the impression that they - and particularly consultant psychiatrist A - were chiefly responsible for the failures in care. We believe there were insufficient grounds at that stage for this conclusion and for the consequential removal of the consultants.

Reflective practice/learning

11.24 The trust put in place many of the components necessary to respond to these tragic events, including commissioning the internal inquiry and producing and acting on the subsequent action plan. Nevertheless, one of the most effective ways of improving practice after such events is for those directly involved to be supported in reviewing their practice themselves and taking responsibility for changes that are hard to identify through the medium of a formal investigation or inquiry. We asked a wide range of those we interviewed whether the tragic events had been used in a positive way to bring staff together to reflect on their practice and to identify where they might have done things better. We were surprised to find that this had not occurred in Conolly ward or in any of the teams involved in MB's care.

Circulation of the internal investigation report and trust action plan

11.25 We asked our witnesses whether they had seen copies of the internal inquiry report and the subsequent action plan and we received a mixed response, with some quite senior people as well as a larger number of junior staff not having seen (or not recollecting having seen) the report or action plan.

11.26 The trust completed an action plan after the internal inquiry. This was completed in a timely fashion, addressed the issues raised by the internal investigation and was reviewed twice in 2007.

11.27 The internal inquiry noted the arrangements in place to meet with various parties soon after the events and we endorse this as good practice. We quote here that part of the report for ease of reference:

> *"On 14th July, members of the SELT met with MB's mother and offered support for her and her family. They also attended a multi-agency meeting involving Social Services, Child and Family Services, Police, Education Services and others. Support to the alleged victim's family was offered through the Transport police, including advising them about this inquiry and offering to talk with them if they should so wish."*

Recommendation

R36 The trust should ensure reflective practice/learning opportunities are always arranged and supported following a serious untoward incident so that individuals can take responsibility for their own learning.

R37 We recommend that the trust's policy on management of incidents should be amended to include the following:

- in what circumstances staff may be relieved of their duties following a serious untoward incident; the status of their absence and their rights regards representation
- the need for staff to be offered opportunities for reflective practice as part of learning from a serious incident.

R38 The trust should amend its policy on managing incidents to ensure it clearly separates out policy, procedure and guidance and to improve its readability.

Appendix A

Extracts from rethinking risk to others in mental health services Royal College of Psychiatrists College report CR150

"Recent government initiatives

In 2006, the government asked the Care Services Improvement Partnership (CSIP) to develop and manage a mental health risk management programme for England. The aim was to improve the assessment and management of clinical risk in adult mental health services and to support services to achieve a balance between assessment and management. The ensuing report, Best Practice in Managing Risk, was published in June 2007. It set out some principles and evidence for best practice in assessing and managing risk to others and to self (Department of Health, 2007). Further reports are expected on public and media perceptions of risk and information sharing by mental health services. The Best Practice report is a useful document on which the Scoping Group has drawn for its conclusions. ***We endorse the statement of fundamental principles for risk management as summarised in our introduction."*** (Our emphasis).

These principles are set out below and are in the introduction of the report on pages 9-10. The majority of these principles and in particular 1, 3, and 5 were not evidenced in the care that was given to MB:

1. *"Accurate risk prediction is never possible at an individual level. Nevertheless, the use of structured risk assessment when systematically applied by a clinical team within a tiered approach to risk assessment can enhance clinical judgement. This will contribute to effective and safe service delivery.*

2. *Risk assessment is a vital element in the process of clinical assessment. It enables psychiatrists to reach a reasoned judgement on the level and type of risk factors for violence present in an individual case. This facilitates clinical interventions for those risk factors amenable to clinical treatment within the resources available to a clinical team.*

3. *Risk assessment informs risk management and there should be a direct follow-through from assessment to management.*

4. *The best quality of care can be provided only if there are established links between the needs assessments of service users and risk assessment.*

5. *Positive risk management is part of a carefully constructed plan and is a required competence for all mental health practitioners.*

6. *Risk management must recognise and promote the patient's strengths and should support recovery.*

7. *Risk management requires an organisational strategy as well as competent efforts by individual practitioners.*

8. *Risk management needs to recognise the role of other agencies."*

The following recommendation (page 10) directly relates to our comment on discharge letters and supports our view that they should contain explicit reference to risk and risk management.

"2 The content of discharge letters to GPs should be audited regularly. Discharge letters to GPs, copied to patients and carers (as agreed), must include:
details of risk to self or others;
diagnosis; treatment;
indicators of relapse;
and the details of any agreed risk management plan."