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

December 2011

A report for NHS London

NHS London

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1. Introduction

1.1 C killed his mother on 6 April 2008 whilst in receipt of mental health care from the East London NHS Foundation Trust. At court he admitted manslaughter on the grounds of diminished responsibility. He was sentenced to be detained indefinitely in a secure unit for treatment under sections 37 and 41 of the Mental Health Act.

1.2 C had been in the continuous care of psychiatric services for 15 years and was diagnosed with paranoid schizophrenia. Following an incident of attempted arson at his mother's home, he was sent to prison and then transferred under the Mental Health Act section 37/41 to a medium secure psychiatric unit. He spent six years in the medium secure unit and three years in a forensic community hostel before being discharged from his section by a mental health review tribunal (MHRT) in May 2002.

1.3 In 2002 C moved to a supported housing hostel, living in a flat with a low- level of support. A community mental health team (CMHT) from East London & City NHS Trust[1] (the trust) also provided support.

1.4 During the time he was cared for by the trust, C was transferred to another CMHT because of a service reorganisation.

1.5 Just before the homicide, on 26 March 2008, a care planning meeting took place, and C was seen by his care coordinator on 4 April 2008 when he received his depot injection.

1.6 NHS London commissioned Verita to conduct an independent investigation into C's care. Verita is a consultancy that specialises in the management and conduct of investigations, reviews and inquiries in public sector organisations.

[1] The trust became the East London NHS Foundation Trust in November 2007.

2. Terms of reference

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

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

- a review of the trust's internal investigation to assess the adequacy of its findings, recommendations and action plans
- reviewing the progress made by the trust in implementing the action plan from the internal investigations
- involving the families of both C and the victim as fully as is considered appropriate
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident
- an examination of the mental health services provided to C and a review of the relevant documents
- the extent to which C's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- the appropriateness and quality of assessments and care planning
- consider the effectiveness of interagency working
- consider other such matters as the public interest may require
- complete an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

3. Executive summary, overall conclusions, findings and recommendations

Executive summary

3.1 C killed his mother on 6 April 2008 whilst in receipt of mental health care from the East London NHS Foundation Trust. He had been in the continuous care of psychiatric services for 15 years and had a diagnosis of paranoid schizophrenia. He was 45 at the time of the homicide, single and living in a supported hostel.

3.2 C had five siblings living in and around London. He left school with four GCSEs. He began work as a trainee chef and spent a year at college but did not complete his training. He had a number of various short-term jobs in the catering industry latterly as a kitchen porter.

3.3 Following an incident of attempted arson at his mother's home on 1 April 1993, he was sent to prison and then transferred under the Mental Health Act section 37/41 to a medium secure psychiatric unit. He spent six years in the medium secure unit and in 1999 C was given a conditional discharge[2] from his Mental Health Act section 37/41. In the same year he was transferred to a forensic hostel in Tottenham run by Barnet, Enfield and Haringey Mental Health NHS Trust (BEH). He spent three years in this hostel. His mental health improved and he was completely discharged from his section by a mental health review tribunal (MHRT) in May 2002.

3.4 While the conditional discharge remained in place C's forensic history was a factor in decisions about his care. The removal of the section coincided with a transfer to another residence (see below) we believe this had the effect of obscuring his forensic history and leaving new staff with less options if his mental health deteriorated.

3.5 In July 2002 he was transferred to Heather Lodge in east London which was run by a housing association and provided supported living. C lived in one of the 'low-support flats' in Heather Lodge which provided him with his own bedroom, lounge and kitchen.

[2] A conditional discharge carries with it conditions (e.g. residence, treatment, supervision) and the risk of being recalled to hospital by the Ministry of Justice.

3.6 For the first year in Heather Lodge, C continued to be supported by his consultant from BEH and he returned to Tottenham for day services. He began training as a cook again and went to college and obtained a vocational catering qualification. Following referral to the East London & City NHS Trust and after a number of transfer care planning meetings he was eventually taken over by the Bow and Poplar Community Mental Health Team (CMHT) from that trust. He continued to be supported by this CMHT until September 2005 when he was transferred to the Isle of Dogs CMHT because of a reorganisation of CMHTs.

3.7 Just before his transfer to the new CMHT, C's mental health started to relapse. The deterioration continued after transfer. His new care coordinator became concerned about his mental health and, in November 2005, she organised a Mental Health Act assessment. This resulted in his admission to hospital on 15 November 2005 where he remained until 30 December 2005. His new consultant from the Isle of Dogs CMHT was involved in the assessment which had led to his admission and she continued to care for him in hospital. After discharge C was not reviewed again by a psychiatrist or seen by a medical member of the CMHT until after he killed his mother in April 2008. A period of two years and three months.

3.8 The reorganisation of CMHTs in September 2005 resulted in the transfer of over 100 new clients to the Isle of Dogs CMHT. Despite the large number of clients transferred there were few additional resources made available to the team. Additionally the transfers took place over a short time and without any effective transfer plan. This resulted in clients moving without up-to-date care summaries or risk assessments and the team being under considerable pressure. The team wrote to the then sector manager expressing its concern about the standard of care it was able to offer as a result of the increased workload. The investigation team (referred to from now on in this report as 'we') has seen no evidence of a response.

3.9 From September 2005 C was supported by the same care coordinator from the Isle of Dogs CMHT. He was seen regularly about every two to three weeks when he was given a depot injection. The care coordinator used the opportunity of the injection to review with C his mental health condition. As Heather Lodge offered supported housing there was always staff on duty and there was good communication and partnership working between the staff and the CMHT. Any changes in his mental state could therefore be identified quite quickly.

3.10 In the period after C's discharge from hospital and the incident in 2008 (approximately two years and three months), C's mental health fluctuated. In his low times he would sometimes avoid being available for his depot injections or not attend his care programme approach (CPA) planning meetings. At other times he was noted as bright in mood with good interactions.

3.11 2007 was generally a good year for C. He was described as happy at Heather Lodge, joining in groups. He was attending a centre run by MIND where he helped to cook meals. He also attended a day course in first aid and begun an IT course. He was in regular contact with his mother who he met about every two weeks. He spent some time with his family over Christmas and New Year including his half sister who was visiting at the time.

3.12 From the middle of February 2008 until the incident in April 2008 his interactions with staff changed. At times he was mute and needed encouragement to converse. Staff who knew him well said that this was not unusual.

3.13 His Heather Lodge project worker recorded on the 6 March 2008 that C *"complained of being 'up and down' sleepless nights due to worry. Visiting family and joining in music group and house meeting"*. He was assessed again on 12 March 2008 and his care coordinator noted that *"C initially mute, then interacted well admitted feeling up and down. No suicidal thoughts no thoughts of fire setting"*.

3.14 A care planning meeting took place on 26 March 2008 and the records show that a needs assessment was completed along with a risk summary and plan. The forms were signed by the care coordinator and team leader but there was no record of C or a doctor being involved. C was then seen by his care coordinator on 4 April 2008 when he received his depot injection.

3.15 We conclude from our review of the records and our interviews that C was reviewed in the days before the incident and there were insufficient clues in his behaviour that would have caused the staff involved with C to do anything more than maintain their usual level of supervision. His care coordinator had previously been instrumental in arranging for C to be assessed and subsequently admitted to hospitals so she was alert to his signs of relapse.

3.16 This investigation follows on from the trust's own investigation which was set up within 72 hours of the incident with appropriately senior and experienced panel members. The panel used root-cause-analysis methods to investigate C's care. Its report identified the following care delivery problems:

- lack of information about and from the family
- lack of full personal and psychiatric history and risk chronology
- lack of psycho-social formulation problem
- lack of medical review
- lack of case load management process for the CMHT and medical staff
- lack of formal system to ensure medical reviews are regularly undertaken of all users on consultant caseloads
- medical workload distribution and transfer of work arrangements
- lack of an assertive outreach team approach.

3.17 We are in broad agreement with these findings. Having said this we do not believe the report sufficiently outlined the organisational systemic problems that may have contributed to the problems listed above.

3.18 The panel made eight recommendations and developed an action plan to implement them. The recommendations essentially promote better and more effective CMHT team working. We have reviewed the action plan with the trust and are confident that there have been significant improvements to CMHT working which address the recommendations. We describe in detail the improvements later in this report.

3.19 Alongside the implementation of the action plan and prompted by this incident the trust undertook a community services review, which identified systemic and organisational problems. This resulted in two key changes to team working. First, the forming of smaller clinical teams within CMHTs. Secondly, and most importantly, the designation of consultants as clinical leads of CMHTs working alongside team managers to ensure more effective team working.

Overall conclusions

3.20 C was supported by two CMHTs whilst under the care of East London NHS Foundation Trust. His care was marked by a similar approach and outcome from both CMHTs: individuals delivered effective care but care was not effectively coordinated, monitored or documented. His transfer to the Isle of Dogs CMHT in 2005 was also ineffectively carried out and subsequent changes to consultant responsibility in that team led to an almost complete absence of medical oversight.

3.21 It was clear to us and to the trust's investigation panel that at that time the Isle of Dogs CMHT did not work effectively. Both investigations identified a large number of processes that should have been in place to provide safe and effective care but which were either absent or working inadequately.

3.22 Partly as a result of the trust's investigation into C's care but also as a result of the trust's community service review, significant changes have occurred to CMHT team working that have resulted in a much needed focus on coordinating care.

3.23 Our summary note of our meeting with nine members of the Isle of Dogs CMHT records:

> *"…a team which appears to be functioning at a high level. The systems in place for ensuring that the outcomes and clinical pathways for clients are routinely and effectively reviewed, appears robust and well managed. The involvement of clinical medical staff in the running of the team is well integrated."*

3.24 In our view the improvements to the operation of the Isle of Dogs CMHT are a combination of two important factors. First, the trust's explicit designation of a consultant psychiatrist as a clinical lead with responsibility for ensuring that the clinical practice of all clinicians, whatever their professional background, is coordinated and of a high standard.

3.25 This explicit designation of a consultant clinical lead is in our experience an uncommon feature of the way that community teams operate. This approach to ensuring clinical leadership sitting alongside team management provides a safe and effective

approach to delivering community services. The approach is to be commended and is worthy of sharing with other mental health trusts as an example of excellent practice.

3.26 The second factor is the impressive team leadership and clinical focus of Dr Z (the current Isle of Dogs CMHT clinical lead) who has organised the team in a way that ensures that service users receive high-quality care. She has also ensured that the team review-systems provide a means of identifying the potential relapse of clients. In particular she has implemented a robust approach to ensuring care programme approach (CPA) reviews are effectively carried out. The team has also significantly improved its work with carers.

3.27 It will be important to ensure that the role of consultants as clinical leads is properly embedded and that the trust has a means of developing other consultants to take on this role as effectively as it is in the Isle of Dogs CMHT. We have made a recommendation that may help in this regard.

3.28 Finally we believe that our investigation has endorsed most of what was identified by the trust's own investigation including some serious shortfalls in CMHT practice between 2005 and 2008. We are pleased however that our investigation has shown that the Isle of Dogs CMHT is now working in a safe manner and providing an excellent service to its client group.

Findings

F1 C was being supervised on a regular basis in the weeks before the incident and there was no evidence available to staff caring for him that would have alerted them to the deterioration in his mental state.

F2 We believe that the removal of the Mental Health Act section 37/41 by the MHRT contributed to the obscuring of C's forensic history from those who were responsible for regularly reviewing his care and assessing the risks he posed. It also reduced the ability of community staff to be more assertive with C to ensure that he complied with regular attendance at the depot clinic.

F3 Despite the failures in care identified, we have found no evidence that they had any causal link to the homicide of C's mother.

F4 The appointment of consultants as clinical leads of CMHTs is an important development and the trust is to be commended for introducing this change.

F5 The six monthly reviews of the care coordinators' cases by the clinical lead provides them with valuable support, and is a key factor in ensuring that the standard of case management is consistent and of a high quality.

F6 Situating all the members of the Isle of Dogs CMHT in one place has had a beneficial impact on the quality of team working.

F7 The Isle of Dogs CMHT has significantly improved its involvement with carers and family members as required by the trust's CPA policy.

F8 The manner by which clients were redistributed to consultants in the Isle of Dogs CMHT, in 2007, failed to ensure that a system was in place that enabled the new locum psychiatrist to quickly identify which clients should be prioritised and was therefore unsafe.

F9 The trust's own investigation was set up in a timely manner. The panel members were appropriate to the incident and sufficiently senior and experienced to carry out a robust investigation.

F10 The trust has implemented the recommendations from its investigation in a timely and effective manner.

Recommendations

R1 The trust should produce a short document that sets out the key functions of a clinical lead. It should include guidance that will enable clinical leads from any service to be clear about their key responsibilities.

R2 The trust should ensure that there is a trust-wide set of protocols geared towards ensuring successful client transfers between consultants and between teams.

4. Approach and structure

4.1 We have reviewed details taken from C's documented care notes, documents from the initial East London NHS Foundation Trust panel review report into the incident plus the report itself, and transcripts of the interviews taken at the time (including written clarifications from those interviewed). We also examined relevant policies and procedures from the trust and the transcript of interviews carried out for this investigation and documents provided for clarification. A list of the documents reviewed is given in appendix A.

4.2 Although C's care notes provided a great deal of information, they were difficult to follow in parts because the files are not all in chronological order and some written notes were hard to decipher.

4.3 The investigation team comprised of Geoff Brennan, Tariq Hussain and Dr Fin Larkin. Biographies of the team are given in appendix B.

4.4 We interviewed the following people:

- consultant psychiatrist , clinical lead
- nurse, Isle of Dogs CMHT
- clinical director
- associate director community services
- team operational lead
- associate director for cognitive services
- operational lead, Bethnal Green Community Mental Health Team
- community mental health nurse
- project manager, Heather Lodge

4.5 We followed established good practice in conducting interviews. The interviewees could be accompanied by a representative or a friend and were able to comment on the factual accuracy of their interview transcript.

4.6 The trust was invited to comment on the draft report and to provide an update on changes made to services in the light of its reflective review.

Contact with service user C and his family

4.7 We met C twice, first to explain the purpose of the investigation and to receive any information that he wished to give. Secondly, to discuss with him the findings and conclusions of the final draft report.

4.8 We invited C's sister to meet with us but she preferred us to provide regular reports by email of the progress of the investigation, which we did.

5. Care issues

Background

5.1 At the time C killed his mother on 6 April 2008 he had been in the continuous care of psychiatric services for 15 years and had a diagnosis of paranoid schizophrenia. He was 45, single and living in a supported hostel.

5.2 C had five siblings living in and around London. He left school without qualifications. He began work as a trainee chef and spent a year at college but did not complete his training. He had a number of various short-term jobs in the catering industry latterly as a kitchen porter.

5.3 Following an incident of attempted arson at his mother's home on 1 April 1993, he was sent to prison and then transferred under Mental Health Act section 37/41 to Kneesworth House, a medium secure psychiatric unit. From there he was transferred to a forensic hostel run by Barnet, Enfield and Haringey Mental Health NHS Trust (BEH).

5.4 We set out below a detailed examination of C's care from his time at BEH until the incident on 6 April of 2008.

Transfer between BEH and East London & City Mental Health NHS Trust (1999 to June 2003)

5.5 In 1999 C was given a conditional discharge from his Mental Health Act section 37/41 and transferred to Cascade House, a forensic rehabilitation service in Tottenham, London, run by BEH.

5.6 In 2002 C was granted an absolute discharge by a mental health tribunal (MHRT) from his Mental Health Act section 37/41. While still under the care of BEH, C attended day services which he told us he enjoyed. During this time he studied for and received a vocational qualification in catering.

5.7 Shortly after C's absolute discharge C was transferred from Cascade House in Tottenham to Heather Lodge in east London which provides supported accommodation for

adults with a mental health diagnosis. This transfer took place before a formal transfer of his care from BEH to East London & City NHS Trust, which latter became East London NHS Foundation Trust (the trust). During this time he continued to travel back to Tottenham to attend day services.

Comment

These changes were part of service user C's movement from forensic services to mainstream services.

5.8 A CPA review meeting was convened by BEH and held on 24 October 2002. The East London & City NHS Trust was represented by the senior social worker/senior practitioner based in the Stepney and Wapping CMHT. A representative from Heather Lodge also attended.

5.9 On 29 October 2002, Dr Y of BEH wrote a referral letter to Dr X of the east London trust which was copied to the manager of the Bow and Poplar CHMT. In this letter he outlined the progress of C though the forensic services. Dr Y reported that *"Although there have apparently been no delusions and hallucinations for a number of years, Dr W's assessment in 1993 appears to confirm a diagnosis of schizophrenia."*

5.10 Dr Y also passed on the details of a previous incidence of arson and the information that C had *"been profoundly handicapped by negative symptoms of schizophrenia for a number of years before improving very considerably from about 1997/8"*.

5.11 Dr Y also reported that administration of medication by means of a depot injection had been discontinued in July of 2002 in favour of oral medication. He stated that this was done in an attempt to control side effects of the medication.

5.12 Dr Y noted that C visited the West Indies with his family for four weeks in late July and early August of 2002.

5.13 Dr Y stated that C then moved to Heather Lodge, in the east London trust's catchment area, in the third week of October 2002. There is some discrepancy about C's moving date with Heather Lodge documentation, but what is not in doubt is that C was fully transferred with regards to accommodation by the first week of November 2002.

5.14 Heather Lodge is owned and managed by Providence Row Housing Association. It offers supported accommodation for adults with mental health needs. There are 21 flats that offer high to medium support, and eight low-support flats.

5.15 Following Dr Y's letter correspondence indicates that Dr Y retained an involvement with C as C continued to attend an outpatient appointment with him.

Comment

At this stage although service user C is living in the East London and City NHS Trust's catchment area responsibility for his care still remains with BEH.

5.16 Responding to the referral letter to him on 25 November 2002, Dr X wrote *"I shall accept consultant responsibility in due course, provided that the Bow and Poplar CMHT has also been involved in the handover and accepts responsibility"*. On 18 March 2003 Dr Y wrote to Dr X again noting that a formal transfer of care has not taken place.

5.17 A handwritten note dated 21 March 2003 signed by the Bow and Poplar CMHT team manager indicates that the senior social worker/senior practitioner based in the Stepney and Wapping CMHT (who had attended the CPA meeting on 24 October) had advised that the Bow and Poplar CMHT did not need to be involved at that time. There is no explanation why this was thought to be the case.

Comment

As service user C was to be transferred to the care of the Bow and Poplar CMHT it would have been more appropriate for a representative of that team to be involved in the discussions about transfers.

5.18 On 22 May 2003 Dr Y wrote to Dr X noting that C had failed to attend a planned outpatient appointment on 1 May 2003. He said that he could not continue to offer support as C was not within his trust's catchment area.

5.19 In this letter, Dr Y stated:

> *"C has been an extraordinary pleasure to work with. Almost everyone finds him one of their easiest clients. I understand his social worker thinks that he could live completely independently within a year. I nevertheless have to record my view that there is a 30% chance of a seriously dangerous incident in the next five years."*

Comment

This statement is not further qualified in the letter or subsequent communication and Dr Y's assessment of risk was very accurate.

5.20 On 2 July the senior social worker/senior practitioner from the Stepney and Wapping CMHT wrote to Dr Y to confirm C's formal transfer to Bow and Poplar CMHT. The senior practitioner from Stepney and Wapping CMHT continued to be recorded as C's case manager and chaired placement review meetings with Heather Lodge with Bow and Poplar CMHT staff in attendance.

5.21 The following documents are listed as having been sent to the CMHT from BEH as part of the transfer in June 2003:

- Basic patient information
- Referral information
- Care plan
- Full needs assessment
- CPA contact and crisis form
- CPA care planning record
- Rick checklist
- Risk assessment
- CPA &117 review form.

5.22 The transfer letter (2 July) also noted:

> *"…it was agreed that the date of his next CPA would be in Tower Hamlets when consultant* [Dr X] *assumes responsibility for his medical care in Tower Hamlets."*

The letter advises for a CPA to be arranged in due course.

5.23 Dr X began to see C as an outpatient in June 2003 and started a six monthly outpatient appointment system. This continued with good attendance until C's discharge from Dr X's caseload in August 2005.

Comment

The documentation sent on transfer from BEH in June was comprehensive and provided the receiving staff with up to date information on service user C's care.

5.24 Immediately before C's transfer some significant changes to his management took place: the removal of MHA section 37/41 and a change from depot to oral medication. It is of particular note that in the letter to Dr X, Dr Y stated that C had *"…no delusions or hallucinations for a number of years",* whilst under 37/41 and receiving regular depot medication.

Comment

Service user C was transferred from Cascade House in Tottenham to Heather Lodge in east London in November 2002 but he was not formally accepted by the appropriate local care team in East London and City NHS Trust until June 2003. In essence, therefore C was not in contact with a local care team for eight months.

The records do not include the formal handover procedures between teams and individuals in 2003. Whilst it seems clear that Dr Y and the BEH care team attempted to hold handover/discharge CPA meetings with staff from the east London trust, and there was a transfer of relevant documents, it is unclear as to how or when the east London teams met to co-ordinate the care of C or who was responsible for coordinating the transfer.

It is also not clear why the Stepney and Wapping CMHT was included in transfer arrangements or what involvement it actually had in C's care. Because the transfer occurred in 2003 and did not have a direct influence on later actions by east London trust staff we have not investigated why this confusion existed.

Bow and Poplar CMHT to the point of transfer to Isle of Dogs CMHT (June 2003 to September 2005)

5.25 From June 2003, C was under the care of the Bow and Poplar CMHT until his transfer to the Isle of dogs CMHT in September 2005. C's notes show that he had a series of care coordinators in that time, as indicated by the chronology and the chart in appendix C.

5.26 The trust investigation report states that *"C appears to have been followed up by Dr X and the community Mental Health Team who reviewed him regularly"*. We agree with this conclusion and the following observation made by the trust investigation team:

> *"Although voluminous, the records do not contain a full and personal psychiatric history. The fullest account is contained in an undated forensic psychiatric report written by Dr X, probably written in 1993."*

5.27 It is unclear to us what model of case review existed within the team and what formal handover arrangements there were for new care coordinators throughout this time (2003-2005). Although the notes record individual professionals' involvement with C's care, the care was uncoordinated. There is also a lack of evidence regarding whether the team were monitoring C's positive symptoms (hallucinations and delusions).

Comment

We have not examined these matters further as they had little impact on subsequent events.

5.28 The lack of a case review process makes it very difficult to get a picture of C's progress during this time including whether the gains noted while at Cascade House in Tottenham were maintained, or if there was a fluctuation over time. The trust's internal report also states *"C had been in the service for some years and had been handed over*

several times from one team to another. At these times, there were no full reviews of his case". We agree with this summary and, given the confusion concerning C's move from BEH, it would seem that the difficulties in coordinating his care continued with successive care coordinators.

Comment

By the time of service user C's transfer to the Isle of Dogs CMHT, he had been with the east London trust for some years and had had a number of care coordinators. However, there is little direct evidence of his care being coordinated across the range of professionals who were engaged with him. This is not to say there was no intervention with C, but rather that it was not effectively coordinated, monitored or documented.

Transfer to Isle of Dogs CMHT

5.29 In our interviews we received a number of accounts of the circumstances leading to C's transfer of care from Bow and Poplar CMHT to the Isle of Dogs CMHT. In 2005 clients were allocated to care teams via their GPs, a system known as 'sectorisation'. C's care was transferred when the CMHT providing a service to C's GP changed from Bow and Poplar to the Isle of Dogs.

5.30 Unlike the transfer from BEH to the east London trust when C was the only client transferred, a large number of clients on the GP's register were transferred from Bow and Poplar CMHT to the Isle of Dogs CMHT.

5.31 It was clear throughout our investigation that the new 'sectorisation' arrangements caused considerable difficulties. A number of our interviewees described a significant increase in caseload for the Isle of Dogs CMHT at this time with little in the way of increased workforce. One written response to our investigation states that *"only one community psychiatric nurse transferred with 100 plus cases".* At that time there were also only two consultant psychiatrists covering both inpatient and community services for the Isle of Dogs.

5.32 The residents of Heather Lodge were under the auspices of a specific GP practice and their transfer was overseen by two care coordinators. V, C's care coordinator, was one of these. She told us that:

> *"I started care coordinating for C sometime October, November 2005. He had come as a block package, as it were, for the whole of Heather Lodge of which there are about 30 clients. They were transferred due to sectorisation and we were told to accept them and organise CPA reviews in due course. The way the transfers happened were bitty, the documentation was incomplete and some people didn't attend their CPAs so the whole background was quite chaotic.*
>
> *…can I just make the point that the clients at Heather Lodge are chronic, severe and they do fit the severe and enduring mental illness criteria."*

5.33 In our interview with a senior CMHT team member we heard that on transfer, C's:

> *"…documentation was incomplete and I think C had been conditionally discharged or taken off the* [Mental Health Act section] *37 point discharge. Also that he came in as high risk…but it was weakened as things went on."*

5.34 We asked V what knowledge she had of C's forensic history and she told us:

> *"…I will be honest there was a lot going on at that time so I flicked through the files. I obviously knew what his major risks were."*

5.35 This was borne out when C started to become preoccupied with fire and fire extinguishers in Heather Lodge at which point V organised a Mental Health Act assessment and arranged for him to be admitted to hospital.

5.36 It is also clear that C's relapse started in the months before his transfer of care to the Isle of Dogs team. We do not suggest that the transfer itself was a causal factor in this relapse, but that it began whilst still under the care of Bow and Poplar CMHT. However, a decision to reinstate a depot injection as opposed to oral medication was made in response to this change in his condition and before he had been transferred to the Isle of Dogs CMHT.

Comment

The transfer of a large number of clients to the Isle of Dogs CMHT presented a considerable challenge. The Isle of Dogs CMHT was being asked to engage with service user C and coordinate his care, along with a large number of other clients, whilst C was unwell and without a comprehensive multi-disciplinary review in place.

Given that there had been difficulties in coordinating multidisciplinary team working with C before the transfer, the change of CMHT under the new sectorisation arrangements presented an opportunity to correct this. The opportunity was in fact missed. The possibility of ensuring better coordination of C's care was further hindered by his relapsing mental health, which did not seem to be factored into the timing of the transfer.

Admission to hospital in November 2005

5.37 From September 2005 C was supported by the same care coordinator from the Isle of Dogs CMHT. He was usually seen about every two or three weeks when he was given a depot injection prescribed to be given on a fortnightly basis. The care coordinator used the opportunity of the injection to review with C his mental health condition. As Heather Lodge was a supported housing unit there was always staff on duty and there was good communication and partnership working between the staff and the CMHT. Any changes in C's mental state were therefore able to be identified quite quickly.

5.38 In our interview with C he told us that at Heather Lodge he used to get annoyed because the fire alarms would go off as a result of residents frying food. He said he complained several times but nothing was done. There were also disagreements when C turned on the fan in the lounge as other residents could not hear the TV. One resident would stand in the open doorway smoking. Because of the disagreements he would sleep during the day and stay awake at night. He told us he remembers disagreements with residents when he had toothache.

5.39 As stated earlier C became increasingly unwell from July 2005. As a result in August his medication was changed from oral administration to a long-acting depot injection. C's relapse continued after his transfer and this caused concern within his new team. There

were a few instances where his depot injection was not administered as C missed a number of his appointments.

5.40 As a consequence, a Mental Health Act assessment was organised for 15 November and C was subsequently admitted to hospital under the Mental Health Act section 3.
Dr U his new Isle of Dogs consultant was involved in the assessment and this was the first time she had met C. Following his admission, C was restarted on depot as he had missed a number of injections. The evidence from his clinical records is that his mental health seems to have greatly improved. The trust investigation report, commenting on the admission, states;

> *"There is no discharge summary. The notes do not include a full and personal history at this time. There is no record of any contact with the family."*

Comment

This is not entirely accurate in that there is a discharge summary in the notes, although the actual summary is severely lacking in the detail that we would have expected.

5.41 The trust report also states that:

> *"C was seen by the consultant* [psychiatrist Dr U*] and medical staff during this admission and this is the last time he was seen by the psychiatrist."*

Comment

Service user C was in hospital from 15 November to 30 December 2005. This is his first major relapse requiring hospital admission since his transfer from Tottenham and seems linked with his non-compliance with medication. The admission provided an opportunity to review and coordinate C's care before he was discharged but unfortunately this opportunity was missed.

Changes to Isle of Dogs CMHT in 2006/2007

5.42 On discharge from hospital (30 December 2005) C returned to Heather Lodge and his mental state improved. His contact with the CMHT settled back to a regular visit from the care coordinator who collaborated with Heather Lodge staff to monitor his treatment.

5.43 Around the time of C's discharge from hospital there were many changes within the CMHT. In addition to the increased workload caused by service changes, documents gathered for the trust's own investigation indicate that the team was unsettled and was trying to adjust to the major changes associated with the transfer of a large number of clients to the team, GP sectorisation and a recent move to new premises. There was also a high turnover in key posts - such as the senior practitioner - who oversaw care and supervised staff.

5.44 By 2007, the medical input to the CMHT had been increased from only one consultant in post and a part time staff grade to three consultant appointments. At this time consultants were covering both the ward/inpatient and community teams and we were told in interview by a number of people that they were difficult to access partly because they were not in the same building as the CMHT.

5.45 On 20 August just before Dr T, the third consultant was appointed as a locum, the clinical director sent an email to the Isle of Dogs CMHT manager, copied to the three consultant psychiatrists. This email set out the arrangements for the distribution of the clients. We deal with this in detail later in the report as the re-allocation of clients was not actioned in a safe manner.

5.46 The trust's internal report states:

> *"The clinical director* [For that trust geographical sector] *said that although he asked for the appropriate information, he did not receive good enough data on population morbidity or historical activity on different GP Surgeries to accurately divide the work load. He, therefore, did a best guess estimate from the information he had."*

5.47 A common thread from the interviews carried out for the trust's internal investigation and this review was that many of the clients from the GP lists allocated to

Dr T had complex and challenging care needs. The interview the trust's investigation panel had with the then clinical director identifies that he made little effort to gain data from staff at local level. S team manager/operational lead told us that there were data that the clinical director could have used.

5.48 C was one of the clients who moved from the care of Dr U (who had become responsible for C when he transferred to the Isle of Dogs CMHT) to Dr T. In the trust investigation Dr T stated that he did not know that C was on his caseload, although S the CMHT team manager/operational lead indicates that he was given the names of those clients at Heather Lodge – including C - who needed CPA. We deal with the handover arrangements later in this report.

5.49 The Isle of Dogs CMHT operational lead supplied us with a copy of a letter dated 19 October 2007 which was sent to the sector manager, from *"The Isle of Dogs and South Poplar Community Mental Health Team"*.

5.50 The letter states:

> *"The Isle of Dogs & South Poplar CMHT* [The isle of Dogs and South Poplar is the area covered by the Isle of Dogs CMHT] *as a team are concerned about the increasing workload of the team and our ability to continue to operate safely at our current level of performance. We as a staff team are concerned about the increasing possibility of serious untoward incidents or poor service delivery within this context."*

5.51 The letter is detailed and sets out the team's specific concerns and how they were trying to manage the increased workload. It also proposes some suggestions for addressing their concerns. The letter is not signed and does not specify who drafted or agreed to its contents. We do not know what response was given to this letter. There is no evidence that it was copied to anyone else.

Comment

The evidence would suggest that the Isle of Dogs team was working in an environment where the demand for its services was increasing while the resources available to

meet this demand were fluctuating - and that members of the CMHT including medical staff were highlighting these problems before the incident.

5.52 In the period after C's discharge from hospital up to the incident in 2008 (approximately two years and three months), the clinical records show that his mental health fluctuated and that in his low times he would sometimes avoid being available for his depot injections or attending his CPA planning meetings. At other times he was noted as bright in mood with good interactions.

5.53 There is evidence in the notes that 2007 was generally a good year for C. He was described as happy at Heather Lodge, joining in groups and going to a centre run by MIND where he helped to cook meals. He also attended a day course in first aid and began an IT course. He was in regular contact with his mother who he met about every two weeks and spent time with his family over Christmas and New Year, including with his half sister who was visiting them.

5.54 The trust's investigation report sets out a chronology of contacts between the service and C. An extract covering 2008 is set out below. We provide this information because it is important to determine whether there were any indications or warnings that should have been picked up by staff in contact with C before the incident.

Date	Profession	Intervention	Comment
9.1.08	CPN (V)	Depot	Stable mental state. Seeing a lot of his family due to half-sister being over
23.1.08	CPN (V)	DNA depot	DNA
29.1.08	CPN	Depot	Missed previous appointment due to dentist appointment. Stated he is fine and mood OK
2.2.08	Key Worker, Heather Lodge	1:1	Stated his mental health was 'good state of mind' stress last week due to tooth pain. Self care good and joining in groups
14.2.08	CPN (V)	Depot (at Heather Lodge)	Did not speak and was withdrawn, V discussed with manager at Heather Lodge who confirmed he had been like this since his return
6.3.08	Key Worker, Heather Lodge	1:1	Complained of being 'up and down' sleepless nights due to worry. Visiting family and joining in music group and house meeting

12.3.08	CPN (V)	Depot	C initially mute, then interacted well admitted feeling up and down. No suicidal thoughts no thoughts of fire setting
26.3.08	CPA	CPA forms	Signed CPA forms in notes with needs assessment risk summary and plan. Signed by care coordinator and team leader. No written notes. No attendance list to confirm whether C attended or Dr attended
4.4.08	CPN (V)	Depot	C mute throughout contact

5.55 It can be seen from the table above that C had a variable mental state at this time. From the middle of February 2008 up to the incident in April 2008 the records show that his interactions with staff changed: at times he was mute and needed encouragement to converse. Staff who knew him well said that this was not unusual.

5.56 His Heather Lodge project worker recorded on 6 March 2008 that C *"complained of being 'up and down' sleepless nights due to worry. Visiting family and joining in music group and house meeting"*. He was assessed again on 12 March 2008 and his care coordinator noted that *"C initially mute, then interacted well admitted feeling up and down. No suicidal thoughts no thoughts of fire setting."*

5.57 A care planning meeting took place on 26 March 2008. The records show that a needs assessment was completed and a risk summary and plan produced. The forms were signed by the care coordinator and team leader but there was no record of C or a doctor being involved. C was then seen by his care coordinator on 4 April 2008 when he received his depot injection.

5.58 We interviewed V, C's care coordinator, and discussed her assessment of him in the months before the incident.

> *"I worked with him for 2½ years, C was a very guarded, elusive character. He was an eccentric in terms of the fact that he would always be dressed in a big heavy anorak and heavy shoes in the middle of summer. He was a very private man and the nature of my engagement with him, throughout the whole time I worked with him, was sometimes he would be very forthcoming and open and sometimes he would be mute. That was how he was and during his mute periods he would be*

irritable and because I knew that about him I would ring and say I'm coming to see you and then he would disappear. I would say, 'is C here' to the Heather Lodge staff and 'oh no he's just gone out'. So if he didn't want to engage he took every step to make sure that he didn't."

"He wasn't particularly forthcoming in terms of being spontaneous although there were occasions when he was, for example, with the first aid course and his plans for the future. It would really depend on where he was that day. So sometimes he would be completely mute and therefore I couldn't engage with him at all. Sometimes it was apparent that he wasn't particularly happy to see me but through winkling information out of him he would tell me what I needed to know, reluctantly. Then there would be times when he would engage in a normal fashion, but those were rare. Mainly it was me extracting information from him and him giving it reluctantly."

"Obviously when he was mute then that was a trigger for concern and I would monitor him more closely. I had a very good working relationship with the Heather Lodge staff and R, the manager, and I would specifically seek her out and say C is disengaging, he's mute, he's not talking and can you please be vigilant."

5.59 We asked V whether there was any deterioration in the six months before the homicide or anything on reflection she should have picked up:

"No. In fact, obviously the family being an issue in this whole investigation, he had said that [at] *Christmas that he'd spent time with his family and was actually more forthcoming than he ever had been about them. Saying his half sister had come over from the West Indies and he'd enjoyed spending time and that was unusual for him."*

5.60 In our interview with the Heather Lodge manager we asked about C's presentation and whether there were any indicators before the incident that C was deteriorating. She told us:

"C was usually well presented. Sometimes he would wear the same clothes for quite a long period of time and we would have to prompt him to change his

clothes. But other than that, his personal appearance and certainly his flat was always maintained to a high standard."

"…if the fire alarm went off, that would upset C and he would be mute for some time. He would still come to the communal areas but he would be mute and just ignore you. You would speak to him and he just would not even indicate that you were there. He had had a quarrel with another service user, which I know had upset him. I think that was a couple of days before. But there were not that many indicators. ***To be honest with you, it was quite a surprise. It was quite a shock."*** [Our emphasis]

Comment

From our examination of the records and our interviews it is clear that service user C was reviewed in the days before the incident. There was also good communication between V and the Heather Lodge staff who were able to alert V to any deterioration. C was one of the first clients into Heather Lodge in 2002 and the staff there knew him well. His care coordinator had previously been instrumental in arranging for him to be assessed and subsequently admitted to hospital so she was alert to his signs of relapse. We therefore conclude that there were insufficient clues in C's behaviour to have caused the staff involved with him to do anything more than maintain their usual level of supervision.

5.61 The trust's investigation report states:

"A better appreciation of C's mental state in the weeks prior to the incident and a better understanding of any risk factors associated with C's relationship with his mother may have led mental health workers to recognise an increased level of risk, thereby providing a higher level of support."

5.62 We agree that more could have been done to provide contextual information to inform risk assessments but it must be remembered that C was in supported housing and therefore he was subject to regular review almost on a daily basis, by staff who knew him well. This doesn't make the need for further information unnecessary but even if it was available it cannot be assumed that this would have alerted staff to any deterioration.

5.63 There is a complete lack of information about C's family relationships in particular with his mother, which we deal with later in the report. Again it is only conjecture that if that information was available then there may have been clues that could have contributed to evidence of deterioration in his mental state. There is no evidence that indicates why C killed his mother. In our interview with C he told us that he used to bottle up his anger and his mother wasn't his target - it was one of the residents who used to annoy him over the TV.

Finding

F1 C was being supervised on a regular basis in the weeks before the incident and there was no evidence available to staff caring for him that would have alerted them to the deterioration in his mental state.

Analysis of service user C's psychiatric care

5.64 This section of the report provides a medical/psychiatric overview of C's care and primarily deals with two main issues:

1) (Approx) 2002 - stopping of depot medication
2) May 2002 – absolute discharge from the protection of the Mental Health Act section 37/41.

5.65 We know that by 2002 C had been psychotic, insightless, convicted, and inclined towards arson, regardless of risk to life (e.g. in dwellings) for many years. There was some improvement in C's mental state for about two years after he was discharged from his section, but it was limited, and Dr Y from BEH believed there was still risk.

Comment

Regular depot injections of antipsychotic medication and the protection of section 37/41 of the Mental Health Act were amongst the most effective interventions in helping service user C. It is difficult to understand why, on a Mental Health Act section 37/41, and a depot injection that was leading to some improvement, C was switched to oral medication; and why he was given an absolute discharge by a MHRT

in a relatively short space of time. These were of course two separate steps. But both significantly impacted C's care.

5.66 The most significant impact was the discontinuation of the protection of section 37/41. A depot can at least be restarted (and was in 2005).

5.67 The protection of section 37/41 allow for a person to be recalled to hospital if they are not compliant with treatment or conditions of residency etc required by the responsible consultant. Having these sections in place ensures that the service that is caring for an individual does not lose sight of his or her forensic history. It also helps to ensure a more stringent approach to reviews of clients so restricted. Arson in or near dwellings is extremely dangerous and C's preoccupation with setting fires was known to have continued well beyond his conviction for arson.

Comment

At a time when service user C was being transferred to a new trust and a new care team, continuing the conditional discharge would have provided C's new care team with more options if he deteriorated and would have helped to keep his forensic history in sight.

Finding

F2 We believe that the removal of the Mental Health Act section 37/41 by the MHRT contributed to the obscuring of C's forensic history from those who were responsible for regularly reviewing his care and assessing the risks he posed. It also reduced the ability of community staff to be more assertive with C to ensure that he complied with regular attendance at the depot clinic.

Compliance with depot medication

5.68 One of the particular concerns of the forensic psychiatrist who reviewed C's care following the incident (3 November 2008) was the erratic administration of depot medication as can be seen by the following extract of his report:

> *"Analysis of medication for psychosis/schizophrenia*
>
> *The medication was prescribed for injection every two weeks. The injection was given on the 8th January 2008. Following the missed further appointment on 26 February it was next given on 11 March representing a 63-day gap rather than the prescribed 14-day gap. The injection was then given on 1 April representing a 21-day gap rather than the prescribed 14-day gap."*

5.69 The record of depot medication is difficult to extract from case notes, but the handwritten integrated patient notes indicate that the following pattern of depot administration in the months leading up to the incident.

Date	Entry
09/01/08	*"Service user C attended Crisp Street yesterday. Administered depot injection. Next Depot 22/01/08"*
23/01/08	*"Service user C DNA'd"*
29/01/08	*"Barkentine- service user C attended. Respiridone Consta administered as prescribed."* **[20 day gap]**
15/02/08	*"Administered service user C his depot on the 14/02."* **[15 day gap]**
12/03/08	*"Service user C attended Crisp Street clinic on 11/03. Administered his depot. Next appt at Crisp Street 25/03/08"* **[25 day gap]**
04/04/08	*"Service user C attended Crisp Street clinic on 01/04/08. Administered his depot."* **[20 day gap]**

This timeline also correlates to the chronology of contacts from the trust's internal report.

5.70 The extracts of records above show that C's depot injections were not being administered in accordance with his prescription which stipulated a gap of 14 days. Very few entries record why his depot injections were not given at the required intervals. His last depot injection was given two days before he killed his mother.

5.71 Q who was a CPN with the Isle of Dogs team in 2008 and involved in running depot clinics described to us how the depot clinics were organised. She said that generally the clinics ensured that medication was administered on time. If clients did not turn up they were followed up. If there was a delay in a client receiving their medication it was not more than a week.

5.72 Q also provided relief support for depot clinics for Heather Lodge. She told us:

> *"…that at the time there were a lot of pressures at Heather Lodge, and it was quite a difficult caseload to manage anyway."* And *"Heather Lodge probably didn't feel as organised as the other clinics."*

Comment

The extract of records above shows that there was not a 63 day gap in administering service user C's depot medication but a maximum interval of 25 days. We believe the forensic psychiatrist's analysis was wrong but that this was caused by the poor quality of the notes. (We were told by the team manager that when the notes were transferred to trust HQ for the internal trust investigation they were photocopied and filed incorrectly). Whilst the medication was not always given at exactly the prescribed intervals, it is uncertain what effect this had on C's mental state in the absence of any medical review taking place at that time.

Summary analysis of service user C's care history

5.73 What can be seen from C's care history is that he had a large number of transitions in care. He moved from secure accommodation to supported living; from being subject to Mental Health Act restrictions to having no restrictions at all. He was also cared for by three different care teams from two different trusts.

5.74 Transitions in care are inevitable in mental health care. However, if they are not handled properly and efforts made to ensure that an individual's history and needs are not lost, they can increase the risk that relapse can take place and not be identified quickly enough. In C's case the manner in which the transitions were handled was far from satisfactory.

5.75 The trust's report identified a number of factors in the care of C that were serious such as failures in case management and the operation of regular medical and other reviews in the Isle of Dogs CMHT. Such problems meant that the care offered to C was below what he should have received.

Finding

F3 Despite the failures in care identified, we have found no evidence that they had any causal link to the homicide of C's mother.

6. Key changes to CMHT team working since the incident

Consultant leadership

6.1 In this section of the report we examine the changes to the operation of the Isle of Dogs CMHT made since the incident. Some of the changes have occurred as a direct result of the recommendations of the trust's investigation report. Others have been as a result of a review of community services commissioned by the trust. These changes have significantly improved the way the Isle of Dogs CMHT operates.

6.2 One of the key issues in the trust's report was the non-involvement of medical staff in C's care and treatment. In particular that C had not had a face-to-face meeting or medical review with the relevant consultant or one of the consultant's team after his discharge from hospital in December 2005.

6.3 One of the consultant psychiatrists interviewed by the trust in June 2008 stated that the:

> *"CMHT* [Isle of Dogs] *is historically very proud to be independent of doctors. I don't know about other Trusts whether or not the Consultants feel in charge of the CMHT. I feel like I am divided in 2 and it's difficult to be in charge. Working across different teams does not help."*

6.4 Not directly as a result of this incident but influenced by it, the trust has made changes to the role of consultants within the CMHT. The trust carried out a review of its community services and as a consequence decided to give a significant clinical leadership role to consultants. Previously consultants were involved in the clinical care of CMHT clients but not fully engaged as leaders of clinical practice. For example they were not managing team compliance with CPA, risk assessments and audit.

6.5 Dr P the current clinical director for Tower Hamlets (which covers the area covered by the Isle of Dogs CMHT) told us that the trust had decided that CMHTs should have clinical leadership from consultants, and that the clinical leadership of each CMHT should be divided into sub-teams, small enough to manage and to analyse data.

6.6 The practical consequence of this change was described by Dr Z (the current clinical lead for the Isle of Dogs CMHT) who told us:

> *"…the trust decided to build teams around consultants, so you would have a very hands on leadership role for consultants, so each of the CMHTs has a lead consultant, each of the wards has a lead consultant. The [Isle of Dogs] CMHT is split into the two teams; team 1 is the team which I lead and it is the bigger team and my clinical director asked me to lead for the CMHT."*

6.7 Dr Z was appointed as a consultant in the Isle of Dogs CMHT in September 2008 six months after the homicide. She was subsequently appointed as clinical lead for the team in 2010. We asked her what practical change has resulted from the change in the role of consultants. She told us:

> *"When I started in September 2008, it was quite chaotic in the team: I had come in as a new consultant, there were quite a few locum members of staff in the team, they did not know their patients, I did not know the patients, because I had just come in; you would think that I could then go and find out about the patients from the notes, but sometimes there would be letters and letters and no one would mention what the diagnosis was or anything and it was quite a challenge to get that information."*

6.8 S, team manager/operational lead, Isle of Dogs CMHT told us:

> *"Lines of accountability are much clearer, consultants are much more on side, much more available, open door policy, more policy, their doors are open, they are much more approachable and that is very different from how it was three years ago."*

6.9 In addition to our individual interviews we also met eight clinical and administrative representatives of the Isle of Dogs CMHT in a group meeting. We did not invite the consultant clinical lead or the team manager in order to encourage open discussion. The meeting was called to validate (or not) what we had been told in individual interviews. In respect of the involvement of consultants as clinical leads the group endorsed the view that the change had considerably enhanced the involvement of

medical staff and that as a consequence there appeared to be more focus on clinical outcomes and the clinical pathway.

6.10 Dr P, clinical director, Tower Hamlets, told us that the trust initially planned these changes four years ago but they did not come into effect until two years ago. This was because initially the local authority would not agree to a consultant psychiatrist managing local authority staff such as social workers. Following further negotiations the introduction of clinical leadership of CMHTs by consultants was agreed.

Comment

We believe that the introduction of the role of consultants as clinical leads is important to ensuring high quality clinical care. Giving a consultant explicit responsibility to ensure that the team's clinical work as well as their own delivers effective clinical care is to be greatly welcomed. It also places clinical leadership alongside managerial leadership which is important in delivering an effective service.

Finding

F4 The appointment of consultants as clinical leads of CMHTs is an important development and the trust is to be commended for introducing this change.

Consultant clinical leadership: role description

6.11 Our investigation has principally focused on the work of the Isle of Dogs CMHT. Therefore our assessment of the effectiveness of the changes to clinical leadership by consultants has been through the lens of Dr Z's leadership. We set out below the various elements of team practice that we believe are indicative of a high performing team such as team structures, review processes, and approaches taken to case management.

6.12 We have no doubt that Dr Z's contribution of providing clinical leadership to the team and her rigour and ability to help the team work together effectively is of a high order. We therefore explored how much of the improvement brought about as a result of the appointment of a clinical lead is located in the skills of Dr Z or driven by a clear expectation by the trust of how these roles should be performed.

6.13 We asked Dr Z how much of what she does as clinical lead is directed by the trust. She told us:

> *"I think that over the past year it has been a learning process as to what that means, because there is no specific job description about what being the lead for the CMHT or the ward entails."*

> *"There is not a clear direction in terms of what the lead consultants do; we had an away day for lead consultants last week and that was one of the things that we were discussing and that was very helpful because that was an opportunity for everyone to discuss what they do, and compare and decide what we should be doing."*

6.14 Dr Z told us that there is some development work going on with clinical leads to look at what each team does in order to come up with a common plan.

6.15 We discussed this with Dr P, clinical director, Tower Hamlets, who told us:

> *"For example, someone would want me to write what is a clinical lead of the CMHT, and I could say they meet their operational manager once a week. It might be that they might have to meet that operational manager twice a week, or once a month, depending on the maturity of the team, so I am, a little bit resistant, to actually writing exactly what is a clinical lead."*

> *"...clinical leadership is something that people have to develop and there are masses of developments in this area, and it depends on context. It could be a clinical lead for a psychological therapy service; it could be a clinical lead for a hepatitis clinic which is nursing-led."*

> *"We all have an idea what clinical leadership is and what the trust means when it says that it wants to build teams around consultants, we want you to take a hands on approach to clinical leadership. The nitty-gritty, day to day details of what that means, how much time to be spent in CMHT and how involved the consultant should get is being worked out as it were and we are sharing best practice between us which has been really helpful."*

Comment

For almost every other role within a trust there is either a job/role description or a framework setting out the key activities that are required to deliver a particular responsibility. We accept that these are senior roles and a detailed job description would not provide the flexibility necessary for different service contexts. Nevertheless Dr P, clinical director, agreed that there was a need to have in place a framework that sets out key principles or responsibilities for this vital role. Setting out such a framework also helps to identify what development or training individuals may need to step into these roles and against what standards the performance of clinical leads are to be assessed.

Recommendation

R1 The trust should produce a short document that sets out the key functions of a clinical lead. It should include guidance that will enable clinical leads from any service to be clear about their key responsibilities.

Comment

Since our interview took place with Dr P, clinical director he has produced guidance on the role of inpatient and community clinical leads. The guidance on community clinical leads is attached at appendix A.

Case management

6.16 At the heart of good mental health clinical practice is the existence of effective case management processes. These ensure that the care of service users is reviewed regularly; that the requirements of CPA are complied with and that the most effective recovery strategies are being used. At the time of the incident in 2008 it is clear that such processes were not sufficiently robust. The trust's report states:

> *"There is no formal case management process in place for consultant staff i.e. they do not review all their cases with anyone and do not undertake a process in the round with the Community Team."*

"Dr U [who took over C's care when he was transferred from the Bow and Poplar CMHT to the Isle of Dogs CMHT] *has her own system for monitoring all users under her care and is able to use this to ensure all users have had reviews etc. She designed her own system and does not use the Trust Clinical Information system RIO to provide this type of information."*

"Dr T [who took over C's care from Dr U] *saw all the users who were booked in to see him in out-patients clinic and undertook regular reviews with the CMHT. To his knowledge there was no reliable IT or paper based system in place to ensure all the users under his care were known to him directly or indirectly and was unaware that C was under his care."*

6.17 The following quote from the trust's panel's interview with the clinical director in post in 2008 shows the lack of integration of medical staff with the CMHT at this time.

"Q Does caseload supervision occur in the CMHT?
A I don't know.
Q Standards around CMHT practice?
A I don't see them as being my responsibility. I don't think that the CMHT manager sits with the doctors and goes through the entire caseload."

6.18 In written evidence to us, S team manager/operational lead told us that there were meetings to discuss case loads but that these were held separately with each consultant and separately with other members of the team.

6.19 S told us in interview that it was difficult in 2008 to develop an effective case management process. This was because:

"The team were working across the two consultants; each consultant did not have their own firm or team, sub team. They worked across and would attend two ward rounds too. Around the time of the homicide, a third consultant was appointed, perhaps six months before that, so we had three consultants, which meant care coordinators were working across three consultants, three ward rounds, three clinical meetings because each operated very much within their own. They did not crossover, or did not cover for each other at clinical meetings. So it was very chaotic."

6.20 The quotes above provide a clear picture of medical staff working as individuals but not using team case management processes. These processes are important to ensure that service users do not slip through the net as did C and possibly others but with less tragic consequences.

Case management: weekly clinical team meeting

6.21 We examined in some detail what changes have occurred to case management processes. One of the key case management processes is the weekly clinical team meeting. This provides a forum for the team to support each other in the management of cases and to emphasise that cases belong to the team and not just individuals.

6.22 V (C's care coordinator) told us that in 2008 there were weekly team clinical meetings but that *"Certainly things were in place but I would agree they weren't as robust as they are now."*

6.23 Dr Z told us how the weekly clinical team meeting is run:

> *"When I started, people seemed to think it was optional whether to come to a clinical meeting or not, this is the team meeting that we have on a Friday, when care coordinators can discuss cases with me and where the new referrals are discussed. Now they are very clear that it is not optional, you come unless you have a very good reason not to be there."*

Comment

The change from optional attendance at this meeting to expected attendance, coupled with having a consultant leading the meeting, integrates consultants much more firmly within the team and makes clear the importance of a team review of the cases.

6.24 In our meeting with the CMHT staff we were told that the meeting is now run more robustly and that the focus of the meeting is on compliance with CPA; whether clients are

attending their CPA reviews, client clinical safety matters and other issues directly related to the clinical care of the team's clients.

6.25 We reviewed a number of sets of minutes of this weekly meeting which show the extent of review for the clients. The minutes cover:

- triage and access
- continuing care
- current cases
- inpatients.

6.26 The minutes we checked reflect that the number of clients reviewed at each meeting was not too large to cause the reviews to be superficial and not too small to not be able to review all clients regularly. The minutes also showed that the individual reviews were thorough.

6.27 S team manager/operational lead told us that:

> *"Care coordinators are very clear that if there is a concern at all about not being able to see someone, it has to be brought up at the Friday* [weekly] *meeting, at the clinical meeting for each of the consultants to have. And it is brought there. There is also informal supervision, so there are lots of systems in place and lots of opportunities for people to address concerns."*

6.28 She also told us:

> *"I* [also] *meet with the consultants and both senior practitioners and the lead admin. We meet once a month and discuss clinical issues within the team and look at how we manage them."*

6.29 As part of the team ownership of cases Dr Z has also instituted a buddy system to ensure that service user's needs are not overlooked:

> *"If a coordinator is away we have a buddy system which I have instigated – it took a bit of pushing through, because people weren't keen on it – but basically every*

time someone goes on leave they have to have a buddy, they have to give their buddy a written handover of their cases."

Case management: individual case reviews

6.30 Dr Z also told us about other case management processes that check the quality of the individual work of care coordinators.

"So, cases are discussed there [weekly clinical team meeting] *but on top of that we have also started a programme of consultants reviewing outside that meeting and outside of CPAs the caseloads with the care coordinators. So every six months I will sit down with a care coordinator, the senior practitioner and we will go through their patients and just discuss each of them in terms of when they were last seen, what is going on and what the plan is. That has been really useful because it gives you time to be really focused on it. We have just come to the end of a six month period so every week I will sit down with one of the care coordinators for an hour, that will happen over about six weeks or so and then in the second part of the year we will do it again."*

Comment

This approach to case management provides a valuable means of checking the quality of work being carried out by care coordinators. Previously this may have only been undertaken within clinical supervision discussions. This approach helps to ensure that standards of case management are maintained at a consistent level across the team.

Finding

F5 The six monthly reviews of the care coordinators' cases by the clinical lead provides them with valuable support, and is a key factor in ensuring that the standard of case management is consistent and of a high quality.

Case management: clinical data reports

6.31 A weekly clinical meeting and a six monthly review with the clinical lead cannot, because of the number of clients on the team list, ensure that some service users are not overlooked. Dr Z told us that she had a case load in 2010 of 260 patients of which 129 were part of the CMHT. There is therefore a need for a robust system of case load data reporting. At the time of the incident a computerised case management system known as RIO was in place. This provided CPA reports but these could only be accessed by team administrators. This system has now been enhanced and is accessible by all clinical staff and can identify the number of clients that have not had a CPA or face-to-face contact with a professional.

6.32 Dr Z told us:

> *"…what we have now is the RIO reporting system and each month we get a report of face-to-face contacts, we have a target to reach and we get a report of whose CPAs risk assessments – when they are done, whether they are done. If they have not been done a certain number of times they go into the red. Those, for me, are the most important targets, the face-to-face contacts and that the CPAs have happened on time."*

> *"The system documents the completion of the document [CPA record], rather than the user attendance, but the face-to-face contact would show up if people had not been seen. So people have to be seen once a month, so if someone has not been seen, that will show up as red; you can also see who the health care professionals are who have been seeing that person."*

6.33 The RIO reporting system provides data not only for local clinical leads and managers but also directorate level leaders so they can review clinical practice at local level.

6.34 Dr P, clinical director, Tower Hamlets showed us a report that provides him with an overview of the work of consultants, for example referrals and transfers and what happens to referrals. He told us:

"For example, I know what my consultants are doing every month. I know for example that Dr A has had the least assessments in the last month, Dr D has had quite a large number of assessments, and it also gives me an opportunity to look across the whole directorate. So someone might say to me, 'I've got a really high workload', and yet I can look across and say, 'Yes, you rank number six or seven and I know why your workload is great. It's not because you have a high CPA number. It is because you are doing a lot of assessments'."

Comment

This ability to use data to manage clinical practice is vital, particularly where the number of clients is large. There is a danger that some service users, who are not showing overt signs of deterioration, can easily be overlooked because of the urgency of a small number that can dominate caseloads. The value of the use of data to help manage caseloads was reinforced in our meeting with members of the CMHT.

Business meetings

6.35 Apart from clinical team meetings there is a need for there to be an overview of team working, such as covering leave; developments needed; the use of resources; and other operational matters. The team manager told us:

"I have an operational business meeting with both senior practitioners. We meet every Tuesday and discuss [the] *kind of general and operational issues and how best they can be managed, if there are staffing issues or concerns about staff, performance issues, complaints – whatever."*

6.36 One example we were given concerned how the team manager and the lead consultant agreed how they were going to manage a staffing issue following a staff member leaving suddenly and another going on maternity leave without any replacement for them.

6.37 We were also told by Dr Z that senior clinical practitioners meet once a month:

> *"Seniors – consultants, senior practitioners, also meet once a month to discuss any issues which are affecting the team. We also sometimes discuss the caseloads and resources within the team and whether things need to be moved around."* [S team manager/operational lead also attends this meeting]

Comment

Both the business and the senior practitioner meetings are important in providing an operational overview. By involving senior clinical and operational staff they help ensure that the business discussion remains focused on improving the service for users.

Team base

6.38 At the time of the incident in 2008, consultants were based at the Mile End Hospital. When a consultant is not based in the team location it can at times give the appearance that they are not a full member of the team. If a consultant visits a team for meetings or appointments then it is natural that they do not feel a full member of it. Locating the whole team together rather than having virtual teams that come together for specific discussions provides the opportunity for informal contacts and the development of closer working relationships. Dr Z told us:

> *"The other thing that has happened in the Isle of Dogs since I started in 2008 is that we are the first team to move everything to the actual CMHT base: so all of our outpatients clinics are there, all of our admin is there.*
>
> *…the only thing that is not there are the inpatients, who are over at Mile End, whereas before admin and outpatients were over at Mile End, so as a consultant, you would not be physically in the CMHT quite so much, whereas now all three of the consultants who work there are there a great deal more. Also, because I am lead consultant, I have looked at my timetable and it is organised so that I spend a great deal of time at the CMHT, I am just physically there most of the week."*

6.39 N, associate director, cognitive services (to who the Isle of Dogs team manager/operational lead reports), told us that the trust is planning new premises for all the teams. She said that the Stepney and Wapping CMHT was due to move to new premises within weeks of our interview and that the consultants would be based with the rest of their team.

Finding

F6 Situating all the members of the Isle of Dogs CMHT in one place has had a beneficial impact on the quality of team working.

Management of the depot clinic

6.40 C was principally reviewed by his care coordinator when he received his regular depot injection. This was given either at Heather Lodge or at the depot clinic at Crisp Street GP centre. C failed to attend for his injection on a number of occasions. We examined how the depot clinics are now managed and in particular what happens if a service user fails to turn up for their depot injection, as this may be a sign of deterioration. Dr Z told us:

> *"If someone has missed their depot, that will be raised in the clinical meeting that week after they have not turned up to the depot, so someone will say that so and so has missed their depot. We would probably talk about how they were, whether they had been seeing them, what the history was. I would then want to see them, either I would want to see them myself or I would want one of my staff grades to go, to come up with the plan: they have missed the depot, so are you going to section them and bring them into hospital to give them the depot? Or are they are going to go on oral and you are going to follow them up closely to see if they are taking the oral medication? Something needs to happen. That is what would happen: someone has not turned up for their depot, they have not had their depot, so we would ask if they had been spoken to."*

Comment

We are assured that there are robust systems in place to ensure that follow up takes place if service users miss their depot injection or if at the depot clinic there are concerns that they are deteriorating.

Heather Lodge

6.41 C moved to Heather Lodge in late October 2002 or early November (the exact date is unclear from records).

6.42 C lived in one of the low-support flats. His flat was self contained with its own front door. He did his own shopping and cooking.

6.43 We asked the manager of Heather Lodge what partnership working existed between Heather Lodge and the Isle of Dogs CMHT.

> *"The staff at Heather Lodge do not have a social work or a nursing qualification…. So we have had a lot of training and really, we work with the service users on all aspects of their lives. Not just maintaining stable mental health, it can be maintaining stable physical health, managing finances, managing your tenancy, looking for education, training, maintaining links with family. We look at the whole package with our service users and assess service users on ten key areas. Because we work quite closely with our service users, we do notice changes in their behaviour quite quickly. If we felt that any of the behaviour was a risk trigger or an early warning sign, then it is our role to contact the community mental health team, the care coordinators and then they would come in then and they would support us.*
>
> *We get the CPA documents. We are usually invited to all the CPAs, which is good. Then we receive the CPA document and that has the early warning signs and the contingency plan and the crisis plan, which we incorporate into our risk management plans as well. If we do contact the care coordinator with concerns, they usually come either that day or the next day - either the care coordinators themselves or they might bring the doctor."*

6.44 We also asked Dr Z about working partnerships with Heather Lodge and she told us:

> *"…what we did from our point of view was, rather than having lots of care coordinators go to Heather Lodge, we have a nurse whose responsibility is Heather Lodge, and that is M. Also, once I got a community staff grade, they go once a month to do a CPA clinic at Heather Lodge. The idea is that Heather Lodge has two people who visit each month and whom they are quite happy to ring up at any time. Staff grades can go at any time as well, but they have a fixed one monthly clinic there."*

Comment

The trust report and the clinical records confirm that service user C was seen and reviewed regularly by staff at Heather Lodge and by members of the CMHT. The partnership working with the Heather Lodge staff team is consistent with good practice and appears to have been in 2008.

Forensic support

6.45 C had a forensic history. He spent six years in a medium secure unit under section 37/41 of the Mental Health Act. He was then transferred to a forensic unit in Tottenham, but by the time he was moved to Heather Lodge in 2002 he had been removed from the sections. So during his time at Heather Lodge and while under the care of the Isle of Dogs CMHT, C was not under the care of the forensic services but did have a forensic history. We therefore examined with interviewees what forensic support is available to the team.

6.46 Dr Z told us:

> *"There is this forensic CPN... who comes once a week and can co-work people with care coordinators and he is part of the forensic services. There is a consultant, Dr L, who can provide forensic opinions and for example, my 37/41 patient, if I recall him to hospital, then the policy is that Dr L has to come and do an assessment."*

6.47 Dr P, clinical director, Tower Hamlets, also told us that the trust is in talks with its commissioners to increase the forensic facilities locally in particular the provision of local forensic step- down hostel-type places for service users. This would mean closer working with the Hackney forensic service and the trust's assertive outreach service.

6.48 Dr P wrote to us on the 27 September 2011 and updated us on the current position with forensic services. The current forensic services directorate (based in Hackney) will be based in Tower Hamlets at the end of October 2011 and this will provide a greater local community forensic resource. Discussions are continuing with commissioners on the provision of higher needs forensic hostels.

Carers

6.49 As part of the CPA process there is a requirement to carry out a carer's assessment. The trust policy relevant at that time states:

> *"The needs of the service user can often have an affect not just on their own lives, but on the lives of their family and close friends. Relatives and carers have often had first hand experience of the service user's illness."*

6.50 The policy also states that as part of a *'full needs assessment'* account should be taken of *'social function and family relationship'*.

6.51 C was regularly in contact with his family and his mother visited him and he visited his mother about every two weeks. C spent some time with his family during Christmas 2007 and the New Year.

6.52 As C killed his mother it is important to know what contact the trust had with his mother and other family members. The following lengthy quote from the trust's report identifies what contact the team had with his family in particular his mother.

> *"There is very little information in the notes about the family and no apparent contact between the services and the family. There is no information about the quality of the relationship between C and his mother and other members of the family. It is unclear whether there were any tensions between C and members*

of the family, albeit it was known that the earlier fire setting incident that led C to being placed on a section 37/41 occurred at his mother's house. This meant there was a significant lack of information which was required for accurate risk assessments.

There was no apparent contact with the family, therefore, it is unclear how any information from the family about any significant changes in the relationships between C and family members or any other potentially significant life events were monitored by staff and their effect on C. This information was therefore not available when assessing C's changes in mental state and this information did not inform any risk assessments.

There appears to have been little contact with the family throughout all the episodes of care, and the reason for this remains unclear. There is a suggestion that C's mother may have had mental health problems in one entry in the notes only. If that is the case, this should have been even more of a reason to clarify and undertake a carer's assessment."

Comment

This failure to involve service user C's family and to have an understanding of the dynamics that existed in those relationships was important and part of the basic requirements of good mental health practice. A better understanding might have helped identify any risks that may have been present in 2008. Despite this we have seen no evidence that in the weeks preceding the incident C was becoming an increased risk to anyone.

6.53 In our meeting with the CMHT members we were told that they now use a wider definition of carer and seek to ensure that family perspectives are incorporated into care planning. Where a client refuses to allow contact with their family this is not considered to be unable to be infringed. If circumstances - particularly the need to manage risk - require it the clients view will be overridden, though matters of clinical confidentiality will be maintained.

6.54 We were shown documentary evidence by N, associate director, cognitive services, that there have been improvements in carers' assessments. She told us that in the year following the incident carers' assessments almost doubled and that the trust has also

reinforced the need to do carers' assessments. The team has also introduced a support worker to improve the quality of the support to carers.

6.55 S, team manager/operational lead told us:

> *"What I have introduced – and again it is an initiative within the Isle of Dogs – is a bilingual support worker,… Anyway, what was clear was the carers were not being assessed as robustly as they should be. So the support worker… will often go with the care coordinators and meet the carers and she builds that up and the statistics are there of the assessments being carried out. She will link them into the carers' centre, she will provide the family with information on the various services available and family action – she will link them into that."*

Finding

F7 The Isle of Dogs CMHT has significantly improved its involvement with carers and family members as required by the trust's CPA policy.

Transferring clients between consultants

6.56 C's care was taken over in 2007 by Dr T a new locum consultant appointed to relieve pressure on the two substantive consultants. These consultants were managing a large case load that had resulted from a transfer of clients from the Bow and Poplar CMHT to the Isle of Dogs CMHT in September 2005. Even with the new appointment C was not reviewed by his consultant or one of his team prior to the incident and had not been reviewed by a consultant or a junior since his discharge from hospital in December 2005.

6.57 In the trust's interview with, the previous clinical director, the arrangements for the transfer of clients to Dr T were discussed. He stated that:

> *"A list of patients were given to him. There was no handover of individual patients. We've had a number of consultants come and go. The usual transfer process after sectorisation was supposed be a gradual process over a number of months. Dr T was brought in as a response to crisis so he was given a caseload from day one."*

6.58 The previous clinical director was asked if risky patients were identified on handover to Dr T. He said:

"Not that I am aware of but I would and did expect people to work together."

"Each consultant is expected to manage their own caseload. The care coordinator would raise any concerns with the consultant. The responsibility is delegated. It's not policy that consultants would actively seek out these cases."

6.59 S team manager/operational lead told us that she was quite concerned about the case load that Dr T had been given. She told us:

"I had significant concerns about the caseload he was asked to manage. He was given one of the most difficult GP practices, Crisp Street, which consisted of all of the Heather Lodge residents, of which C was one. So there were concerns, but they were not taken into consideration."

6.60 She also supplied us with a copy of an exchange of emails between Dr T, locum consultant, about case loads. This exchange occurred on 20 August 2007.

- Time: 13.51 from the clinical director to the team manager:

  "Before we change details on Sepia I thought you should know the approximate breakdown of CMHT client no's. Dr [U] will have 62, Dr [K] 82 and Dr [T] 185. Yes we will go ahead with that for the time being and see how things work out."

- Time: 14.20 From Dr T, locum consultant to the clinical director:

  "When I was told about redistribution I imagined we are going to have more or less a similar caseload. That would be fairer. In the current circumstances, I am not sure what could be my positive contribution to the team. I am new to it and the area, need to get acquainted with the different services here and try to navigate in the current system until I understand what is so difficult. Can we please rethink the issue? I am not ready to get burnt out for a short term locum."

- Time: 16.51 from the clinical director to Dr T:

  "Just to repeat that I am not prepared to get into discussion about this at present. The consultant responsibilities are as previously set out, with effect from today. We will keep the situation under review."

6.61 S team manager/operational lead told us that there was no formal handover from Dr U to the new locum Dr T. *"He came and there was an expectation that he would just get on with the case load he was given."*

6.62 We sent this section of the report to the previous clinical director for comment and we set out below extracts from his response to us.

6.63 In respect of consultant workload the former clinical director told us:

"Overall, I was bringing in an extra consultant to alleviate pressures so that we would have three consultants working where previously two had managed… We expect substantive consultants to become more involved in other issues such as training and management whereas we might expect a locum consultant to concentrate more purely on clinical work… Overall I would not accept that there was clear evidence that he was given a disproportionate workload or that he was overworked."

6.64 In respect of handover arrangements he told us:

"With regard to the practice around handover I have the following comments. It was not particularly unusual at this time that locum consultants would come and go. When they did the expectation was simply that they would take on an existing caseload. There would not be a formal handover of the 200 or more patients who might be under the care of that consultant. What happens is that patients are seen as their outpatient appointments or CPA reviews become due. The doctors are in communication with the care coordinators and the care coordinator would be expected to alert the doctor to any patient who was causing concern and needed to be seen sooner. Thus the fact that a locum consultant would arrive and become responsible for a large number of patients was not out of the ordinary."

"In fact the situation with regard to high risk patients was far less challenging for this locum consultant than would be the case for a locum arriving to take over from somebody who had left. In this instance the locum was working alongside the two consultants from whom the patients had been transferred. Were there any concerns about particular patients there would have been ample opportunity for these to have been informally communicated from these consultants as well as from the care coordinators looking after them."

Comment

This exchange of emails - as well as the evidence given by the then clinical director to the trust panel - appears to show that the transfer of clients and the allocation of case loads emanated from a top down approach by the clinical director. The email chain above shows that Dr T had concerns about the number of cases he had been allocated. Whether or not the distribution was fair is difficult to determine without considerable analysis which is outside the scope of this investigation. What is clear is that Dr T had raised his concerns and the response he received did not allow for any explanation or opportunity for discussion.

Discussion between the clinical director, Dr T and his other consultant colleagues could have resulted in a phased redistribution, ensuring that high risk clients were identified first and that at least case summaries and brief risk assessments were available. The former clinical director told us that a phased redistribution would have meant that Dr T **"…would have been underemployed for the first few months of his post."** ***We do not accept this as an argument for the clinical director not to put in place a process of handover of those clients that were considered to be high risk. At a minimum such a process could have provided an opportunity for the transferring consultant to have a face-to-face discussion with the locum consultant about the high risk clients and, if necessary, to include the relevant care coordinator.***

We accept that at the time Dr T started - even if he had been given a list of clients that were high risk – service user C would not have been one of them. Despite this it is clear from the documentation we have reviewed and the interviews we have conducted that the manner in which Dr T was employed to work in the Isle of Dogs CMHT was unsafe. It is clear to us that there was a failure to put in place a system for a locum psychiatrist to quickly identify which clients should be prioritised.

Finding

F8 The manner by which clients were redistributed to consultants in the Isle of Dogs CMHT, in 2007, failed to ensure that a system was in place that enabled the new locum psychiatrist to quickly identify which clients should be prioritised and was therefore unsafe.

Transfers between teams

6.65 Over 100 cases were transferred to the Isle of Dogs CMHT in September 2005 as a result of sectorisation. At that time there were only two consultant psychiatrists covering both inpatient and community services for the Isle of Dogs. We discussed with the current clinical director Dr P how transfers would now take place in circumstances where a large number of clients needed to be transferred from one team to another. He told us:

> *"I suppose if they* [the trust] *were transferring a group of GP practices and their patients, there has got to be some agreement that there is capacity. It might not be all patients at once, but it is definitely not one at a time. It might be picking one GP in a practice and moving all of those patients with the GP so you can actually sift through and go through all those cases. So I wouldn't say it is a one to one CPA transfer. It would be possible to transfer those patients over say between a month and three months. I don't think it is necessarily that it would be much longer than that.*
>
> *So one way is either doing it by GP; that has to be manageable, or do it by risk. I would prefer to do it by sitting with the care coordinators, going through their risk and saying, 'Actually, can we move him?' because these are patients that are already known to the CMHT so it is not the most difficult task to have a transfer in(sic) consultant."*

6.66 At times there is also a need to transfer individual clients between teams and we were told by a number of interviewees that in these circumstances the transfer would not take place unless the referring team had completed an up-to-date risk assessment and clinical summary.

6.67 One of the recommendations of the trust's report is that there should be standards in place to ensure safe transfers of individuals and groups of clients.

> *"Clear explicit standard should be written to ensure effective handover between teams and between workers within teams, including care coordinators, medical (substantive and locum) and support staff. Such standards should be adhered to in individual cases and when a number of mental health service users are transferred as a group."*

6.68 Dr P the current clinical director told us that in respect of how transfers should be conducted:

> *"… I would rather not dictate exactly, because I would want to see what the competencies are for the team doing the list. Very similar to that, I would check out the competencies of the teams because it might be the care coordinator moves all their patients rather than by GP which would be another way of doing it."*

> *"There is responsibility on the consultant, and what we have produced, the system that we have in place now is a new way of working with the consultants are responsible for working with their team. The CMHT is not distant; it's where the consultants live and work in as well."*

Comment

It is clear to us that the Isle of Dogs CMHT has in place effective processes and standards for the transfer of clients but it appears that these standards are not yet trust wide.

We can understand Dr P's reluctance to be prescriptive about transfer arrangements but at transfer the knowledge of the client and his or her needs and risks can be, and in our experience often are, lost. We are assured that if there was a need to transfer clients the current clinical director would not allow this to take place in the manner that was undertaken in September 2005.

6.69 N, the trust's associate director, cognitive services, told us that she had just issued guidelines on the process of handover. She said:

> *"The actual process of handover is much more considered, so for example we are doing some transfers from AOS [assertive outreach service] into CMHTs at the moment and we are going to have a doctor's referral letter, a transfer letter, we are going to have a face-to-face handover meeting and we are going to make sure that there is CPA documentation – and that is set down as the guidelines for the transfers, and people will follow those in terms of handing cases over."*

Comment

We support the trust's recommendation that explicit standards should be developed. The standards should not be prescriptive in how the transfers should be conducted, as transfers often have different contexts - but they should set out the quality outcomes and expectations of an effective transfer.

6.70 In correspondence to us on 27 September 2011, Dr P, clinical director attached a draft of a document dealing with cross borough transfers. The document is dated 19 March 2009 and was produced by the previous medical director. We have attached the document at appendix B. This document and the guidance produced by the associate director should be reviewed and a trust wide document dealing with transfers should be produced.

Recommendation

R2 The trust should ensure that there is a trust-wide set of protocols geared towards ensuring successful client transfers between consultants and between teams.

7. The trust's panel investigation

7.1 Within 72 hours of the incident, a trust manager produced a two-page summary of C's care and the incident. The trust then set up a panel investigation. The panel consisted of four senior members of the trust: two consultants, the head of nursing, and the head of community services.

7.2 The panel began its work shortly after the incident and its interviews were held in May and June 2008.

7.3 Eight interviews were held with clinical medical and nursing staff, managers and representatives from Heather Lodge.

Finding

F9 The trust's own investigation was set up in a timely manner. The panel members were appropriate to the incident and sufficiently senior and experienced to carry out a robust investigation.

7.4 The investigation was conducted using root-cause-analysis methodology. The trust's report is 33 pages in length and contains the following sections:

- background history including a chronology
- detailed notes of contacts and clinical issues covering December 2007 to April 2008
- mental health services background information
- hypothesis tested regarding immediate cause
- a 10-page table reviewing identifying care delivery and service problems
- a narrative section identifying thematic care delivery problems
- a section on root causes
- a root cause summary table
- a section on recommendations.

7.5 The trust report identifies the following care delivery problems:

- lack of information about and from the family
- lack of full personal and psychiatric history and risk chronology

- lack of psych-social formulation problem
- lack of medical review
- lack of case load management process for the CMHT and medical staff
- lack of formal system to ensure medical reviews are regularly undertaken of all users on consultant caseloads
- medical work load distribution and transfer of work arrangements
- lack of an assertive outreach team approach.

7.6 We are in broad agreement with these findings from the trust's report. Having said this we do not believe the report sufficiently outlined the organisational systemic problems that may have contributed to the problems listed above.

Comment

Senior managers should ensure that at a challenging time of transition of services that there are safe clinical processes in place and support for staff. In this case we believe there were failures in operational and clinical management and leadership not only at the team level but also at directorate level.

7.7 Apart from our comment in 7.6 above, the report is comprehensive, evidence-based and easy to read. The panel's conclusions can be properly drawn from the evidence. We believe that the recommendations are appropriate to the conclusions drawn by the panel. Unfortunately the recommendations are written in a style that makes it difficult for their implementation to be easily audited and reviewed.

7.8 The trust provided us with a copy of the action plan that was drawn up to implement the recommendations. The action plan shows that the recommendations were completed in July 2009. We have reviewed in detail the implementation of the recommendations with the associate director for cognitive services and the operational lead, Bethnal Green, CMHT. We also discussed the recommendations with the clinical director and with the members of the group meeting we held with the Isle of Dogs CMHT. As a result of the major changes in team practice which we have examined and set out in this report, we are confident that the recommendations contained in the trust's report have been implemented.

Finding

F10 The trust has implemented the recommendations from its investigation in a timely and effective manner.

Appendix A

Guidelines - Tower Hamlets Clinical Leads

POST: – Inpatient Services; Community Services (ANNUAL Review)
GRADE: Consultant or equivalent Senior Clinician
HOURS: approximately 0.25SPAs (Drs) or 0.25 days (non-Drs) per week
RESPONSIBLE TO: Borough Director and Clinical Director
ACCOUNTABLE TO: Clinical Director
PROFESSIONAL ACCOUNTABILITY: Based on Profession

Community Clinical Leads:

- The Community Clinical Leads account directly to the Associate Directors of CMHTs and Specialist services (operationally) and to the Clinical Director for clinical governance.
- Individual consultants and psychologists remain responsible for the care of their patients as identified by which team they work with, and in some CMHTs for an identified Sub-team.
- Clinical Supervision of individual staff's work with patients is facilitated via the MDT clinical meetings and via joint reviews e.g. CPAs.
- The Clinical Leads are expected to attend the monthly Senior Mangers & Clinicians Meeting chaired by the Borough Director.
- The Clinical Leads are expected to co-chair their team's Business Meeting and have a leadership role with team's Operational Manager supported by the identified the AD.

Job Description Community Team's Clinical Lead:

The role of Leadership is part of GMC standards and part of the Job Description for all Consultant Psychiatrists including being able to effectively management change, take responsibility to identify areas of poor quality of care and addressing them, being supportive to a MDT and operationally being available to the staff to respond to queries, and have a communication role for staff to other senior clinicians. For other professionals the there is clear professional guidance via the adopted NHS Institute for Innovation & Improvement- Medical Leadership Competency framework (2010). If further training is required then this should be a PDP for the individual via CPD.

There will be a very close working with the teams Operational Manager and supported by the Associate Directors (as per the Community Services Review, which has been operational for more than 1 year in Tower Hamlets), being available daily by phone and email, meeting the Operational Manager face:face weekly (maybe via weekly MDT meeting). This meeting should involve discussion of staff competence (medical, nursing, social workers, admin etc), a joint agreement on areas of concern, recruitment, financial concerns, observance of Trust's policies, appraisal and development, and any service development of innovations. These discussions will evolve over time and the above suggestions are not meant to be prescriptive of an agenda. The involvement and participation of team members in healthcare governance initiatives such as clinical audit should be promoted.

The team's business meeting allows for decision to be made locally to address performance reports, MHA issues, changes to the team Operational Policy, Clinical Protocol, CQC concerns, meetings' procedure, employee relations issues, staff training to meet basic clinical competence and clinical governance for the service area delivery with effective overview, highlighting themes and emerging trends, and how this fits into the Directorate and Trust strategy. SUI learning lessons should be on the agenda.

Appendix B

CROSS BOROUGH TRANSFERS

PART 1

LOCALITY SERVICES

Cross borough responsibility from the funding perspective has been set out in Department of Health guidance and essentially remains with Borough of origin. However, for purposes of care planning, the guidance set out in this document is designed to ensure that optimal care is identified through the CPA process and that responsibility for delivery of this care is handed over in a timely way to the relevant Borough services.

1) The transfer period via handover CPA arrangements when somebody is moved to a different Borough should be within 4-6 months.

2) The aim should be to seek appropriate accommodation with in the Borough of origin as far as is possible and to ensure that General Practitioner and temporary or permanent accommodation is preferentially sought within the Borough of origin.

3) In the event of an urgent admission being required, eg., from a medical ward, the patient should be admitted to the nearest available bed without delay but should be transferred to the responsible locality as soon as possible. In the event that the patient has changed his/her residence and now lives in a different Borough from that through which his/her care has been provided, the handover should be expedited and this may indicate that the in-patient episode should continue in the Borough of current residence.

If a patient is not on CPA and/or is of no fixed abode and/or was recently discharged from another service, the criteria that should define responsibility are, in order of importance, as follows:

a. Usual residence

b. General Practitioner

c. Where he/she was last admitted (within the last 2 years)

d. Wherever the patient was found at the time of admission

These criteria should apply in East London Foundation Trust Boroughs and in respect of other London Boroughs.

Young People in the Process of Transition to Adult Services who have moved Borough

There are a small number of patients for whom the issue of cross Borough transfer is a factor for the transition of the care to Adult Services. The Transition policy applies in these cases. The principles of cross Borough transfer as outlined in this policy will also apply to these cases. The patient's best interests are paramount in all cases.

Resolution of Disputes

In the event of disagreement, this should first be discussed between the relevant consultant teams and with Borough Directors. If this does not lead to resolution, the matter should be referred to the Clinical Directors. Should there be no agreement, then arbitration between the Associate Medical Director or Medical Director should be sought.

Co-working

It may be necessary or desirable to involve two or more teams in any individual patient's care, for example, Forensic and General Adult Services or General Adult Services and Addictions. The best interest for the patients should be interpreted realistically as should the expressed place of residence. Early CPA involvement all relevant parties should provide the framework for establishing placement, care plans and contingency plans.

Co-working with Forensic Sector (see Part 2)

The Forensic sector of origin should retain responsibility for the Forensic aspect of care planning until such time as the individual is placed permanently at which point the Forensic role and subsequent Forensic liaison should be transferred to the sector of residence.

Appendix C

Chart of case management of service user C from Barnet, Enfield and Haringey Mental Health Trust to Isle of Dogs CMHT

Approx date	Residency/teams involved	Notes	Doctor change	Care coordinators
Dec 1999	Kneesworth House to Cascade House (Residential Forensic Service) Transfer of care to Barnet, Enfield and Haringey Mental Health NHS Trust	Conditional discharge for section 37/41 Dr Y receives handover plus documents	Transfer to Dr Y	J (BEH)
May 2002	Cascade House (Residential Forensic Service)	Full discharge from section 37/41		
14 Oct 2002	Moves from Cascade House in Tottenham to Heather Lodge, east London	Moves whilst still under care of Dr Y		J (BEH)
24 Oct 2002	BEH CPA meeting Attended by representative from Stepney and Wapping CMHT, East London and City NHS Trust Representative attends from Heather Lodge			J (BEH)
29 Oct 2002	Living in Heather Lodge, east London (catchment area of East London and City NHS Trust)	Dr Y writes to Dr X requesting transfer of C to his caseload. BEH CMHT withdraws		Unclear Mention of rep from Stepney &Wapping CMHT, who is later referred to as "Case Manager"

18 March 2003	Living in Heather Lodge, east London and receiving outpatients from BEH	Dr Y writes to Bow and Poplar CMHT manager Note at the bottom of the letter of a phone conversation between Bow and Poplar CMHT manager and rep from Stepney and Wapping CMHT		Remains unclear
1 May 2003	Living in Heather Lodge, East London and City NHS Trust catchment area	Misses outpatient appointment with Dr Y		Remains unclear
22 May 2003	Living in Heather Lodge, East London and City NHS Trust area, receiving outpatients from BEH	Dr Y writes to Dr X re transfer request and states concerns: "I understand his social worker thinks that he could live completely independently within a year. I nevertheless have to record my view that there is a 30% chance of a serious, dangerous incident in the next 5 years"		Remains unclear
19 June 2003	Bow and Poplar CMHT (East London and City NHS Trust)	Dr X sees C for first time as outpatient	Transfer to Dr X Unclear if this is through CMHT and what handover actually happened	
9 August 2003		Risk assessment completed		H
21 Oct 2003		Care coordinator allocated		G, Bow and Poplar CMHT allocated

24 Nov 2003	Bow and Poplar CMHT (East London and City NHS Trust)	Change in care coordinator		F, Bow and Poplar CMHT allocated
18 Dec 2004	Bow and Poplar CMHT (East London and City NHS Trust)	C attends outpatients with Dr X		
30 June 2004	Bow and Poplar CMHT (East London and City NHS Trust)	C attends outpatients with Dr X		
17 Dec 2004	Bow and Poplar CMHT (East London and City NHS Trust)	C attends outpatients with Dr X		
23 May 2005	Bow and Poplar CMHT (East London and City NHS Trust)	Change in care coordinator letter		E, Bow and Poplar CMHT allocated
10 June 2005	Bow and Poplar CMHT (East London and City NHS Trust)	C attends outpatients with Dr X		
12 Aug 2005	Bow and Poplar CMHT (East London and City NHS Trust)	C attends outpatients with Dr X. Requested due to non-compliance and concerns		
15 Aug 2005	Bow and Poplar CMHT to Isle of Dogs CMHT (also run by East London and City NHS Trust)	Transfer of CMHT due to sectorisation	Dr X sends letter to GP Unclear what handover takes place	
7 Sept 2005	Isle of Dogs CMHT	Change in care coordinator letter	Dr U Unclear what handover takes place	V, allocated and contacts C
August/ September 2007	Isle of Dogs CMHT	Re-allocation of consultant caseload due to further sectorisation and increase in consultant psychiatrists	Dr U to Dr T Unclear what handover takes place	

Appendix D

Documents reviewed

- Correspondence
- Service user C action plan
- Service user C psychiatric report
- Service use C's clinical notes
- Trust's 72-hour report
- Trust's internal report
- CMHT operational policy
- CPA policy February 2006
- CPA policy January 2008
- CPA policy November 2006
- Isle of Dog CMHT care coordinating activity (March-April 2008)
- Policy for service users who fail to attend appointments
- Risk Management policy
- Supervision policy July 2002
- Supervision policy October 2008

Appendix E

Biographies

Geoff Brennan

Geoff Brennan is a registered nurse for the mentally handicapped and a registered mental nurse. Geoff has worked in a variety of clinical and academic posts, mainly in London and the south east of England. Geoff has practised and taught psychosocial interventions for psychosis since the early 1990's. Geoff was chair of the standing nursing conference mental health group for London for five years.

Throughout his career Geoff has maintained an active involvement with acute care including carrying out the benchmark of London Inpatient Services for the London Development Centre and for three years was one of two city nurses working in east London to improve acute inpatient wards. Since 2006 Geoff has worked as a nurse consultant in acute care both in Berkshire and now in Camden and Islington Mental Health Foundation Trust. Geoff has published numerous articles and research papers on acute mental health and also co-edited a major text book for nurses. For two years Geoff has also been the national chair of the Consultant Nurse Association.

Tariq Hussain

Senior consultant Tariq is a former nurse director who brings to Verita his considerable experience of leading change management in the fields of learning disability and mental health services. Tariq has undertaken a wide range of projects for Verita which have included mental health homicide investigations and an investigation into sexual abuse by an eating disorder clinic manager. In September 2010 he completed a three year term of appointment as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Prior to Tariq's appointment with Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting.

Dr Fin Larkin

Dr Fin Larkin is a consultant forensic psychiatrist in the dangerous people with severe personality disorder service at Broadmoor Hospital. Dr Larkin has worked in all psychiatric sub-specialities, undertook his higher forensic training at the Maudsley Hospital in London, and has considerable clinical and legal experience, both in England and abroad. He has a particular interest in homicide and high risk offenders, and has been based at Broadmoor Hospital for the last six years.