External Investigation into the Case of Mr F

February 2012

A report for NHS London
Undertaken by Caring Solutions UK Ltd

NHS London

APPENDICES

Executive Summary

1. Incident description and consequences

1. On January 7, 2008, the Metropolitan police attended Pond Ward, an acute admission unit, located at the Park Royal Centre for Mental Health. They informed staff that they were seeking Mr F, a then 31 year old man, and patient of local Mental Health Services. Earlier that day Mr F's father had been found dead at his home by Mr F's sister. Mr F senior had been killed as a consequence of severe head injuries inflicted with a blunt instrument. The injuries were so severe that in the first instance police suspected that a firearm had been used.

2. At the time of the incident Mr F was a hospital inpatient, detained under Section 3 of the Mental Health Act (MHA) 1983. He had been on leave from the ward since December 28, 2007, and had been reviewed most recently on the ward on the morning of January 7, 2008.

3. Mr F was previously well known to local Mental Health Services in Brent, North West London, and had been in contact with services since 1998. Mr F's diagnosis is Schizophrenia, and his condition had previously run a chronic relapsing course, with repeated admissions to hospital generally on a compulsory basis. Mr F's condition was complicated by the use of street drugs in the form of cannabis consumption, and his engagement with community Mental Health Services and compliance with prescribed psychotropic medication in the community was problematic. At the time of the incident Mr F was a patient of the Brent Assertive Outreach Mental Health Team.

4. Mr F had a previous history of offending and of conviction, including assaultative behaviour directed towards family members and members of the public who were unknown to him. He had previously spent time in prison, and in the past had received mental health disposals (Section 37, MHA 1983) from the courts subsequent to conviction.

5. Mr F was arrested by police shortly after the death of Mr F senior was reported. He was initially remanded into custody, spending time at HMP Wormwood Scrubs, before transfer to secure hospital services at the Three Bridges Unit, West London, and subsequently to Broadmoor High Secure Hospital where he is located at present. With respect to court matters Mr F was convicted of Manslaughter on the grounds of Diminished Responsibility, and was served with a Hospital Order (Section 37, MHA 1983) and a Restriction Order (Section 41, MHA 1983).

6. Mr F has not been able to provide an explanation for the actions that were taken and there is no supporting evidence to confirm or deny his mental state at the time of Mr F senior's death.

2. Background and Context

1. Central and North West London NHS Foundation Trust covers the London Boroughs of Hillingdon, Harrow, Ealing, Brent, City of Westminster, Royal Borough of Kensington and Chelsea, Hammersmith and Fulham and Hounslow and Camden. This area of London is extremely diverse with over one hundred first languages spoken; there are areas with high levels of deprivation as well as areas of great affluence.

2. The population covered by the Trust is 2.2 million people and the Trust provides services to 35,000 service users.

3. The Trust has an annual turnover of c. £369 million and employs 4,740 staff operating out of over one hundred locations.

4. CNWL provides the following services:

- Mental Health Services for all age groups
- Specialist Child and Adolescent Mental Health Services (CAMHS)
- Addiction services
- Eating disorders services
- Learning disabilities services
- Services for people with challenging behaviours
- Offender care services (including to HMP Wormwood Scrubs, HMP Holloway and HMYOI Feltham)
- Community services in Camden and Hillingdon. This includes a range of adult and child health care services such as district nursing, health visiting, school nursing, physiotherapy and podiatry as well as a large sexual health service in Camden.

5. The Trust is currently in the process of reconfiguring to a Service Line Management model.

3. Terms of Reference - Key Questions

The external investigation panel developed key questions from the terms of reference as follows:

1. Was the Trust Internal Investigation adequate in terms of its findings, recommendations and action plans?

2. What progress has been made on the internal report action plan?

3. Was the family of Mr F involved as fully as considered appropriate?

4. Carry out a chronology of events to assist in the identification of any care and service delivery problems leading to the incident?

5. What were the Mental Health Services provided to Mr F and were relevant documents in place?

6. Was Mr F's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies?

7. Was the care and treatment suitable in view of the service user's history and assessed health needs?

8. The exercise of professional judgement and clinical decision making

9. What was the appropriateness and quality of risk assessments; care planning and interventions of the Assertive Outreach Service?

10. How effective was interagency working, particularly in relation to the sharing of information between Substance Misuse Services and Mental Health Services?

11. What was the level of support to staff, service user and the families of the victim and service users following the incident?

12. Are there any other matters of public interest which need to be considered?

4. Level of Investigation

This is a level 3 Independent Investigation and has been conducted by a panel of three members

5. Findings

1. There were no terms of reference set out for the internal investigation although the panel did develop a set of key objectives. All investigations should be set within terms of reference to ensure a clarity and consist approach which leads to clear outcomes and recommendations.

2. The process for carrying out the review was not managed in a timely and effective manner, this led to the report taking eleven months to complete which had a detrimental impact of the learning from this incident in terms of the time it took for the action plan to be developed.

3. The report did not focus on the wider issues In relation to Mr F such as his non compliance; his cultural and ethnic background, the family's lack of a carers assessment.

4. The report actions do not adequately address poor practice in relation to risk management, care planning (including activities in both ward and community settings), medication management; non-compliance with drug testing and knowledge of dual diagnosis patients; carers assessment and the involvement of families.

5. Whilst the External Panel accept the staff view that the majority of inpatients have a dual diagnosis and that linking patients to the Dual Diagnosis Service should be based on clinical judgement; decisions from clinical judgement must be documented with a review date.

6. The report does not address or question the adequacy of clinical leadership available within both the inpatient ward and the Assertive Outreach Team (AOT) and make a recommendation to review and where applicable strengthen these.

7. The recommendations are not always aligned to the findings and the contributory factors set out within the report.

8. All actions and recommendations are being progressed and using the NHSLA framework comply with either level 1, 2 or level 3. However the Trust must provide assurance that post the new organisational arrangements, the Action Plan will continue to be monitored and progressed.

9. The family were Mr F's main carers although not recognised as such by the Trust. Mr F's Consultant did recognise that the family were at risk from Mr F however this is not reflected in any risk assessments. The Ward Manager in interview however stated that both she and the Deputy Manager were very surprised that this had happened, drawing a possible conclusion for the External Panel that not all key staff were aware of the vulnerability to the family.

10. There is no documented evidence that his family was ever asked for their opinion of Mr F's progress when they visited the ward or when Mr F was on section 17 leave. There is evidence that on a day to day basis when they had a concern that needed to be actioned they could and did speak to staff and vice versa.

11. The family were sent an invite to attend a CPA in April 2008. This demonstrates a lack of responsiveness to ensure all on-going administration processes are updated.

12. The family were contacted soon after the arrest of Mr F but did not take up offers of further contact from the Trust at that time. When the Trust were contacted they responded quickly and ensured the family views were considered as part of the internal review.

13. Mr F was appropriately sectioned to an appropriate inpatient facility and appropriately referred to the AOT, although the AOT and inpatient services did not communicate effectively and AOT did not act in an 'Assertive' way with Mr F.

14. Whilst there was an awareness by the Consultant of the risks Mr F posed to his parents, this was not shared by the Ward and Deputy Ward Manager; it was not included on his risk review form at the time of his admission or at any time during his inpatient stay. Also following his aggressive outbursts and threatening behaviour his risk plan was not updated.

15. The section 17 leave form is unclear. There is a line drawn between the dates covering 28/12/07 – 28/01/08 which has not been signed. The next date covers the period 04/01/08 – 28/02/08 but states only 4 times per month and this was not followed.

16. When staff suspected that Mr F was using cannabis on the ward there is no evidence to demonstrate how this was managed. There is little evidence to indicate that Mr F's illicit drug use was assessed and acted upon.

17. The was a disparity in the decision to commence Mr F on a depot injection and the longer term planning in relation to section 17 leave. This plan does not appear to have been communicated to all members of the medical team, hence Mr F was granted extended section 17 leave before commencement of his depot injection. Mr F was provided with a 7 day supply of oral antipsychotic medication (Risperidone) when he commenced his extended section 17 leave.

18. The ward round record notes that Mr F was granted 7 days leave with a plan to return for a review by ward staff mid week. This is not noted in the clinical notes as a record of the review, the staff therefore did not follow this up. When Mr F returned to the ward on the 07/01/08 he received 7 days worth of medication and yet his section 17 leave requirements was 4 times per month. This does not appear to have been addressed by staff.

19. Whilst there is an entry on the care plan about Mr F joining in Occupational Therapy activates, there is no documented evidence that he did or that he was encouraged to do so on a day to day basis.

20. When the Care coordinator contacted the ward to inform them that Mr F had not turned up for his appointment on the 31/12/07 there is no evidence that this was communicated onwards or that the family were contacted.

21. There is a clear misunderstanding about the status of Mr F when he failed to attend the ward on the 04/01/08 as agreed within his section 17 leave. Whilst he was at that point in default of his leave requirements he was immediately recommenced on section 17 leave and was therefore no longer absent without leave. Staff were unclear about follow up actions required by the medical staff in terms of contacting the police. There is no evidence that this had been a joint decision by the nursing and medical staff.

22. Within the local inpatient setting there was none or partial compliance with regard to the care of Mr F. In particular this was in relation to robust risk assessment and management; care planning; patient observation; the management of his substance misuse; the management of Mr F when he was absent without leave; the management and support to his family as his carers.

23. Within the AOT there was non compliance with the AOT Operational Policy in several areas, namely; employing an assertive approach to engagement; effective care planning and risk assessment; liaison with carers and the inpatient ward; possibly caseload numbers; addressing Mr F's cultural needs. This is detailed as a service and care delivery problem in section 9.9 tables 12 and 13.

24. The Trust had local policies in place to address national requirements, particularly in relation to the Mental Health Act statutory requirements; Care planning and Risk assessment; Assertive Outreach Requirements.

25. There is current evidence of effective clinical care and risk training; carer involvement; Dual Diagnosis Service involvement; increased communication across services; cultural needs awareness; staff supervision and support; excellent initiatives to recruit and select appropriate staff.

26. There is no evidence that his social care needs in relation particularly to engagement of activities in the community, had been assessed and this was not part of his care plan.

27. The wider issues in relation to Mr F's cultural ethnic background were not addressed. Evidence gathered as a result of the external investigation report would indicate that currently the Trust puts a lot of emphasis on dealing with diversity issues at both a strategic and individual CPA level and the panel were impressed with a lot of the work being undertaken in this area. However, in the case of Mr F this was not evident.

28. In terms of Mr F's care planning, professional judgement and clinical decision making did appear to respond to immediate and short term aims. Longer term aims were set out via the AOT but as previously stated this was not assertively managed and there were no clear plans to address the wider issues in relation to Mr F's care.

29. The Internal Panel recommended a review of the AOT service in Brent. This review suffered from a lack of clarity about its purpose and was conducted in a piecemeal manner. Significant management action has, however, been taken in response to the unstated concerns the internal panel had about the functioning of Brent AOT.

30. The future of Brent AOT as a discrete service is uncertain, this was causing some confusion for some staff and has been expressed as a concern by the external investigation panel. Some staff also have a different understanding from managers about the future role of the Brent AOT. Whilst it is clearly for the Trust and it's Commissioners to determine whether the AOT function should continue the Panel has concerns that the needs of complex and high-risk patients should not be compromised by the apparent lack of clarity by staff about the future role of the AOT. Managers have assured the External Panel that this is not the case.

31. These was no requirement for Brent Adult Mental Health Services to liaise with the Substance Misuse service with regard to Mr F, however at interview members of the Substance Misuse Service described the communication with other services such as Brent Adult Mental Health Service as much improved since the Trust implemented an electronic care record system JADE.

32. There is evidence that the GP was communicated with throughout, mainly by the Consultant Psychiatrist and that he was invited to attend CPA meetings.

33. Mr F did not initially have an Appropriate Adult due to cross boundary issues however he was supported by staff who acted in the Appropriate Adult role, until an Appropriate Adult was sourced. There is evidence that the boundary issue has been addressed by developing local protocols to ensure a more efficient approach in the future.

34. The staff felt that they were adequately supported post incident locally, but not from the wider Trust, they also felt that they could also seek individual support as they required it.

35. The Trust is reconfiguring its clinical services into different delivery structures and must ensure that services such as the Dual Diagnosis Service are not compromised as a result of this.

36. The National Service Framework was a ten-year programme that was completed in 2009. Associated with this programme were a series of Policy Implementation Guidance documents (PIG). There is some confusion as to the current status of these documents. Many Commissioners and Trusts are reconfiguring their Mental Health Services to meet new demands in a harsher financial environment including for example, closing Assertive Outreach Services and moving their function back into mainstream Community Mental Health Teams. It is not clear from the current Policy context - "No Health Without Mental Health"; February 2011 – with its focus on well being and prevention, what the optimum way of delivering care for people with an acute mental illness is.

6. Contributory/Associated Factors

The findings of the external investigation does determine that, whilst the Trust has improved in many key areas, there are several contributory factors which affected the delivery of safe and effective care to Mr F and his father. These factors are:

1. Mr F was previously well known to local Mental Health Services in Brent, North West London, and had been in contact with services since 1998. Mr F's diagnosis is Schizophrenia, and his condition had previously run a chronic relapsing course, with repeated admissions to hospital generally on a compulsory basis. Mr F's condition was complicated by use of street drugs in the form of cannabis, and his engagement with Community Mental Health Services and compliance with prescribed psychotropic medication in the community was problematic.

2. Mr F had a previous history of offending and of conviction, including assaults against family members and members of the public who were unknown to him. He had previously spent time in prison, and in the past had received mental health disposals (Section 37, MHA 1983) from the courts subsequent to conviction.

3. Mr F was Chilean and as such part of a small minority group in Brent. During the course of his time within the Mental Health Services his cultural needs were not addressed

4. Mr F's parents were his main carers, they were however not involved in key decisions about his care.

5. Mr F's parents were not offered a carers assessment which would possibly have addressed any risks they were at from him, their cultural needs, their communication with the Mental Health Service and their lack of involvement in key decision making with respect of Mr F's care.

6. Mr F's family views were not sought when he was on section 17 leave. Their perception is that they were informed rather than asked about his leave on the 24/12/07. At that time his mother was in Chile and his sister away, this left Mr F's father to manage him.

7. The family's perception is that they were not consulted when Mr F went on leave on the 28/12/07 for seven days.

8. When Mr F did not attend his agreed appointment with the Care coordinator on the 31/12/07 the ward was informed, but the family were not contacted.

9. Communication between the community and ward staff was poor, particularly in relation to Mr F's section 17 leave status, the decisions made in the ward round which did not filter through to the ward staff (such as the mid week review that should have been carried out by staff during Mr F's seven day leave which commenced on the 28/12/07).

10. The was a disparity in the decision to commence Mr F on a depot injection and the longer term planning in relation section 17 leave. This plan does not appear to have been communicated to all members of the medical team, hence Mr F was granted extended section 17 leave before commencement of his depot injection. Mr F was provided with a 7 day supply of oral antipsychotic medication (Risperidone) when he commenced extended section 17 leave on the 28/12/07.

11. Communication between the AOT and the ward was poor. There was little communication at the commencement of Mr F's section 17 leave between the two services and whilst the Care coordinator did inform the ward that Mr F did not attend his appointment with him there is no evidence that this was communicated to the medical team.

12. There was no communication with the family by the Care coordinator when Mr F failed to keep his appointment or at any other time to assess how the leave was progressing.

13. Mr F's risk assessment did not highlight the family as being at risk although it has been acknowledged that they were.

14. Mr F's care plan does not address his lack of engagement and whilst he had a long history of non compliance it is unclear what attempts were made to try and engage him when he was in the community. Other key areas not addressed within the care plan are his illicit drug use and the rationale for not referring to the Dual Diagnosis Service, and his cultural needs.

15. Mr F's admission care pathway for his final admission in an inpatient unit in Brent was not fully completed and key stages such as updating the risks for a CPA and updating the risk management plan have not been signed as completed. It is unclear from the clinical records that his risks changed during his inpatient stay or that they were updated to include his leave in the community.

16. The section 17 leave form completed on the 21/12.07 is unclear. There is an unsigned line drawn between the dates covering the period 28/12/07 – 28/01/08. The next date covers the period 04/01/08 – 28/02/08 but states only 4 times per month.

17. The depot prescription was incorrectly completed on the 04/01/08, stating the route of medication as oral, not as intra-muscular, this was not immediately corrected by staff on the ward, though subsequently Mr F continued to take oral medication on the ward, up until the time of his arrest.

18. Whilst AOT was an appropriate service for Mr F the service criteria was not applied in the delivery of his care. There appears to have been little attempt to engage Mr F, no communication with the family; little effective care and risk planning, no assessment of his social care needs, no evidence of acknowledgement of his cultural needs.

19. There is a discrepancy in the accounts of caseload sizes. The national guidance is 12, however the Care coordinator stated that case loads were between 20-25 and the Consultant stated that they were between 12-15.

20. There was little evidence of effective liaison between the inpatient services and community services such as AOT and the Dual Diagnosis Service. (the latter to consider a way forward taking the staff view about referral to the Dual Diagnosis Service).

21. There is little evidence that Consultant ward round reviews were regularly attended by the Care coordinators.

22. Whilst it is recognised by the External Panel that Mr F provided a very demanding challenge given his history and behaviour, it is not demonstrated that this was addressed by clear leadership in both the inpatient and AOT services. The evidence to support this includes; poor communication, poor liaison, poor documentation, poor care and risk management, lack of carer involvement, poor compliance with operational and clinical policies.

23. When staff suspected that Mr F was using cannabis on the ward there is clear action taken to address this.

24. There was no clear action taken when Mr F defaulted on his leave conditions, both when he failed to meet with his Care coordinator or when he failed to return from leave on the designated day.

25. Whilst there is an entry in the care plan about Mr F joining in Occupational Therapy activities there is no evidence that he was encouraged to do so on a day by day basis.

26. There is some evidence that Mr F's observation levels were considered but this is not consistently documented, particularly after an aggressive incident.

27. Clinical supervision for ward based staff and within the AOT service did take place however it is unclear how this impacted on the monitoring of high risk patients; robust contingency planning; clear risk plans; clear communication to all parties involved.

28. It is unclear how clinical supervision and other management meetings were used to address staff compliance with policies and procedures.

7. Root Causes/Causal factors

1. The findings from the external investigation have determined that there is no fundamental contributory or causal factor. Mr F's evident risk behaviour was unpredictable and impulsive, therefore it could not have been predicted that he would have killed his father. The incident was of a different order in comparison with previous documented incidents of aggression.

8. Lessons Learned

1. The internal report covered many lessons learned. The findings were developed into recommendations which have been followed up as part of an internal Trust action plan.

2. The external Investigation panel notes the progress on the action plan and adds the following points for consideration within the action plan: Training should take account of all staff; each recommendation should have an audit trail to ensure compliance and learning; recommendation 2 should be reviewed to take account of clinical judgement; recommendation 4 should include all acute services within Brent; recommendation 5 should be more specific to include carer assessments, carer involvement in key decisions, carer involvement in CPAs, improved communication and liaison with carers.

3. The External Panel add the following areas which were not addressed as part of the internal investigation:

- Leadership: The overall clinical and team leadership within both the AOT and the inpatient setting was not demonstrated as robust and effective. There is no evidence that compliance with policies, documentation, risk management and clinical interventions were monitored and where appropriate, challenged within a supervision or caseload management framework. The Trust has provided evidence that all clinical leaders could now access a leadership training programme.

- Ethnicity and Culture: Mr F's ethnic and cultural needs were not addressed at any point. Mr F was Chilean and as such was in a small minority group. The Trust has provided evidence to the External Panel in relation to their strategic approach to address culture and ethnicity.

4. The External Panel would also like the Trust to take into account the follow:

- An on-going governance process which ensures continued monitoring of this action plan. Consideration should be given to how the action plan and additional actions will be monitored.

- The Trust should gain clarity on the national status of the series of Policy Implementation Guidance documents (PIG). There is some confusion as to the current status of these documents.

- Concern has been expressed by staff about the future of both the AOT and Dual Diagnosis Service following the Trust reconfiguring its clinical services into service lines. The Trust should have clear governance processes in place to ensure that clinical care is not compromised as an outcome of reconfiguration.

- During the interviews staff welcomed the installation of JADE as an electronic care records system and it seems to be efficient. However some staff said that it was difficult to enter more qualitative and detailed information onto the system.

9. Recommendations

1. Internal Action Plan: The recommendations and action plan to be reviewed to take account of the external investigation additional findings.

2. The Trust to ensure that the action plan continues to be monitored and its progress reported upwards via governance reporting systems.

3. Leadership: Leadership training and within this mentoring should continue to develop to ensure that all senior clinical leaders have access to leadership development.

4. Ethnicity and Culture: The Trust to continue its strategic approach to address carer involvement, culture, ethnicity and diversity and ensure via audits, monitoring and service user and carer involvement that culture, ethnicity and diversity are addressed.

5. The Trust to ensure that learning from the External Panel findings is shared across its clinical services.

6. The Trust to seek clarity on the national status of the series of Policy Implementation Guidance documents (PIG) in relation to the optimum way of delivering care for people with an acute mental illness.

7. Reconfiguration of services: The Trust to ensure that clear governance processes are in place to ensure that clinical care is not compromised as an outcome of reconfiguration.

8. JADE – Electronic Care Record System: The Trust to address the concerns raised by staff in relation to entering qualitative and detailed information onto the system.

MAIN REPORT

1. Incident description and consequences

1. On January 7, 2008, the Metropolitan police attended Pond Ward, an acute admission unit, located at the Park Royal Centre for Mental Health. They informed staff that they were seeking Mr F, a then 31 year old man, and patient of local Mental Health Services. Earlier that day Mr F's father (Mr F senior) had been found dead at his home by Mr F's sister. Mr F senior had been killed as a consequence of severe head injuries inflicted with a blunt instrument. The injuries were so severe the police suspected that a firearm had been used.

2. At the time of the incident Mr F was a hospital inpatient, detained under Section 3 of the Mental Health Act, 1983. He had been on leave from the ward since December 28, 2007, and had been reviewed most recently on the ward on the morning of January 7, 2008. At the time of the incident Mr F was also a patient of the Brent Assertive Outreach Mental Health Team.

3. Mr F was previously well known to local Mental Health Services in Brent, North West London, and had been in contact with services since 1998. Mr F's diagnosis is Schizophrenia, and his condition had previously run a chronic relapsing course, with repeated admissions to hospital generally on a compulsory basis. Mr F's condition was complicated by use of street drugs in the form of cannabis consumption, and his engagement with Community Mental Health Services and compliance with prescribed psychotropic medication in the community was problematic.

4. Mr F had a previous history of offending and of conviction, including assaultative behaviour directed towards family members and members of the public who were unknown to him. He had previously spent time in prison, and in the past had received mental health disposals (Section 37, MHA 1983) from the courts subsequent to conviction.

5. On account of concern for risk to others Mr F was, in 2006, referred to Specialist Forensic Mental Health Services for assessment. That assessment questioned the strength of any relationship between symptoms of schizophrenia and offending behaviour, and raised issues with respect to aspects of Mr F's personality.

6. Mr F was arrested by police shortly after the death of Mr F senior was reported. He was initially remanded into custody, spending time at HMP Wormwood Scrubs, before transfer to a secure hospital services at the Three Bridges Unit, West London, and subsequently to Broadmoor High Secure Hospital where he is located at present. With respect to court matters Mr F was convicted of Manslaughter on the grounds of Diminished Responsibility, and was served with a Hospital Order (Section 37, MHA 1983) and a Restriction Order (Section 41, MHA 1983).

7. Mr F has not been able to provide an explanation for the actions that were taken and there is no supporting evidence to confirm or deny his mental state at the time of Mr F senior's death.

2. Pre-investigation risk assessment

1. A risk rating was carried out at the commencement of the external review process within a framework which was first developed within the NHS Controls Assurance framework. Using this scoring system, risks can be allocated a score of between 1 and 25, with 1 reflecting negligible risk and 25 reflecting extreme risk. Table 1 sets out the framework.

Table 1 – NHS Controls Assurance Risk Scoring Methodology

Likelihood (the potential likelihood of the risk occurring)			Impact (the potential impact to individuals or the organisation of the risk occurring)
Almost Certain	5	Multiplied by	5 Extremely
Likely	4		4 Very High
Possible	3		3 Medium
Unlikely	2		2 Low
Rare	1		1 Negligible

2. This pre investigation risks were rated at 15 as the potential likelihood of the incident occurring was 3 and the potential impact was 5. A post investigation risk assessment will be completed following the external investigation process. This will take into account the clinical and risk behaviour of Mr F during his time with the Mental Health Services; the incident; the Trust's response to the incident; Mr F's current potential clinical and risk behaviour.

3. Background and Context

1. Mental ill health is estimated to cost the capital nearly £2.5 billion in health and social care costs, as well as £5.5 billion in lost working hours. The combined income of the ten MH Trusts in London for health related activities is £1.59 billion, with significant funding also invested in the voluntary and independent sector. Around 23% of Mental Health service users in London have the most serious level of mental illness compared to the national average figure of 14%. *(London Mental Health Trusts Chief Executive Officer Group)*.
2. Central and North West London NHS Foundation Trust (CNWL) covers the London Boroughs of Hillingdon, Harrow, Ealing, Brent, City of Westminster, Royal Borough of Kensington and Chelsea, Hammersmith and Fulham and Hounslow and Camden. This area of London is extremely diverse with over one hundred first languages spoken; there are areas with high levels of deprivation as well as areas of great affluence.
3. The population covered by the Trust is 2.2 million people and the Trust provides services to 35,000 service users.
4. The Trust has an annual turnover of c. £369 million and employs 4,740 staff operating out of over one hundred locations.
5. CNWL provides the following services:

- Mental Health Services for all age groups
- Specialist Child and Adolescent Mental Health Services (CAMHS)
- Addiction services
- Eating disorders services
- Learning disabilities services
- Services for people with challenging behaviours
- Offender care services (including to HMP Wormwood Scrubs, HMP Holloway and HMYOI Feltham)
- Community Services in Camden and Hillingdon. This includes a range of Adult and Child Health Care Services such as district nursing, health visiting, school nursing, physiotherapy and podiatry as well as a large Sexual Health Service in Camden.

6. CNWL has a number of contractual arrangements in place with NHS Primary Care Trusts which commission a range of core Mental Health Services on a block contract basis. These arrangements are generally for a three-year period. The Trust also tenders competitively for other services, which may be commissioned by a Primary Care Trust, a Local Authority or any other public body. Contracts with Local Authorities can vary from between 1-3 years duration, often with an option for extending for a further 2 years.

7. Within all services there are a range of professionals – medical and nursing staff; social workers; occupational therapists, and psychologists and support workers.

8. At the time of the homicide Mr F's clinical care was being managed by Brent Locality Services. The Trust is currently in the process of reconfiguring to a Service Line Management model.

4. Terms of Reference

The terms of reference for the external investigation (Appendix 1) set out the following:

4.1 Aim

The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr F via the objectives set out in 4.2

4.2 Objectives

The objectives to the terms of reference are as follows:

- 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 investigation;

- Involving the family of Mr F 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 Mr F and a review of the relevant documents;

- The extent to which Mr F's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies;

- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs;

- The exercise of professional judgment and clinical decision making;

- The appropriateness and quality of risk assessments and care planning and interventions by the Assertive Outreach Service;

- Consider the effectiveness of interagency working with particular reference to the sharing of information between the Substance Misuse Service and the Mental Health Services;

- The level of support to staff, service users and the families of the victims and service users following the incident;

- Consider other such matters as the public interest may require;

4.3 Key Questions

The key questions the external investigation panel developed from the terms of reference are:

- Was the Trust Internal Investigation adequate in terms of its findings, recommendations and action plans?

- What progress has been made on the Internal report action plan?

- Was the family of Mr F involved as fully as considered appropriate?

- Carry out a chronology of events to assist in the identification of any care and service delivery problems leading to the incident?

- What were the Mental Health Services provided to Mr F and were relevant documents in place?

- Was Mr F's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies?

- Was the care and treatment suitable in view of the service user's history and assessed health needs?

- The exercise of professional judgement and clinical decision making?

- What was the appropriateness and quality of risk assessments; care planning and interventions of the Assertive Outreach Service?

- How effective was interagency working, particularly in relation to the sharing of information between Substance Misuse Services and Mental Health Services?

- What was the level of support to staff, service users and the families of the victim and service users following the incident?

- Are there any other matters of public interest which need to be considered?

4.4 Key Deliverables

The external Investigation panel will deliver:

- A full Report

- An Executive Summary

- An involvement of the Trust to consider findings and share recommendations

- A presentation to CNWL and NHS London Strategic Health Authority

- An up to date position on the Internal Investigation action plan

4.5 Scope

- The investigation will commence in March 2011 and be completed in 2011.

4.6 Investigation type and process

This is a an Independent Investigation conducted by a panel of three members (section 4.9) details the panel members in terms of roles and experience). The process was:

- Review of documentation – strategies, policies & procedures, clinical notes, Brent County Council practitioner notes, information from other agencies, training records, court statements

- Interviews with staff, family members (mother and sister), General Practitioner (GP),

- Contact and meeting with Police, Brent Metropolitan Police Service

- Contact and meeting with Brent Social Services

- Telephone contact with the Coroner, Northern Jurisdiction, High Barnet

- Contact and meeting with Mr F's current Responsible Clinician

- Contact and meeting with current Social Worker

- The extensive tabular timeline covering Mr F's last two inpatient admissions (appendix 2).

- A chronology of Mr F's Forensic history from commencement with the Mental Health Services and leading up to the event (appendix 3)

- A 34 page evidence trail was compiled from documentation, interviews, case notes, statements

Note: A summary of all documentation reviewed is listed in (appendix 4)

4.7 Communication:

- The report will be presented to the Strategic Health Authority for consideration and subsequent publication.

4.8 Investigating Commissioner:

- The Investigation has been commissioned by the NHS London Strategic Health Authority in accordance with Department of Health Guidelines 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.

4.9 Investigators:

Panel member 1: Chair of the Panel

- Panel member 1 is an RGN, RMN, DMS with significant knowledge of Mental Health Services and systems, having recently retired as an Executive Director of Nursing and Governance for a large Mental Health & Learning Disability Trust; a post which she held for 6 years.

- Prior to that she has worked as a senior clinician and manager in both inpatient and community mental health settings. The Investigator has also taken part in several investigations, both as an individual investigator and as a panel member.

- Currently she has just completed an external review into a homicide; an 8 month fixed term part-time post as a Clinical Director for a Community NHS Service, to support its integration with a Mental Health Trust; a review of an NHS Trust Community Mental Health Service.

Panel member 2:

- Panel Member 2 has extensive experience of working at a senior management level in local and central government, the NHS and regulation and service improvement

- His background is in social work, social care and mental health. He was seconded for several years to the Department of Health to work on the development and implementation of Mental Health and Social Care Policy

- He is currently an Independent Consultant. Recent projects have included work with the Strategic Health Authority (SHA) Mental Health Leads and Interim Head of Mental Health for a SHA.

- He is also a Board Member of two organisations.

Panel member 3:

- Panel member 3 is a Consultant Psychiatrist who previously worked for 12 years in acute/general psychiatry in an inner city area, working across inpatient and community settings. Three years ago he took up his current post with a Community Forensic Mental Health Team with a brief for the care of high risk mentally disordered offenders, including patients subject to restriction orders.

- He has an interest in the Mental Health Act, and has regularly contributed to training courses organised locally and by the Royal College of Psychiatry. He has recently been appointed to the London Approval Panel (MHA Section 12/Approved Clinicians).

- He has previously held posts as a college tutor, and for a time as Acting Clinical Director. He is trained in Structured Investigation of Serious Untoward Incidents.

5. Level of Investigation

- The investigation is a level 3 Independent Investigation

6. Involvement and Support of Service User & Relatives

- Mr F was not interviewed by the panel as part of this investigation because of concerns expressed by his treating Responsible Clinician (Psychiatrist) for his mental health. The panel visited Broadmoor Hospital and had the opportunity of interviewing the Responsible Clinician with current overall responsibility for his care, and also the allocated social worker. They were able to provide the panel with information regarding Mr F's progress to date in hospital, the current view of his mental health difficulties, and Mr F's attitude to the incident. They were also able to provide information regarding contact with Mr F's family during his time at Broadmoor Hospital.

- Mr F's sister and mother were interviewed together. Both gave their opinion of the level of clinical care provided to Mr F and the level of support they received as Mr F's family during his time within the Mental Health Services and following the homicide. This will be covered in detail in section 9.

7. Involvement and support provided to staff Involved

- Following the incident there was a debriefing arranged for all staff. During staff interviews for this investigation staff reported also having access to management support and supervision.

8. Information and Evidence gathered

Appendix 4 sets out the list of documents used to gather evidence for the external investigation. Other information was gathered by the following:

Face to face interviews

- Mr F's Mother and Sister (supported by [1]RETHINK Mental Illness)

[1] RETHINK Mental Illness – supports people affected by Mental illness.

- Current RC and Social worker
- Mr F's General Practitioner
- CNWL staff x 19
- CNWL Non Executive Director
- NHS Brent Head of Contracts and Commissioning for non acute contracts and continuing healthcare.
- Mr F's Consultant Psychiatrist at the time of the incident
- Brent Social Services
- Brent Metropolitan Police
- Telephone Contact - Coroner – High Barnet

9. Findings

This section has been considered within the framework of the key questions, as follows:

9.1 Was the Trust Internal Investigation adequate in terms of its findings, recommendations and action plans.

Process:

1. The Trust internal investigation commenced on the 30/01/08 and completed on the 22/12/08. The extensive length of time for the investigation was explained as a complex investigation which involved contacting a number of services in Brent; the time it took to access all the files; the number of people involved; and the different interfaces with services such as the prison.
2. A panel was formed which consisted of a Consultant Psychiatrist from another area of the Trust; a Trust Service Manager; a Trust Community Service Manager; a second Trust Consultant Psychiatrist, in response to a request by the Consultant Psychiatrist already on the panel, which was supported by the panel. The second Consultant Psychiatrist however was unable to join the panel straight away due to clinical commitments. All members of the panel were Root Cause Analysis (RCA) trained.
3. The External Panel have been informed by the Trust that there were no formal terms of reference for the investigation as the investigation was originally set up as a "general all embracing review of care and treatment without a specific terms of reference. This was then to be followed by the Non Executive Director (NED) led inquiry (for which terms of reference would have been developed). However owing to the time that the internal investigation took to complete, the NED inquiry did not take place". There is however evidence that the internal investigation developed a set of objectives and outcomes for the investigation.

4. Staff involved were interviewed as part of the investigation process, with the exception of one staff member, all staff had been interviewed by May 2008. Members of the Internal Investigation Panel, when interviewed as part of the external investigation, felt that a Member of the Trust Board should have been appointed to the Internal Investigation Panel to give weight to the process, as there was reluctance from some staff to prioritise interviews over other work commitments.

5. Following the interviews, an initial report was drafted. This was sent to Trust Headquarters, and after some time the panel were asked to reconsider its findings. This involved having to reconvene the panel which took considerable time given the panel members other work commitments. Concern was expressed during the external review process that all members of the panel took part in the internal investigation over and above their full time job.

6. The family were not interviewed as part of the initial internal investigation process. It was explained that it would not have been a normal process to do so at this time, however following a letter from them to the Chief Executive of the Trust one Panel member, along with the Chief Executive went to visit the family. It is reported that this took some time to arrange because the family wanted support from the Victim Support Service. As a result of this visit the panel were asked to reconvene again to consider points raised by the family. The internal report was also reviewed by two medical colleagues, one of whom was independent of the Trust to address issues raised by the Internal Investigation Panel relating to aspects of medical care including prescribing and supervision of junior medical staff.

7. The recommendations were finally agreed. During the external investigation concern were raised that the internal report and recommendations were not formally signed off by the Internal Investigation Panel, although it is agreed that the recommendations are reflective of the findings. The panel members signatures do not appear on the report.

8. General Practitioner for Mr F was not interviewed as part of the internal investigation. The Internal Investigation Panel felt that the Root Cause Analysis Process led them to reviewing what had happened in month before the homicide, whilst Mr F was an inpatient.

9. The Board received the Root Cause Analysis report in May 2009 and the action plan in July 2009. Prior to this the Trust Board received a very brief update at the Board meeting on the 9th January 2008, and were then kept informed of the progress of the internal investigation via monthly Board briefings, as part of the Serious Untoward Incident Board report.

Findings of the Internal report:

1. The finding from the Internal Investigation Panel review was that there was no single root cause but there were a number of systems that were not working correctly.

2. There were 6 key areas identified in the internal report as follows:

- Non Compliance with oral medication – Mr F had an extensive history of non-compliance in the past, documented throughout his notes. During this admission depot neuroleptic medication was discussed but Mr F was reluctant to accept this plan.

- Non receipt of depot medication – administration of long acting Risperidone Consta injections was recommended as a treatment for Mr F going forward, with the suggestion that the granting of any subsequent leave was contingent on Mr F accepting such treatment. Mr F was not subsequently established on such treatment leading to a possible break in his treatment with antipsychotic medication. The panel cited concerns regarding communication and incorrect prescribing in relation to this.

- Illicit drug use not monitored – two earlier forensic psychiatric reports had highlighted that Urinary Drug Screening (UDS) was an important part of Mr F's care plan because drug misuse might be the cause of his violent outburst. UDS was requested on admission and later on but not carried out. UDS screening was not part of his care plan

- Failure to keep appointment with Care coordinator – while on section 17 leave Mr F defaulted on his arrangements to meet with his Care coordinator. This was a condition of his extended section 17 leave and as such Mr F had breached his condition of leave.

- Response to Mr F being Absent Without Leave (AWOL) – Mr F was due to return from extended leave on the 04/01/08 but failed to return.

- Insufficient involvement of family in Mr F care plan, and lack of support for family as carers – The family were not involved in Mr F's care or in the decision to name as his parents address as the place he would spend his extended leave over the Christmas and New Year period in 2007/08. The family were informed that Mr F would have section 17 leave over the Christmas break; 24 – 26th December but not that he had been granted leave from the 28/12/07 for 7 days, again to his parent's house or his own flat.

1. The external investigation; whilst the panel agree with the key areas identified it also found the following:

- Mr F had a long history of poor engagement with Community Mental Health Services and non compliance with prescribes psychotropic medication. The internal investigation focussed mainly on his last admission, although there is a commentary describing his history. The clinical decisions were based on Mr F's history and his current clinical presentation, though the internal investigation report does not consistently reflect this.

- Whilst the prescribing antipsychotic medication for Mr F on the inpatient ward is an area of clinical concern, the External Panel are concerned other clinical concerns have not been given the same weight of consideration as the medical staffing and their clinical interventions.

- Mr F's failure to keep an appointment with his Care coordinator was concerning on three points (1) that he defaulted on his extended leave criteria; (2) that no contingency was put in place to mitigate this as part of his care plan; (3) there was no communication to Mr F's parents to take account of their response to this failing to keep his appointment. Points 2 and 3 were not addressed within the findings of the internal report

- Response to Mr F being Absent Without Leave (AWOL) is raised within the internal report as a concern in that other members of the multi-disciplinary team, apart from the Consultant Psychiatrist, had a different perception of the plan of care. What is not addressed within the findings is the failure of the staff to act when the section 17 leave conditions were breached. Part of the confusion appears to arise from an interpretation of the section 17 leave form. The reverse side of the form details overnight leave 4 times per month from 04/01/08 with a review date of 21/01/08. The clinical entry on 05/01/08 details a judgement/interpretation of this from the night nursing staff to the effect that his leave was authorised and valid. This contradicts the entry of 04/01/08 re circulating if fails to return.

- The involvement of the family is detailed within the internal report however what is not included within the conclusion was the (1) lack of carers assessment; (2) the vulnerability of the family from Mr F's violent behaviour; (3) robust risk assessment and contingency planning to take account of his non compliance, dual diagnosis and lack of engagement; (4) the consideration of Mr F's cultural and ethnic needs; (5) lack of application of both ward based and community based activities to address his lack of engagement.

- Whilst there are clear clinical and managerial practice issues there is no recommendation to review the level of clinical leadership available within both the inpatient and community settings.

Recommendations of the Internal Report:

1. Recommendation 1 - 'Skills and Knowledge'. Knowledge relates to management of risks and communication relates to systems of communication between the inpatient unit and the AOT service. Both areas should have been expanded within the internal report findings and conclusion in relation to; consideration of risk and contingency to address planned care on a day to day basis, and a review of all communication systems within Brent Adult Mental Health Services to address this fundamental area of weakness. Given the prescribing concerns in relation to Mr F's medication (addressed in detail in section 9.4) the recommendation should be expanded to cover the safe clinical practice for the prescribing and administration of medication for all relevant clinicians.

2. Recommendation 2 - 'the management of drug related concerns on inpatient units' and within the recommendation description addresses the concern documented in the findings of the report with regard to drug testing and liaison with the Dual Diagnosis Service. As part of the external review concern was expressed by staff with regard to this recommendation. Their expressed view is that the majority of their inpatients have a dual diagnosis therefore linking patients to the Dual Diagnosis Service must be based on clinical judgement.

3. Recommendation 3 - 'Brent Assertive Outreach team', and recommends a review of working practices within the team, its interface with other services, and its communication with service users and carers. Whilst this appears to be a clear recommendation evidence from the external review indicates a misunderstanding of the term 'review of working practices'. The report addresses this in more detail in section 9.7.

4. Recommendation 4 - 'management of detained patients who are absent without leave'. This recommendation relates only to staff on one ward and Brent Assertive Outreach Service. This recommendation should have been expanded to ensure all appropriate clinicians within Brent Mental Health Services have a clear understanding of the AWOL Policy and not just those staff described within the recommendation.

5. Recommendation 5 - 'Involvement of Carers and states that the family's lack of involvement was one factor in this tragic incident. Within the internal report conclusion it is only described as the family's wish to be involved in Mr F's care planning. It does not describe their lack of carer's assessment or full involvement in the CPA Process.

   Action Plan following on from the Internal Report:

   The action plan developed from the internal report does not overall reflect the findings of the report as follows:

1. Knowledge - states that a memo must be sent to all Consultants Psychiatrists and Lead Clinicians in Brent Mental Health Services reiterating these points. There is no clear audit trail which will ensure that the memo is received and that practice will change as a result of this action.

2. Knowledge - states that a system must be put in place to ensure that all Care coordinators attend risk management training and a refresher course every three years in line with CNWL Policy. The recommendation for this action applies to all staff involved in completing risk assessments and not just Care coordinators.

3. Communication - states that procedures for AOT patients on one inpatient ward to be re-written to ensure the recommendation is met. There is no further action to determine how this will be audited to ensure its effectiveness.

4. Communication - states that one Consultant to be based in the inpatient unit and responsible for all AOT and rehabilitation inpatients. There is no action to state how and when this will be progressed and reviewed.

5. Management of drug related concerns on inpatient units - states; Ward Managers to ensure regular drug testing and referral to Dual Diagnosis Specialist where appropriate. This action does not address what happens if the patient refuses to comply with this as in the case of Mr F; training of staff; clinical supervision to manage patients who have a Dual Diagnosis (as many inpatients within Brent do).

6. Brent Assertive Outreach Team - states Review of Brent Assertive Outreach Service. This does not cover in detail the areas set out within the recommendation and give guidance as to what type of review. This will be addressed in more detail in section 9.7

7. Management of detained patients who are absent without leave - states; to provide a briefing for one inpatient ward and Assertive Outreach Service in CNWL Absent With Out Leave (AWOL) Policy. There is no follow up action to ensure all relevant staff within the Brent Mental Health Services have an understanding of the Policy.

8. Involvement of carers - states; to be taken to CNWL Clinical Governance Committee so that learning can be cascaded. Whilst this is an appropriate action there should have been a follow up action to ensure an immediate a response to reviewing the use of carers assessments; the involvement of carers at CPA and other relevant clinical meetings in relation to service users.

Conclusion to 9.1:

The conclusion to this section is set out below, this is also addressed as service delivery problems in tables 2, 3 and 4, as follows:

1. All investigations should be set within terms of reference to ensure clarity and a consistent approach which leads to clear outcomes and recommendations. It is recognised however that the panel did develop a set of objectives and outcomes for the internal investigation.

2. The process for carrying out the review was not managed in a timely and effective manner, this led to the report taking eleven months to complete which potentially would have had a detrimental impact of the learning from this incident in terms of the time it took for the action plan to be developed.

3. The report did not focus on the wider historical issues in relation to Mr F such as his non compliance; his cultural and ethnic background; a carers assessments.

4. The report actions do not adequately detail actions to address poor practice in relation to risk management, care planning (including activities in both ward and community settings), medication management; non-compliance with drug testing and knowledge of dual diagnosis patients; carers assessment and the involvement of families.

5. Whilst the External Panel accept the staff view that the majority of inpatients have a dual diagnosis and that linking patients to the Dual Diagnosis Service should be based on clinical judgement; decisions from clinical judgement must be documented with a review date.

6. The report does not address or question the adequacy of clinical leadership available within both the inpatient ward and the Assertive Outreach Team and make a recommendation to review and where applicable strengthen these.

7. The recommendations are not always aligned to the findings and the contributory factors set out within the report.

Table 2 Section 9.1 –Service Delivery Problem

Service Delivery Problem
There was no clear governance process that ensured the internal report was completed in a timely manner. The report took eleven months to finalise which meant that the action plan took over a year to develop. Key actions should have been addressed immediately in relation to risk management, medication management, carer involvement, working practices within the AOT, effective liaison with other services.

Table 3 Section 9.1 –Service Delivery Problem

Service Delivery Problem
The action plan developed from the internal report does not follow through from the findings. The recommendations and action plan does not represent the level of concerns detailed in the findings.

Table 4 Section 9.1 –Service Delivery Problem

Service Delivery Problem
Clinical leadership across the inpatient and Assertive Outreach Services is not visible There is no recommendation to address the availability of clinical leadership which is critical to leading and improving service delivery.

9.2 What progress has been made on the Internal report action plan

1. Staff were identified to implement specific areas within the action plan. Evidence against each recommendation and action arising was supplied to the External Panel.

2. The panel was able to evidence progress against each recommendation. This is monitored via the Trust Organisational Learning Group and reported to the Trust Quality Committee and upwards to the Trust Board. The Trust is undergoing a reconfiguration of its clinical services; the Trust should assure itself that monitoring will not be lost post reconfiguration.

3. The measurement framework applied to the action plan is those applied by the [2]National Health Litigation Authority (NHSLA) which uses a set of risk management standards within Healthcare Organisations. These are set at 3 levels and the principle applied to each level can be applied to the action plan progress, as follows:

   Level 1 – Policy: evidence has been described and documented

   Level 2 – Practice: evidence has been described and documented and is in use

   Level 3: Performance: evidence has been described, documented and is working across the whole organisation

   Appendix 5 sets out the action plan; its current status in terms of evidence and progress; the NHSLA level against each section.

[2] The National Health Service Litigation Authority has developed a risk assessment framework underpinned by a range of NHSLA standards and assessments. Most Healthcare organisations are regularly assessed against these risk management standards.

Conclusion to Section 9.2

The conclusion to section 9.2 is as follows:

1. All actions and recommendations are being progressed and using the NHSLA framework comply with either level 1, 2 or level 3.

2. Assurance must be provided by the Trust that post the new organisational arrangements the action plan will continue to be monitored and progressed. This will comply with the requirements of the [3]National Patient Safety Agency (2010) which requires 'Commissioners, Providers and Managers of the NHS to ensure that there are systematic measures in place for safeguarding patients, property, NHS resources and reputation'.

9.3 Was the family of Mr F involved as fully as considered appropriate?

This section considers the family involvement in the context of the care and treatment of Mr F; the internal investigation; the external investigation.

Involvement in Care and Treatment:

During the course of Mr F's involvement with Mental Health Services there is little evidence to demonstrate that the family were considered or consulted with regard to Mr F's care and treatment. The chronology of Mr F's last 2 admissions (appendix 2) demonstrates this.

1. Mr F's Consultant Psychiatrist reflected during interview that the family were notable by their absence from a lot of the discussions and that staff had some reservations about getting them involved because of their concerns about his behaviour towards them.

2. Risk assessments carried out on Mr F do note his risks of violence to others based on previous history, however the family are not assessed as being at risk. In an assessment carried out by an Approved Social Worker in October 2007 it is noted by the Social Worker that Mr F's parents felt scared of him. This was not followed up and does not appear as a potential risk in Mr F's risk assessment.

3. The family did visit Mr F when he was an inpatient but there is no record that they were spoken to by staff and asked their views on Mr F's recovery. There is little evidence within the clinical notes that Mr F's parents were considered as his carers. No [4]carers assessment had been carried out and the family were not aware that they should have been offered a carer's assessment.

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[3] National Patient Safety Agency – Arms length body of the Department of Health – set up to lead and contribute to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

[4] Carers Assessment - Carers Equal Opportunities Act 2000 - duty to inform carers of their right to an assessment.

4. When Mr F was given section 17 leave over the Christmas period of 2007, it is clear from the records that he would be spending his leave at his parents' home. Mr F's mother states that a telephone call was made by the ward to Mr F's father informing them that he was being released into their care. From the family's perspective there was no discussion to assess the appropriateness of this. It later transpired that Mr F's mother was in Chile over the Christmas period. This meant that Mr F's father and sister predominately had to manage Mr F with little support from the service. At New Year Mr F again turned up at his parents home, no telephone call had been made by the ward to inform them of this.

5. Mr F should have met with his Care coordinator from the Assertive Outreach Team on the 30/12/07 whilst on leave, he failed to keep the appointment which was Mr F's normal pattern of behaviour. Although the Care coordinator contacted the inpatient ward to inform them of this, no contact was made to the family, either by the Care coordinator or the inpatient ward staff.

Involvement in the Internal Investigation:

1. The internal investigation commenced on the 30th January 2008. The family were not initially interviewed as part of the investigation, although they were seen following the incident. Section 9.11 addresses this. A member of the internal panel stated that meeting the family was not part of the RCA process at that time and that they were not required to meet with them.

2. In June 2008 the family, at their request had a meeting with the Trust Chief Executive and a member of the Internal Investigation Panel. In response to the issues raised by the family the report was amended to include the family views.

3. Following the meeting in June with the family and the Chief Executive the family raised 41 questions and points of concern. These reflected their concern about Mr F's care in relation to:

- The sharing of information
- Clinical risk assessments and the robustness of these at the time of his section 17 leave
- Medication administration
- Care coordinator follow up when he was in the community on section 17 leave
- Whether correct procedures were followed with regard to Mr F's section 17 leave
- Lack of involvement of the family with his clinical care and when he went on leave
- Lack of awareness of Mr F's ethnic and cultural needs
- Why Mr F was released to his parents home and not his own flat
- Why they were sent a letter 4 months after the incident inviting them to a CPA meeting

4. The Trust provided a response to the 41 points raised and also in September 2008 provided the family with a final copy of the internal report which reflected the issues raised by the family.

Involvement in the External Investigation:

1. Mr F's mother and sister were interviewed as part of the external investigation by two members of the panel. They were supported during the interview by a member of RETHINK.

2. During the course of the interview they again expressed their concerns with regard to:

- Their fear of Mr F and how difficult it had been over the years to manage his aggressiveness.
- Their observation that Mr F was calmer when he was on medication, he had previously been on a depot injection for 2 years and their observation was that he had been fine.
- The lack of explanation and information about Mr F's mental illness.
- Their wish to be involved in his care and the poor response to this.
- The lack of knowledge about a carers assessment and the general lack of support from the Trust when Mr F was in the community.

3. Notes of the meeting were taken for the family to confirm. The panel confirmed that their overall concerns would be reflected within the external investigation report.

Conclusion to 9.3:

In conclusion to section 9.3 it is considered that the family were not appropriately involved as follows, this is also set out as a care delivery problem in table 5:

1. The family were his main carers although not recognised as such by the Trust. Mr F's Consultant did recognise that the family were at risk from Mr F however this is not reflected in any risk assessments. The Ward Manager in interview stated that both she and the Deputy Manager were very surprised that this had happened, drawing a possible conclusion for the External Panel that not all key staff were aware of the vulnerability to the family.

2. No carers assessment had been carried out with the family, so their level of involvement with Mr F was unclear and crisis information was not shared with them, even though Mr F was judged to be high risk and unpredictable.

3. Whilst the family had contact from the Trust following the incident they did not feel involved in the internal investigation process until they contacted and met with the Chief Executive of the Trust and a panel member. Following this meeting the family's concerns were reflected in the final internal investigation report. A recommendation within the internal report does covers carers involvement.

Table 5 - Section 9.3 - Care Delivery Problem

Care Delivery Problem
Non involvement of carers The family were not involved in the planning of the care and treatment of Mr F, their views were not regularly sought. They were not offered a carers assessment to ascertain their needs in relation to supporting Mr F

9.4 Carry out a chronology of events to assist in the identification of any care and service delivery problems leading to the incident.

Appendix 2 sets out a chronology of care for Mr F's last 2 inpatient admissions however for the purposes of this report this section will cover Mr F's last admission.

1. 09/11/07: Mr F was admitted to an inpatient ward under section 3 of the Mental Health Act (MHA) 1983, from Chelsea and Westminster hospital, he had presented as an emergency with a laceration to his right forearm. He was reported to have smashed the television at home, possibly in response to auditory hallucinations. He was commenced on oral medication (Lorazepam, a benzodiazepine/sedative, on an as required basis. Also prescribed the antipsychotic Haloperidol as required which he refused to take). Whilst the risk tool was completed, the risk event history tool was not completed and the admission/discharge audit tool was not fully completed. Three care area were identified (1) diagnosis of schizophrenia (2) risk of violence and assault to others (3) laceration on his right arm. Interventions to address all three areas were described.

2. 12/11/07: Consultant ward review was carried out and Mr F was observed to be very agitated and laughing to himself, his medication was reviewed.

3. 13/11/07: multi-disciplinary care plan was reviewed and his mental state noted as unstable. The next evaluation was set for the 20/11/07.

4. 16/11/07: Consultant ward review was carried out, Mr F refused to attend. A decision was taken that Mr F should remain without medication apart from Lorazapam as required.

5. 17/11/07: Mr F's parents visited. He was observed as being "chuffed" to see them. It is not noted in the clinical notes that staff spoke with the parents as his carers.

6. 18/11/07: it is noted that Mr F "appears calm at the moment, in the early hours of the morning he reported that 'people on the ward are too looney man, they seem to know what I am about to do and I don't know how they read my mind' He gave an example of someone going to occupy a seat he is about to use. He walked away afterwards and did not discuss this further".

7. 18/11/07: (later): noted that Mr F was very agitated, shouting at staff and being threatening, uttering racist comments. 2mg Lorazepam administered with good effect.

8. 19/11/07: documented that Mr F made aggressive threats. Mr F took oral prn Lorazepam 2mg after much persuasion. He said if staff continued to give him prn he would be back with two spanners. Mr F insisted this was a threat and not a warning.

9. 22/11/07: noted in the clinical notes that the nursing admission pathway, care plan and risk assessment were not complete. The plan was to complete these.

10. 23/11/07: Mr F was commenced on a treatment with anti psychotic Haloperidol 5 mgs at night.

11. 24/11/07: noted that Mr F was worried that his father would go to his flat and take his cables. He had lent the cables to his father and had just taken them back. However on the 25/11/07 his father visited Mr F and Mr F was noted to be very calm.

12. 26/11/07: risk screening tool was completed by the team as per the admission pathway. The risk tool has a question which asks if the service user has children. This is ticked as no, whereas Mr F does have a daughter who he was not in contact with.

13. 26/11/07: Mr F's mental state was reviewed by the ward doctor. There were no positive symptoms of psychosis elicited.

14. 27/11/07: Mr F presented as very agitated and verbally abusive to another patient. He was informed by staff that his behaviour would not be tolerated.

15. 30/11/07: noted that in the ward round that the incident of 27/11/07 was recorded and treatment with Haloperidol increased to twice daily – and no leave was granted

16. 02/12/07: noted that Mr F was asleep all morning and went back to bed in the afternoon. It is possible that this was the reason he was not sleeping at night.

17. 03/12/07: Mr F was awake all night, refusing medication. Staff documented that they smelt cannabis however there is no evidence that any action was considered as a result of this concern.

18. 05/12/07: Documented that Mr F wanted to stop his medication. He was persuaded by staff to wait until he had discussed this with the doctor. He was then awake all night pacing the corridors. He stated that his job does not allow him to sleep and that he was a CID Officer but on 6 months leave.

19. 07/12/07: Consultant ward review. Documented that Mr F was settled but still prone to aggressive outbursts. Plan from this was to change Mr F's medication to Risperidone (from Haloperidol) and to stop Clonazepam in a few days. A further plan was to establish him on long acting Risperidone Consta injections, 37.5mg two weekly (out of concern for previous poor compliance with treatment in the community). Once established on Risperidone Consta injections to manage utilising long term section 17 leave. Only oral medication was prescribed at the time.

20. 08/12/07: Mr F was visited on ward by his father who spoke with staff about arranging a medical/hospital review for Mr F's wound.

21. 11/12/07: noted that Mr F refused his night medication saying that it made him drowsy. He stated that he had done his research and that medication was bad. He walked up and down the corridor all night.

22. 12/12/07: noted that Mr F did not believe he had a mental illness. He was very concerned that antipsychotic medication was wrong. The conversation was disjointed and staff ended the conversation. Earlier entries that day indicate that Mr F was "bright and appeared to be interacting with others". This could suggest that he was beginning to respond to his medication.

23. 12/12/07: Mr F raised concerns with staff re access to benefits and lost post office/cash card. Staff made contact with Mr F's father, who agreed to bring keys and relevant letter to the ward the next day.

24. 13/11/07: noted that Mr F "continues to improve in his mental state – no episodes of aggressive or threatening behaviour. He is amicable and very polite in his approach and interactions with staff as well as some other patients".

25. 14/12/07: Mr F became very annoyed with another patient and started shouting. Staff calmed him down but not noted if any follow up actions such as increased observation were taken.

26. 14/12/07: Ward review was led by the Specialist Registrar. Mr F was given planned unescorted leave for 15 minutes two 2 times a day plus 4 hours so that he could go out with his family on the 16th for his birthday.

27. 15/12/07: Mr F had a care plan review. As part of this it was documented in his care plan that he had not displayed any aggressive behaviour. Whilst he was at times interacting well with others, Mr F had also displayed aggressive behaviour. It would have been more accurate for the care plan to state that Mr F had displayed some aggressive behaviour and at other times had been interacting well with others.

28. 16/12/07: Mr F went out with his father and sister for his birthday. It is noted in the clinical notes that he had been appropriate in mood. When the External Panel spoke with the family his sister commented that Mr F was very inappropriate in behaviour when they were out but that the family had not been asked by staff how Mr F had presented, although the notes indicate that they had been able to contact the family and visa versa with regard to Mr F's needs in relation to wound care and Benefits.

29. 21/12/07: Mr F was reviewed in the ward round by the Specialist Registrar. Mr F's medication was changed and his section 17 leave was increased to 10 hours daily. It is not noted that his extended leave was communicated to his family. During the 21 – 24/12/07 Mr F is noted to have been appropriate to staff and to using his leave appropriately.

30. 24/12/07: Mr F's section 17 leave was increased to cover the period from the 24th to the 26th December. On his section 17 leave form it states that he will be residing at his father's address or home address. Mr F's father was contacted about this however the family felt that they had been told Mr F was going on leave, and that their views about its suitability were not sought.

31. 26/12/07: Mr F returned from leave and said that it went well. It is not noted if this was confirmed with the family. When the family met with the External Panel they said that the leave was difficult.

32. 27/12/07: noted that Mr F had good interaction on the ward except with one patient who he felt was following him and on the 28/12/07 he had remained awake all night

33. 28/12/07: noted in the ward round record that Mr F's Christmas leave went well. There is no evidence that this was confirmed with the family. There is also no evidence that Mr F's presentation on the 27th with regard to his concern about another patient and his lack of sleep was discussed or taken into account.

34. 28/12/07: At the ward round review led by the Specialist Registrar Mr F was granted one week's section 17 leave and arrangements were made for him to meet with his Care coordinator from the Assertive Outreach Service (AOT) on the 30/12/07 at Mr F's flat. Mr F was also required to come back to the ward mid week for a review by the nursing staff. Again the leave was arranged to his father's address or Mr F's flat. The section 17 leave paperwork shows the leave to be from the 28/12/07 to 28/01/08 which conflicts with the ward round record. A line has been put through this date without a signature and the next leave is shown as the 04/01/08 to the 28/2/08.

35. 31/12/07: Care coordinator from the AOT was due to meet with Mr F at his flat as arranged (although in the clinical notes it states that they were due to meet on the 30/12/07 they actually agreed to meet on the 31/12/07 at Mr F's flat). Mr F was not in when the Care coordinator arrived. The Care coordinator contacted the ward to inform them but did not contact his father's home. There is no documentation to show that Mr F did not attend his appointment or that any contact was made to the family. There is no evidence that Mr F came back for a mid week review by the nurses as stated in the ward round record on the 28th.

36. 04/01/08: Mr F did not attend the ward review as planned. The ward staff tried to contact his father, it is noted that they were unable to contact him.

37. 04/01/08: stated in the ward round record that if Mr F did not return then the police were to be informed. Mr F did not return that day, however the Police were not informed as when Mr F did return, albeit late, he was as part of a previous ward round granted section 17 leave from the 04/01/08 for up to 4 times per month until the 28/02/08.

38. 04/01/08: As part of the ward round Mr F's medication was reviewed and it is noted that he was to commence a depot injection that day and to stop oral medication in two weeks time. The medication prescription however was incorrectly written up stating the route of administration as oral. A depot is given via an intra muscular injection.

39. 05/01/08: noted that ward staff discussed contacting the AOT about Mr F, they had not previously been in contact even though Mr F was on leave and being followed up by AOT.

40. 05/01/08: Mr F returned to the ward having reported that he overslept the previous day. His depot was not given due to the medication administration error. Instead he had his night medication (Risperidone 4mg) at approximately 18.30 and told to return the next day for more medication until his tablets to take out (TTOs) were ready.

41. 06/01/08: Mr F again returned to the ward. He stated that he was not aware of a plan for him to have a depot, it had not been discussed with him. His oral medication (Risperidone 4mg) was administered to him and he was told to return the next day for TTOs. It is noted that he appeared calm, playing the guitar for other patients.

42. 07/01/08: Mr F returned to the ward and 7 days worth of medication were given to him. He was told to return to ward for a Care Programme Approach (CPA) meeting on the 11/01/08 and discharge.

43. 07/01/08: Police attended the ward stating that Mr F was a suspect in the death of his father and warned staff they he may be armed with a gun. A communication plan was set up within the service and within this it stated that Mr F's risk assessment was to be updated if Mr F was involved. It is unclear from the clinical notes that staff realised that if Mr F was involved he would be arrested and charged.

44. 07/01/08: Police again contacted the inpatient ward for more information about Mr F including his Mental Health Act status. They confirmed that his father was murdered. Later pathologist evidence showed that his father had been murdered by use of a blunt instrument causing massive head trauma. The time of death was difficult to establish however given the physiological changes to the body it is noted in the pathology report that 'it must be seen as in order of several days'. As no time of death was established with accuracy it is very possible that Mr F visited the ward following the murder of his father.

45. 08/01/08: Police arrested Mr F in connection with the murder of his father, and contacted the ward to request an Appropriate Adult. The staff contacted Brent Social Services but were informed that they could not provide an Appropriate Adult as the Police requesting this were outside the borough of Brent. The staff worked with the Police to provide an alternative Appropriate Adult but this was not resolved until the next day.

46. 08/01/08: current list of medication was faxed to the Police this did not include his depot injection as this had not been given.

47. 09/01/08: Senior House Officer documented a retrospective note in the clinical record, stating that he saw Mr F briefly on the 07/01/08 when Mr F collected his medication and that Mr F acknowledged him and appeared calm.

48. 10/01/08: Mr F remained in custody but had not been charged with Mr F senior's murder. During this time Mr F did not admit to killing Mr F senior but did admit to being in the house with his dead body. Mr F was formally charged with his murder and remanded to Wormwood Scrubs until the 18/04/08. He was also formally discharged from his section 3 and from the inpatient ward.

49. 09/04/08: Mr F's mother was written to from the service inviting her to attend a CPA meeting to be held on the 21/04/08. The administration system which supported the planning of follow up CPAs had not been stopped.

Conclusion

The conclusion to section 9.4 is in four sections – documentation, clinical interventions, carer involvement and support and communication. (This is also set out in table 6, 7 and 8.)

Documentation:

1. Whilst there was an awareness by the Consultant of the risks Mr F posed to his parents, this was not shared by the Ward and Deputy Ward Manager; it was not included on his risk review form at the time of his admission or at any time during his inpatient stay.

2. Following his aggressive outbursts and threatening behaviour his risk plan was not updated.

3. The admission pathway had commenced but was not completed by ward staff. The admission pathway is an aid and a prompt to managing the patient's journey through inpatient care and out to the community in an effective and organised way.

4. The section 17 leave form is unclear. There is a line drawn between the dates covering 28/12/07 – 28/01/08 which has not been signed. The next date covers the period 04/01/08 – 28/02/08 but states only 4 times per month and this was not followed.

Clinical intervention:

1. There is evidence that Mr F's inappropriate aggressive behaviour was addressed but this was not consistently applied to him throughout his stay.

2. There is some evidence that Mr F's observation levels were reviewed to ensure his safety and that of other patients following his aggressive and threatening behaviour, but this was not consistently documented.

3. When staff suspected that Mr F was using cannabis on the ward there is no evidence to demonstrate how this was managed.

4. The was a disparity in the decision to commence Mr F on a depot injection and the longer term planning in relation to section 17 leave. This plan does not appear to have been communicated to all members of the medical team, hence Mr F was granted extended section 17 leave before commencement of his depot injection. Mr F was provided with a 7 day supply of oral antipsychotic medication (Risperidone) when he commenced extended section 17 leave on the 28/12/07.

5. The ward round record notes that Mr F was granted 7 days leave with a plan to return for a review by ward staff mid week. This is not noted in the clinical notes as a record of the review, the staff therefore did not follow this up.

6. Whilst there is an entry on the care plan about Mr F joining in Occupational Therapy activates, there is no documented evidence that he did or that he was encouraged to do so on a day to day basis. There is little evidence to show how observation levels were considered and applied.

7. When on the 15/12/07 Mr F had a care and risk review it was documented in his care plan that he had not displayed any aggressive behaviour, yet on the 14th he had been shouting at another patient. The record should have noted that at times he was still displaying aggressive behaviour.

8. The depot prescription was incorrectly completed on 04/01/08, stating the route of medication as oral, not as intra-muscular. This was not immediately corrected by staff on the ward, although subsequently Mr F continued to take oral medication on the ward, up until the time of his arrest.

9. The ward staff do not appear to have contacted the AOT service to get an update on Mr F until the 04/01/08 even though Mr F had effectively been on leave since 28/12/07. This raises a concern about the level of communication between the two services in respect of the patient pathway.

10. When Mr F returned to the ward on the 07/01/08 he received 7 days worth of medication and sent on leave and yet his section 17 leave requirements was 4 times per month. This does not appear to have been addressed by staff.

Carer involvement:

1. There is no documented evidence that his family was asked for their opinion of Mr F's progress when they visited the ward or when Mr F was on section 17 leave. There is evidence that when they had a concern they did speak to staff and vice versa.

2. The family were not contacted when Mr F failed to attend his appointment with his Care coordinator on the 31/12/07.

3. The family were sent an invite to attend a CPA in April 2008. This demonstrates a lack of responsiveness to ensure all on-going administration processes are updated.

Communication:

1. When the Care coordinator contacted the ward to inform them that Mr F had not turned up for his appointment on the 31/12/07 there is no evidence that this was communicated onwards or that the family were contacted.

2. There is a clear misunderstanding about the status of Mr F when he failed to attend the ward on the 04/01/08 as agreed within his section 17 leave. Whilst he was at that point in default of his leave requirements he was immediately recommenced on section 17 leave and was therefore no longer absent without leave. Staff were unclear about follow up actions required by the medical staff in terms of contacting the police. There is no evidence that this had been a joint decision by the nursing and medical staff.

Table 6 - Section 9.4 - Care Delivery Problem

Care Delivery Problem
Poor management of documentation Documentation pertinent to Mr F's care was either not completed, not updated or incorrectly completed.

Table 7 - Section 9.4 - Care Delivery Problem

Care Delivery Problem
Clinical interventions were not demonstrated as planned or considered Clinical interventions were not always based on Mr F's current need e.g. there is no evidence that he was encouraged to join in Occupational Therapy activities.

Table 8 - Section 9.4 - Care Delivery Problem

Care Delivery Problem
Communication across profession groups; from the inpatient ward to the community and with the family. Communication was not was not always effective or responsive to Mr F's clinical management and/or his behaviour which led to potentially uninformed follow up

9.5 What were the Mental Health Services provided to Mr F and were relevant documents in place.

The Mental Health Services provided to Mr F mainly consisted of inpatient services and community services provided by the Assertive Outreach Service.

Inpatient services:

1. Mr F was always admitted to the Brent Inpatient Services under section of the Mental Health Act. Mr F's forensic history set out in appendix 3 indicates that following an assault on members of the public he was invariably admitted under section to a mental health inpatient facility. His last admission however was due to the expressed concern of his parents and his self harm to himself re: laceration to his right arm.

2. It is reflected throughout Mr F's records, including a forensic assessment, that the content of his mental state was generally difficult to access. In such cases abnormal mental health is often inferred through altered behaviour, either directly observed or reported.

3. Section 9.4 addresses the day to day interventions with regard to Mr F's clinical management. It is clear from this that there were fundamental practices which were not robust, namely:

- Clinical care based on Mr F's day to day clinical presentation rather than on his diagnosis and risk history. This would have included making sure Mr F was involved in ward activities as set out within his care plan; regular one to one time with his named nurse; more engagement and involvement with his Care co-coordinator whilst he was in inpatient; possible engagement of a community support worker; ensuring his cultural needs were addressed. It is not evident from the clinical notes that this was considered.

- Effective communication both across the inpatient medical and nursing staff, and across the community services, namely the AOT.

- An effective approach with regard to Mr F's section 17 leave both in the planning of this and the response when Mr F defaulted on his leave.

- Effective relationships with the Dual Diagnosis and Substance Misuse services – Mr F did take illicit drugs and there is no evidence that involvement with the Dual Diagnosis Service was considered. Given Mr F's long history of substance misuse and its cited role in his mental ill health, referral to the Dual Diagnosis Services might have been usefully considered. It is however acknowledged that the evidence base for such interventions is not compelling and furthermore Mr F did not give any indication that he wished to address his cannabis use. During the external investigation process staff expressed the view that a majority of inpatients within Brent had a dual diagnosis and that linking to the Dual Diagnosis Service should be about clinical judgement. Whilst the External Panel accept the view, decisions from clinical judgement must be documented with a review date.

- Mr F denied that he used substances so would not have benefited from a referral. Whilst this is a very valid point it should be noted within the clinical notes that this was considered and not acted upon due to Mr F's presentation. Also the Care coordinator felt that Mr F needed to be motivated to change before the Dual Diagnosis Service could be approached, but motivation is not one of the key purposes of a Dual Diagnosis Service.

- Full involvement with Mr F's carers either with his inpatient care or as an outcome of his leave to the family home.

- Evidence that Mr F's race or culture formed part of his care. This is addressed in more detail in section 9.7

1. As part of the external review the panel reviewed the current practices and policies which are detailed in the action plan in appendix 5 and as follows:

- There is now Care Programme Approach and risk training which is part of a mandatory programme. Evidence suggests that many staff have now received this training.

- Ethnicity and Diversity are integral to the Trust's philosophy and culture with the Ethnicity and Diversity lead for the Trust reporting to the Chair of the Trust.

- The Dual Diagnosis Service and Substance Misuse Service are much more able to work with inpatient services, although it is recognised that there is still room for improvement. Liaison and communication is more effective since the Trust electronic clinical computer system JADE was installed. Staff however have raised an issue in relation to the functionality of JADE and the information which can entered. There is a concern that the JADE system does not allow for pertinent quality information to be entered.

- Communication systems have been improved within and across the inpatient services with clear guidelines for ward reviews; handover communication between working shifts; a current Observation and Engagement Policy which includes staff competency training; a clear Leave Policy for all staff across the inpatient and community setting which sets out standards of communication in the case of all patient leave.

Assertive Outreach Service:

1. The clinical practice with regard to this service is addressed in detail in section 9.9. Nationally Assertive Outreach Services were set up to manage patients who did not engage easily with Mental Health Services and who had a severe and enduring mental health illness. Mr F met this criteria and as such, whilst his follow up by the Care coordinator was not robust, the service was the correct community service for Mr F.

Relevant documentation within the services:

1. Documentation in relation to Mental Health Act practice, care planning and risk assessment was evident in 2007. However documentation in relation to ethnicity and diversity and carer involvement was not evident.

2. Policies in relation to risk management care planning and have now been amended within the Trust to take account of national changes within the [5]Care Programme Approach and the [6]Recovery Approach. There are also strategies in relation to Ethnicity and Diversity and Carer Involvement. This section is covered in more detail in 9.6

[5] Department of Health (2008, 19th March) *Refocusing the Care Programme Approach*
[6] Making Recovery a Reality – Sainsbury Centre for Mental Health 2008

Conclusion:

The conclusion to 9.5 is as follows:

1 Mr F was appropriately detained under the Mental Health Act (1983) to an appropriate inpatient facility.

2 The AOT was an appropriate service for Mr F to be referred to, although the AOT and inpatient services did not communicate effectively and Mr F's care was not planned in a partnership way between the two services.

3 The AOT did not act in an 'Assertive' way with Mr F as set out within section 9.9.

4 There is no documented rationale for not referring Mr F to the Dual Diagnosis Service.

5 Current policies and procedures are available and there is clear evidence that staff are trained to be competent in meeting the requirements set out within the Policies and procedures.

9.6 Was Mr F's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies.

Mr F's care was provided mainly within an acute mental health inpatient setting and the Assertive Outreach Team when in the community. This section will review the local and national relevant guidance and operational policies with regard to these clinical areas. Mr F also had a dual diagnosis; this section will review the national guidance in relation to this.

Local operational policies:

Inpatient Policies:

1. Clinical Supervision Policy: This Policy was issued in April 2007 and sets out clear process for supervision both in terms of the practice of supervision and the recommended period for supervision to take place. One interviewee, as part of the external investigation, described the difficulty historically of implementing supervision, particularly in an inpatient setting. This is currently being reviewed by the inpatient unit; however, the interviewee reiterated that clinical supervision was currently in place.

2. Mental Health Act (MHA) Policies: all statutory policies are in place and are legally required to be so. The MHA Policy in relation to 'Patients absent without leave' issued in February 2006 describes leave requirements under section 17. It states that every effort must be made by the nurse in charge to contact the patient, the patient's nearest relative or other carer if the patient fails to return to hospital as required by the conditions of leave. Mr F failed to return on the 4th January, it is documented that a staff member tried to contact the next of kin. It also requires a recall if the patient fails to reside at the address stipulated on the section 17 leave form. Two addresses were put on Mr F's section 17 leave form; his flat and his parents home. This raises a question of good practice when completing a section 17 leave form in order to ensure that it is as consistent as possible

3. Care Programme Approach Policy: This Policy was issued in 2005.

- Within the Policy (section 13) it states that when considering risk consideration also "needs to be given to the service user's social, family and welfare circumstances". There is no evidence that this was considered.

- Within the Policy (section 15) it states that "an explicit plan of action must be implemented should a crisis occur and that service users on an enhanced CPA must have crisis plan arrangements documented in their CPA care plan". There is no evidence that Mr F who was on an enhanced CPA did have a crisis plan.

- Within the Policy there is a section on involvement of carers (section 26) and states the Nation Service Framework for Mental Health – Caring for carers – which stipulates that "all individuals who provide regular and substantial care for someone on a CPA should; have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis; have their own written support plan which is given to them and implemented in discussion with them". This was not offered to the family, also appendix 2 – the tabular time line - shows that on the 26/03/07 the family were not invited to attend Mr F's CPA.

- Within the Policy (section 31) it gives a definition of Dual Diagnosis defined as "the presence of a problematic drug/alcohol use in individuals who are diagnosed as having a severe and enduring mental illness". Mr F did use illicit substances but does not appear to have been seen as a dual diagnosis patient. It is not evidenced that the Dual Diagnosis Service was contacted for advice.

- The Policy also has a section on equality and diversity (section 34). It is the Panel's view that the care provided to Mr F and the subsequent internal inquiry was not sensitive to issues of race and culture. There are four aspects to this –

    - *Factors associated with Mr F's care and his racial and cultural identity which were not addressed*
    - *Assaults by Mr F on people from particular ethnic backgrounds which were not addressed*
    - *The cultural background of Mr F's family and the background to their living in the UK*
    - *The fact that the internal inquiry did not address these issues in any way.*

4. Dual Diagnosis: A Dual Diagnosis strategy was in place from 2003 to 2006 and from 2010 to 2015. There was no evidence made available to the External Panel that a strategy existed between 2007 and 2009. Both strategies clearly set out the vision and approach for addressing Dual Diagnosis service users. There is significant evidence that Mr F had a Dual Diagnosis although he denied using illicit substances. Whilst it may not have been appropriate to refer to the Dual Diagnosis Service, there is no documented rationale for not referring him.

5. Search Policy: this Policy was issued in April 2007. One of the reason's stated for the Policy is the "to attempt to find illicit substances (e.g. illicit drugs, prescribed drugs not taken and hoarded, alcohol)". Mr F was suspected of taking cannabis one evening, it is not documented that any discussion took place re using the Search Policy.

6. Close Observation Policy: whilst the External Panel were not able to view the Policy current in 2007 they were submitted evidence which indicated that many staff on the inpatient ward had signed the policy off. There are two incidents where Mr F is verbally aggressive to staff and another patient. A consideration of his observation levels following these incidents is not documented.

Assertive Outreach Service

1 The Policy for the Brent Assertive Outreach Team was compiled in June 2004. It sets out clear criteria for patients who meet this service. Mr F met that criteria and would have done so from 2004 when the service was first set up.

2. Within the Operational Policy for AOT there is clear guidance on the need to be assertive as follows. "Assertive means the service will be outward in its thrust and delivered *in vivo.* That is, in the individual's home or environment and other locations of their preference, such as cafes, parks etc. The service will be proactive and creative in enabling and encouraging service users to access and maintain appropriate support as needed from the Team. The service will rigorously follow up any break in contact with service users". There is no evidence that these principles were followed in the case of Mr F.

3. The AOT Operational Policy also states that they will "provide a service that is sensitive and responsive to service users cultural, religious and gender needs". Mr F's cultural and ethnic needs were not addressed.

4. The caseload numbers for each Care coordinator was set at 12 in order for the Care coordinator to have the capacity to carry out assessment, care planning, organising regular CPA meetings, keeping clients records (manual and electronic) up to date, liaising with carers and other agencies involved, report writing and also acting as the point of access to other services on the service user's behalf. The case load for Mr F's allocated AOT Care coordinator was between 20 - 25, although this is not confirmed by the Consultant Psychiatrist for the AOT who stated that caseload numbers were between 12 - 15.

5. The Policy states that "The team will work closely with carers and involve them in the planning and delivery of care to clients, ensuring that the wishes, expectations and needs of the clients are well balanced with those of the carers. The team will also provide care and support to Carers as part of its functions". There is no evidence that care and support was provided to Mr F's family.

National Guidance and Statutory requirements

The Government has produced a number of publications, which set out its vision for Mental Health Services across the country. Those key to the care of Mr F are as follows:

1. [7]Mental Health National Service Framework (MHNSF) published in 1999, and reviewed in 2004 (MHNSF 5 years on). This sets out national standards and defines service models for promoting mental health and treating mental illness.

[7] Mental Health National Service Framework - Department of Health (1999) and Mental Health National Service Framework 5 years on - Department of Health (2004)

2. [8]Care Programme Approach: The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care. Its four main elements are: (1) Systematic arrangements for assessing the health and social needs of people accepted into Specialist Mental Health Services; (2) The formation of a care plan which identifies the health and social care required from a variety of providers; (3) The appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care; (4) and regular review and, where necessary, agreed changes to the care plan.

3. [9]Mental Health Implementation Guidance for Adult Acute Inpatient care provision (2002). This supports the standards set out in the MH NSF guidance and is based on feedback from users and carers, expert professional opinion and recognised good practice.

4. There have been a number of Statutory policies developed to address the needs of carers. These are; Carers (Recognition and Services) Act 1995 - carers can ask for assessment; NSF MH 1999 - Standard 6; needs of carers should be assessed and a written plan compiled and reviewed yearly; Carers and Disabled Children Act 2000 - carers RIGHT to ask for assessment; Carers Equal Opportunities Act 2000 - DUTY to inform carers of their right to an assessment; and [10]Developing Services for Carers and families of people with mental health problems (2002). The aim of this document is to help local Mental Health Services develop support services for carers of people with mental health problems. It contains guidance on developing and sustaining mental health carer support services

5. [11]Policy Implementation Guidance on Developing Positive Practice and Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings (2004)

6. [12]Policy Implementation on Dual Diagnosis and Good Practice - In May 2002, the DH published a dual diagnosis good practice guide) aimed at all those who commission and provide mental health, drug and alcohol services. It was set up to address the integrated care needs of people who had a mental health problem and a substance misuse problem.

7. Mental Health National Service Framework (MHNSF) published in 1999, and reviewed in 2004 (MHNSF 5 years on) focuses on 7 key standards. Within this there are three care areas which impact on the care and treatment of Mr F and this family as follows:

- Special care: All Mental Health Service users on CPA should be able to access services 24 hours a day, 365 days a year; receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk; have a copy of a written care plan which:

    - *includes the action to be taken in a crisis by the service user, their carer and their Care coordinator;*
    - *advises their GP how they should respond if the service user needs additional help;*
    - *is regularly reviewed by their Care coordinator;*

[8] Effective Care Co-ordination of Mental Health Services - modernising the Care Programme Approach Department of Health (1999)
[9]Mental Health Implementation Guidance for Adult Acute Inpatient care provision (2002).
[10]Developing Services for Carers and Families of people with mental health problems(2002)
[11] Policy Implementation Guidance on Developing Positive Practise and Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings - Department of Health (2004)
Policy [12]Implementation Guidance on Dual Diagnosis and Good Practice – Department of Health (2002)

- Hospital and crisis accommodation: Each service user who is assessed as requiring a period of care away from their home should have timely access to an appropriate hospital bed or alternative bed or place, which is:

    - *in the least restrictive environment consistent with the need to protect them and the public;*
    - *as close to home as possible;*
    - *a copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the Care coordinator, and specifies the action to be taken in a crisis.*

8. Support for carers: All individuals who provide regular and substantial care for a person on CPA should:

    - *have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;*
    - *have their own written care plan, which is given to them and implemented in discussion with them.*

9. Care Programme Approach (CPA) sets out a framework for assessment, care planning, review, care co-ordination, and service user and carer involvement. CPA is categorised at two levels, (1) those service users who had standard needs and (2) those service users who had enhanced needs. Mr F met the enhanced level as follows:

10. People on enhanced CPA are likely to have some of the following characteristics:

    - *they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;*
    - *they are only willing to co-operate with one professional or agency but they have multiple care needs;*
    - *they may be in contact with a number of agencies (including the Criminal Justice System);*
    - *they are likely to require more frequent and intensive interventions, perhaps with medication management; they are more likely to have mental health problems co existing with other problems such as substance misuse;*
    - *they are more likely to be at risk of harming themselves or others;*
    - *they are more likely to disengage with services.*

11. Mental Health Implementation Guidance for Adult Acute Inpatient care provision defines the purpose and place of adult inpatient care. If has been devised to; establish effective means of service co-ordination of acute services to provide a safe, structured and therapeutic inpatient experience; develop effective service user centred decision-making processes and ward arrangements; address the need to enhance the role, status, training, support and career development of inpatient staff; direct clinical leadership and management attention and expertise on the organisation and management of inpatient services; ensure adequate clinical and support inputs to inpatient wards.

The key target areas are:

- *Referral and admission criteria.*
- *Community treatment and support options.*
- *Continuity of care arrangements.*
- *Managing bed and alternative service availability.*
- *Inpatient treatment and care options.*
- *Links and support to inpatient services.*
- *Managing risk.*
- *Creating and maintaining a safe environment for users, visitors and staff.*
- *Links to both child and adolescent and older peoples services.*
- *Communication standards.*
- *Out of hours on call system to provide support, advice and guidance.*
- *Dispute resolution.*

12. Each NHS Trust was required to establish an Acute Care Forum, with links across the acute care system (to include intensive care) and with involvement of service users and carers to agree and regularly review the operation and co-ordination of the range of acute care services. This was carried out within the Trust at both Corporate and local service level.

13. Each Trust was charged to ensure that acute inpatient wards had:

- *Effective care planning*
- *involvement of the service user and carer in care and treatment*
- *Service user centred assessment of needs and risks*
- *Joint assessments that focussed on inpatient and community care*
- *Clarity regarding the processes and communication of care planning*
- *Integrated care pathway documentation to enhance care delivery and communication across the range of acute care services*
- *Great emphasis on early assessment and initial care plans*
- *Attention to the interpersonal consequences of service user behaviour*
- *Effective joint working with other agencies*
- *Improved leadership that was consistent across all acute inpatient wards*
- *A dedicated lead Consultant Psychiatrist who could provide expert input into key matters of inpatient service delivery, staff support and supervision, and overall acute care service co-ordination*
- *Improved staff training, practice development and supervision*
- *Reduced bank and agency usage*

14. Developing Services for Carers and Families of people with mental health problems (2002) aimed to assist local Mental Health Services to develop support services for carers of people with mental health problems.

15. Key to this guidance in terms of Mr F was the opportunity to offer Mr F's parents a carers assessment, which is a nationally driven strategy set within key statutory documents.

16. Policy Implementation Guidance on Developing Positive Practise and Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings (2004) sets out the positive practice standards to support Mental Health Service providers and to enable them to review their current policies and procedures relating to education, training and practice in the safe and therapeutic management of aggression and violence. It sets out standards for:

- Positive practice in relation to recognition, prevention and de-escalation of risk via training; policies and procedures; excellent clinical risk assessment.

- The prevention and minimising of aggressive and violent behaviour by setting standards for effective risk management plans that are timely and responsive and in collaboration with the service user and carer; ensuring risk plans are regularly reviewed, with clear triggers for potential aggressive and violent behaviour; ensuring changes to levels of risks are recorded, communicated, and risk management plans changed accordingly.

- Ensuring systems in place to regularly review multi-disciplinary staffing levels and skill mix on inpatient wards.

- Ensuring that services work in collaboration with service users and where appropriate their carer(s) to develop individualised advanced directives so that future interventions, wherever possible, meet the specific needs and wishes of service users as part of their overall package of care.

- Clear and effective communication is an integral part of prevention and de-escalation of aggression and violence, but is of greater importance for people who have hearing or visual impairment, cognitive impairment or whose first language is not English.

17. The Good Practice Guidance for Dual Diagnosis, published by the Department of Health in 2002 was set up to address the integrated care needs of people who had a mental health problem and a substance misuse problem. Within the Guidance there is a section on acute inpatients which is relevant to the care of Mr F as follows:

- Illicit drug use is a widespread problem within acute inpatient units, including psychiatric intensive care units. The presence of significant numbers of individuals within these units with dual diagnoses presents a number of challenges to staff which need to be addressed.

- Staff should receive training in the area of Dual Diagnosis; evidence does indicate that this was available in 2007 however there is little clarity on the overall uptake. The potential resultant lack of knowledge, coupled with the pressure upon the staff to maintain a drug free inpatient environment, can lead to a lack of understanding and tolerance towards dual diagnosis patients. Individuals who have a dual diagnosis can be perceived as 'non-compliant', and responsible to some extent for their own ill health. This militates against effective therapeutic collaboration between staff and these individuals.

Conclusion to section 9.6:

Local Policies and Procedures:

1. Within the local inpatient setting there was no or partial compliance with regard to the care of Mr F. In particular this was in relation to robust; risk assessment and management; care planning; patient observation; the management of his substance misuse; the management of Mr F when he was absent without leave; the management and support to his family.

2. Within the AOT there was non compliance with the AOT Operational Policy in several areas, namely; employing an assertive approach to engagement; effective care planning and risk assessment; liaison with carers and the inpatient ward; possibly caseload numbers; addressing Mr F's cultural needs. This is detailed as a service and care delivery problem in section 9.9 tables 12 and 13.

National Guidance and Statutory requirements:

1. The Trust had local policies in place to address national requirements, particularly in relation to the Mental Health Act statutory requirements; care planning and risk assessment; Assertive Outreach requirements.

2. The Trust had set up the Acute Care Forum (ACF) as set out in the Acute Care Policy Implementation Guidance. This continues to drive inpatient improvements.

3. The Corporate ACF is attended by both the Trust Chair and the Trust Chief Executive and this has been the case since 2007. There is current evidence of effective clinical care and risk training; carer involvement; Dual Diagnosis Service involvement; increased communication across services; cultural needs awareness; staff supervision and support; excellent initiatives to recruit and select appropriate staff – see table 9 – notable practice.

Table 9 - Section 9.6 – Notable Practice

Notable Practice
Improving the quality of the nursing workforce All nurses who are recruited have attended an assessment centre to ensure they meet specific quality standards. This has improved the calibre of nursing workforce.

9.7 Was the care and treatment suitable in view of the service user's history and assessed health and social care needs.

1. Whilst Mr F did receive care and treatment from the Brent Mental Health Services it is evidenced that his admission was normally under a section of the Mental Health Act and as a result of a violent act. The chronology (appendix 3) details his forensic history and involvement of the Mental Health Services which was often linked. Whilst it is clear that the Consultant Psychiatrist had full knowledge of his history, it is not clear that other clinical staff had the same knowledge.

2. As an inpatient Mr F received and was compliant with medication. The prescription of antipsychotic medication (initially Haloperidol and subsequently Risperidone), supplemented by use of Benzodiazepines was appropriate, Mr F responded favourably to treatment

3. As an inpatient it is documented several times in Mr F's clinical records that he was quiet and listening to his music. There is little evidence of ward activities being on offer or of Mr F refusing to take part in ward activities.

4. Mr F's care and treatment on the inpatient ward appears to have focussed on managing acute mental illness, inferred largely from altered behaviour, and positive symptoms that were difficult to identify. Concordance and non engagement would more actively been addressed in the community, by use of an 'assertive' approach, as addressed in section 9.9.

5. As stated throughout the report Mr F's care and treatment were not fully addressed in relation to risk management; medication management; non-compliance with drug testing; carers assessment and the involvement of families.

6. Mr F's illicit drug use was not monitored – two earlier forensic psychiatric reports had highlighted that Urinary Drug Screening (UDS) was an important part of Mr F's care plan because drug misuse might be the cause of his violent outburst.

7. On the admission/discharge checklist and audit tool there is a standard for carrying out UDS screening. Against this it is written that Mr F refused but there is no documented plan to follow this up as part of his care plan. There is evidence that this has now been addressed within the Trust and that all patients are aware that they will be screened using the UDS approach.

8. The services were not sensitive to issues of Mr F's race and culture. There are four aspects to this.

    - *Factors associated with Mr F's care and his racial and cultural identity which were not addressed*
    - *Assaults by Mr F on people from particular ethnic backgrounds which were not addressed*
    - *The cultural background of Mr F's family and the background to their living in the UK*
    - *The fact that the internal inquiry did not address these issues in any way as set out in section 9.2*

9. There is no evidence from the documentation or interviews with staff that Mr F's racial and cultural background was addressed in any significant way by those providing care to him. Throughout the files he is variously described as "Portuguese", "Mexican" and "Chilean". The family's perception was that Mr F was in a "minority ethnic minority". Small minority groups should have no less consideration than larger minority groups.

10. On at least one occasion Mr F asked to be put in touch with Chilean groups; there is no evidence that this was followed up.

11. There are numerous references to assaults by Mr F on people from specific ethnic minority backgrounds which are recorded in files but seemingly, no action was taken to address this issue from a clinical and risk management perspective.

12. Mr F's care and treatment in the community is evidenced as sparse, in part due to Mr F's non-compliance and in part due to the minimal intervention of AOT. This is covered in detail in section(s) 9.5 and 9.9.

13. There is little evidence that his social care needs were considered. It is not clear how he spent his time, particularly, when in the community. This may have been due to his lack of engagement but this is not clear from the evidence. He was unemployed and receiving benefits. As part of the AOT service his social care needs should have been assessed.

Conclusion:

The conclusion to section 9.7 is as follows. This is also set out as care delivery problems in tables 10 and 11.

1. The care Mr F received was suitable in that the acute episodes of illness were clinically managed. However his clinical management appears to have addressed his immediate clinical needs. There is evidence that the planned longer term needs would be addressed via AOT.

2. There is significant evidence to indicate Mr F's poor level of compliance but not very much evidence to show how this was being addressed as part of his plan of care, when he was an inpatient and/or discharged to the Community Mental Health Services, in particular via the AOT. (This is set out as a care delivery problem in table 13 under section 9.9).

3. There is little evidence to indicate that Mr F's illicit drug use was assessed and the clinical judgement outcome decision documented.

4. There is no evidence that his social care needs in relation particularly to engagement of activities in the community, had been assessed and this was not part of his care plan.

5. The wider issues in relation to Mr F's his cultural ethnic background were not addressed. Evidence gathered as a result of the external investigation report would indicate that currently the Trust puts a lot of emphasis on dealing with diversity issues at both a strategic and individual CPA level and the panel were impressed with a lot of the work being undertaken in this area. However, in the case of Mr F this was not evident.

Table 10 - Section 9.7 – Clinical Delivery Problem

Clinical Delivery Problem
Care plan did not focus on all the needs of Mr F The care and risk management plan only focussed on clinical interventions which managed Mr F's positive symptoms and acute needs. There were no needs identified and documented in relation to his illicit drug use; non compliance; social inclusion

Table 11 - Section 9.7 – Clinical Delivery Problem

Clinical Delivery Problem
The ethnic background and cultural needs were not addressed The service did not address Mr F's cultural and ethnic needs. This was not documented as part of his care plan.

9.8 The exercise of professional judgement and clinical decision making

Professional judgement and clinical decision making are key factors in delivering health care, and thus is a key factor in the delivery of Mr F's care throughout. There are several fundamental key care areas which have emerged as themes throughout the external investigation. All of which did require a professional judgement and a clinical decision, as follows:

1. The lack of pursuance of urine for drug screening: This was not followed up even though it is part of the admission pathway; Mr F used illicit drugs and it was questioned as to whether this led to his behaviour; his potential use of cannabis on the ward.

2. The lack of communication: This is a theme across several areas as set out; clarity with regard to the link between Mr F's depot medication and section 17 leave; consultation with the family to ascertain how Mr F presented on leave and/or after his leave; unclear agreement as to his section 17 leave status when he did not return on the 04/01/08; no communication between the Care coordinator and the family when Mr F did not attend his appointment whilst on leave; poor communication between the Care coordinator and the ward team.

3. Medication Administration: There are two issues with respect to the suggestion that Mr F should be established on long acting Risperidone Injections, and that establishment on such be linked to use of long term section 17 leave.

4. This plan was appropriate given Mr F's previous history of poor compliance and the clinical judgement involved sound. It was not followed through, a matter that appears to be determined largely by issues around communication and dealt with elsewhere.

5. On 04/01/08 the Consultant Psychiatrist learned that Mr F had not been commenced on long acting Risperidone Consta injections, and wrote Mr F up for Risperidone Consta 37.5mg fortnightly. It was correctly written in the "Prescriptions for Long Acting Injections" section of the prescription card, and the only error was to write 'O' (oral) in the route box rather than IM (intramuscular).

6. Mr F was not on the ward on 04/01/08 and returned to the ward on Saturday, 05/01/08 when, according to the medication card, received his oral Risperidone medication, 4mg nocte, at 18.30hrs on the ward, and returned for the same on 06/01/08 at 19.15hrs.

7. The prescribing error of 04/01/08 (listing the route as oral rather than intra-muscular), did not in fact lead to any lack of treatment with Risperidone. Mr F was not on the ward on 04/01/08, and had his treatment on the following 2 days before his father was found. Risperidone injections are not clinically more effective than Risperidone tablets.

8. Immediate care focus of care plan and risk management plan: Mr F's care plan did respond to his immediate needs but did not address his wider and longer term issues in relation to compliance, illicit drug use, social inclusion, cultural needs.

9. Clinical supervision: Whilst is was confirmed by the Ward Manager and the Care coordinator that clinical supervision did take place for ward based staff and within the AOT service it is unclear how this impacted on the monitoring of high risk patients; robust contingency planning; clear risk plans; clear communication to all parties involved; clear care planning.

10. The practice of the Specialist Registrar taking the AOT ward round was previously considered by the Internal Investigation Team, and a second report commissioned by CNWL. The External Review has also considered this matter and discussed it with the Consultant involved. We share the views expressed by the CNWL commissioned report which found the Consultant's explanation of the arrangement persuasive, and to be based on identified development needs for the Specialist Registrar and supported by supervision.

Conclusion:

The conclusion to 9.8 is as follows:

1. In terms of Mr F's care planning, professional judgement and clinical decision making did appear to respond to immediate and short term aims. Longer term aims were set out via the AOT but as previously stated this was not assertively managed and there were no clear plans to address the wider issues in relation to Mr F's care.

2. A external review in 2009 commissioned by the Trust Medical Director to establish whether or not the medical care of Mr F fell below the acceptable standards found that no conclusions could be drawn that any of the medical doctors had acted, or failed to act in a manner that indicated clinical medical negligence. The External Panel concur with this.

3. There is no clear evidence that professional judgement and clear clinical decision making was used with regard to Mr F's illicit drug use; consultation and communication with the family in relation to his care needs; response to Mr F not returning from leave; medication prescription error.

4. There is no clear evidence that professional consultation with the family to ascertain how Mr F presented on leave and/or after his leave; unclear agreement as to his section 17 leave status when he did not return on the 04/01/08; no communication from the Care coordinator to the family when Mr F did not attend his appointment whilst on leave; poor communication between the Care coordinator and the ward team throughout; no clear evidence of the rationale for not referring Mr F to the Dual Diagnosis Service.

9.9 What was the appropriateness and quality of risk assessments; care planning and interventions of the Assertive Outreach Service.

This section will consider the role of the Brent Assertive Outreach Team and the quality of care it provided to Mr F.

Assertive Outreach.

1. As stated in section 9.6 Assertive Outreach Services were established following the publication of the Mental Health Policy Implementation Guidance (PIG) in March 2001.

2. The PIG supported the implementation of the Mental Health National Service Framework (MHNSF) published in September 1999.

3. Though the PIG was badged as "Guidance" there were clear expectations from the Department of Health that the teams would be established in compliance ("fidelity to the model") with the service specification described in the PIG.

4. In addition the PIG laid out, in some detail, the key components of AOT and described how AOT should emphasise maintaining contact with service users and building relationships with care co-ordination being provided by the team. The PIG also stated that staff in AOTs should have a small caseload - no more than 12 service users per member of staff.

5. The PIG also describes how the AOT should engage with service users with a history of violence and/or dual diagnosis as stated in 9.6.

6. The Panel has had sight of the Brent Operational Policy dated June 2004. This describes in detail the working of Brent AOT and is clearly in line with the PIG.

7. Mr F quite clearly met the criteria in the PIG and the Operational Policy for assertive outreach. As stated in 9.6 the Operational Policy states "Assertive" which means that the service will be outward in its thrust and delivered in vivo.

Appropriateness and Quality of Care provided to Mr F by Brent AOT.

This section reviews the appropriateness and quality of care provided to Mr F by Brent AOT as would have been expected at the time of their engagement with him.

1. On 22/09/06 Mr F was admitted to Pond Ward following an assault on a woman; he was admitted under section 3 of the Mental Health Act. At the time of the assessment it was noted his family were concerned because of his aggressive behaviour towards them.

2. Over the next weeks Mr F had several periods of leave during which police arrested him on two occasions (once for sexual assault and once for failure to appear in court).

3. At the ward round on 14/10/06 it was agreed that Mr F should be referred to the AOT with a plan to discharge him on 30/10/06; in effect two weeks' notice of discharge. By 13/11/06 the AOT had still not accepted the referral – two weeks after his formal discharge from section. Mr F was allocated to the AOT on 14/12/06 – six weeks after his discharge.

4. To be compliant with the AOT Operational Policy it would be expected that Mr F would be the subject of co-ordinated care planning, rigorous risk assessment and assertive engagement.

5. In the file covering the period August 2006 to December 2006 it is not evidenced in the clinical notes that there were care process notes, records of CPA meetings or risk assessments undertaken by the AOT. There are two reports in this file both of extremely high quality; a Forensic Psychiatric report dated 09/10/06 and a Court Psychiatric report dated 05/10/07. It is not evident what action was taken with this useful information contained in these reports.

6. In the file covering the subsequent period until January 2008 there is nothing of substance [apart from ward notes] in the file until November 2007. There is a risk plan which is only partially completed and a multi-disciplinary care plan which is, in effect an inpatient plan. The care process notes consist of ward notes only. It is possible that the AOT kept separate clinical records, if so these were not made available to the External Panel.

7. The ward notes for 02/01/07 show Mr F ringing the ward requesting his depot injection. It was agreed to phone him on 05/01/07 to arrange a time to meet. No immediate response was made to Mr F despite his history of non-engagement. On 05/01/07 several telephone calls were made to Mr F with no response. There is no evidence in the notes that any attempts were made to visit him despite the role and function of the AOT.

8. On 08/01/07 Mr F rang several times saying he no longer wanted a depot. It is not clear from the notes what, if any, action was taken.

9. On 18/05/07 it was noted that the AOT had not had any contact with Mr F despite numerous calls to him. It was agreed that if he could not be contacted within two months he should be referred back to the CMHT. This is not compliant with Operational Policy or within the spirit of an assertive service.

10. This examination of the files covering the period of Mr F's referral to AOT and his subsequent care by the AOT suggest that there was poor quality risk assessment and care planning with regard to his non compliance, illicit drug use, social inclusion, communication with carers, his cultural needs, his high risk status and robust contingency planning .

The Internal Management Inquiry and the Brent Assertive Outreach Service.

1. It is not evident why Mr F received a minimal service from the AOT and what clinical discussions took place to agree this level of service.

2. As stated in section 9.6 the Care coordinator stated that an average case load was about 20 to 25. The Consultant Psychiatrist for AOT however disputes this saying that caseload sizes were between 12 – 15.

3. The internal management inquiry recommended that there be "a review of working practices within the team, its interface with other services, and its communication with service users". It is not clear from the report why the internal inquiry team felt that a review of the team was required.

4. The External Panel had concerns about the way this review was undertaken – in particular

   - *Different interpretations of what "review" meant in this specific context*
   - *No clear terms of reference*

- *A lack of robust governance arrangements*
- *A piecemeal approach to conducting the review*

5. There is no overarching project report and action plan arising from this review. However, the External Panel has had sight of numerous documents, grouped under the headings of the internal review findings. This has assured the Panel that significant management activity has been taken undertaken to address whatever concerns there were about the Brent AOT.

The current context and Brent AOT

1. The Panel has been given several conflicting accounts about the future of the Brent AOT. What is clear however is that the Trust's Commissioners have reduced the funding for the service which has had a significant impact on the AOT with caseloads doubling due to a reduced workforce.

2. The External Panel has been informed that the Trust is moving to "service line management arrangements" and that the AOT will be absorbed into these new arrangements.

3. The External Panel has been told that, in common with many Mental Health Trusts across the country, CNWL is conducting a Trust wide review of AOT to address whether there is a need to continue with a stand-alone AOT function. Some staff are not clear about the status of this review and what the implications of it will be.

4. Some staff have a different understanding from managers about the future of Brent AOT.

Conclusion:

The conclusion to this section also set out as a service delivery problem in table 12 and a care delivery problem in table 13 is as follows:

1. Mr F did meet the national criteria as set out in the Policy Implementation Guidance in that he was non compliant and high risk, however the service interventions of the AOT with regard to Mr F's management do not comply with that expected or set out within the Policy Implementation Guidance in terms of an "Assertive Approach".

2. The service was possibly not operating within the guidance with regard to caseload numbers. This potentially would have impacted detrimentally on time the Care coordinator could have had to work with and alongside Mr F.

3. The Care coordinator did not liaise with the carers when Mr F failed to keep his appointment during his section 17 leave, although he did discuss this within the AOT team meeting. It is not clear what the outcome of this discussion was.

4. The internal panel recommended a review of the AOT service in Brent. This review suffered from a lack of clarity about its purpose and was conducted in a piecemeal manner. Significant management action has, however, been taken in response to the unstated concerns the internal panel had about the functioning of Brent AOT.

5. The future of Brent AOT as a discrete service is uncertain, causing confusion for some staff. Some staff also have a different understanding from managers about the future role of the Brent AOT. Whilst it is for the Trust and it's Commissioners to determine whether the AOT function should continue the Panel has concerns that the needs of complex and high-risk patients should not be compromised by the apparent lack of clarity. Managers have assured the External Panel that this is not the case.

Table 12 - Section 9.9 – Service Delivery Problem

Service Delivery Problem
The AOT service did not meet the AOT Policy Implementation Guidance The service was not proactive and creative in enabling and encouraging service users to access and maintain appropriate support as needed from the Team.

Table 13- Section 9.9 – Care Delivery Problem

Care Delivery Problem
Care planning to reflect Mr F's needs. Mr F did not have a care plan which reflected his needs in terms of his non compliance, illicit drug use, the need for social inclusion, the need for staff to work with his carers, his cultural needs, his high risk status and robust contingency planning.

9.10 How effective was interagency working, particularly in relation to the sharing of information between Substance Misuse Services and Mental Health Services.

Interagency working does not have a high profile within the care of Mr F as follows:

1. Mr F had a dual diagnosis and no rationale has been documented with regard to the lack of referral to this service.

2. During the interview process it was explained by more than one interviewee that there was one dual diagnosis worker covering the Brent Mental Health Services. Whilst the work of the dual diagnosis worker has been described as excellent it is also recognised that the role is very stretched, given the high number of patients who present with substance misuse and mental health problems.

3. The Substance Misuse Service was not part of the Brent Adult Mental Health Directorate. Within the care of Mr F the Substance Misuse Service would not have been the first line of treatment for Mr F as he had both a substance misuse and mental health problem. The primary service for his treatment would have remained within the Adult Mental Health Services with input from the Dual Diagnosis Service.

4. The AOT care team employed both Health and Social Care workers. Should Mr F have need of social care input there would have been the knowledge within the team to expedite this.

5. As part of the external review process the panel did interview Mr F's General Practitioner. (GP) who stated that he had never been involved in the care of Mr F and that he had never been invited to a CPA, however there is evidence that the Practice was kept informed by the Consultant Psychiatrist, and that invites to CPAs were made.

Conclusion:

1. There is no evidence that the Dual Diagnosis Service was considered. It is possible that given his level of denial and non compliance it was felt not to be therapeutically appropriate to refer Mr F, however there is no evidence that this decision was documented.

2. These was no requirement for Brent Adult Mental Health Services to liaise with the Substance Misuse service with regard to Mr F. At interview members of the Substance Misuse Service described communication as much improved since the Trust implemented an electronic care record system JADE.

3. There is evidence that the GP was communicated with throughout, mainly by the Consultant Psychiatrist and that he was invited to attend CPA meetings.

4. There is no evidence of liaison with social care in respect of Mr F's assessed needs.

9.11 What was the level of support to staff, service users and the families of the victim and service users following the incident.

The level of support to staff, Mr F and his family is set out as follows:

Family:

1 At the time of the incident Mr F's mother was in Chile. However on the 11/01/08 the Consultant Psychiatrist spoke with Mr F's sister's partner to advise him of the internal investigation procedure. The Consultant Psychiatrist offered to see the family, left contact details for them and offered condolences.

2 On the 08/02/08 the Consultant Psychiatrist met with Mr F's mother, sister and 2 family friends. A number of points were discussed at this meeting and as part of the meeting the Consultant reiterated the internal and external investigation process.

3 During the external review process it was confirmed that a Service Manager did visit the family at home but the family wanted no further contact at that stage.

4 As stated in 9.3, the family requested a meeting with the Trust Chief Executive. The meeting was held in June 2008. Following this meeting the internal panel was reconvened to ensure that the family views could be considered and reflected in the report. This is set out in more detail in section 9.3.

Mr F:

1. Mr F was formally arrested on the 8th January 2008. Due to his mental health issues he required an Appropriate Adult to be with him during questioning from the Police. As he was detained in Barnet the appropriate Adult services in Brent could not attend as Barnet was outside of the borough. An Appropriate Adult was eventually sourced on the 09/01/08, however a staff member from the Trust acted as in this role for 4 hours on the 08/01/08.

Staff:

1. A staff de-brief was arranged on the 14/01/08 which was well attended. There were also opportunities to discuss issues on an individual basis within management and supervision structures.

2. Staff stated during the external review process that they felt very supported by their local managers but not well supported by the wider Trust.

Conclusion:

The conclusion to 9.11 is as follows:

1. The family were contacted soon after the arrest of Mr F but did not take up offers of further contact from the Trust at that time. When the Trust were contacted by the family they responded quickly and ensured that the family views were considered as part of the internal review.

2. Mr F did not initially have an Appropriate Adult due to cross boundary issues however he was supported by staff who acted in the Appropriate Adult role, until an Appropriate Adult was sourced. There is evidence that the boundary issue has been addressed by developing local protocols to ensure a more efficient approach in the future.

3. The staff felt that they were adequately supported post incident locally, but not from the wider Trust, they also felt that they could also seek individual support as they required it.

9.12 Are there any other matters of public interest which need to be considered?

1. The External Panel has been given several conflicting accounts about the future of the Brent AOT. What is clear however is that the Trust's Commissioners have reduced the funding for the service which has had a significant impact on the AOT with caseloads increasing. The Trust and Commissioners should consider the future of the AOT in relation to the AOT Policy Implementation Guidance referred to in section 9.6.

2. The Trust is reconfiguring its clinical services into different delivery structures and must ensure that services such as the Dual Diagnosis Service is not compromised as a result of this.

3. The National service Framework was a ten-year programme that was completed in 2009. Associated with this programme were a series of Policy Implementation Guidance documents (PIG). There is some confusion as to the current status of these documents. Many Commissioners and Trusts are reconfiguring their Mental Health Services to meet new demands in a harsher financial environment including for example, closing Assertive Outreach Services and moving their function back into mainstream Community Mental Health Teams. It is not clear from the current Policy context - "No Health Without Mental Health"; February 2011 – with its focus on well being and prevention, what is the optimum way of delivering care for people with an acute mental illness.

10. Contributory/Associated Factors

1. The National Patient Safety Agency (NPSA) determines "contributory factors as those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to patients and hence the likelihood of Care Delivery or Service Delivery problems occurring". Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. The removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or 'root causes' will be expected to prevent or significantly reduce the chances of reoccurrence".

2. The findings of the external investigation does determine that, whilst the Trust has improved in many key areas, which is addressed in section 12, there are several contributory factors which affected the delivery of safe and effective care to Mr F and his father. These factors are:

Patient:

1. Mr F was previously well known to local Mental Health Services in Brent, North West London, and had been in contact with services since 1998. Mr F's diagnosis is Schizophrenia, and his condition had previously run a chronic relapsing course, with repeated admissions to hospital generally on a compulsory basis. Mr F's condition was complicated by use of street drugs in the form of cannabis, and his engagement with community Mental Health Services and compliance with prescribed psychotropic medication in the community was problematic.

2. Mr F had a previous history of offending and of conviction, including assaults against family members and members of the public who were unknown to him. He had previously spent time in prison, and in the past had received mental health disposals (Section 37, MHA 1983) from the courts subsequent to conviction.

3. Mr F was Chilean and as such part of a small minority group in Brent. During the course of his time within the Mental Health Services his cultural needs were not addressed

Carer:

1. Mr F's parents were his main carers, they were however not involved in key decisions.

2. Mr F's parents were not offered a carers assessment which would possibly have addressed any risks they were at from him, their cultural needs, their communication with the Mental Health Service and their lack of involvement in key decision making.

Communication:

1. Mr F's family views were not sought when he was on section 17 leave. Their perception is that they were informed rather than asked about his leave on the 24th December. At that time his mother was in Chile and his sister away, this left Mr F's father to manage him.

2. The family's perception is that they were not consulted when Mr F went on leave on the 28/12/07 for seven days.

3. When Mr F did not attend his agreed appointment with the Care coordinator on the 31/12/07 the ward was informed, but the family were not contacted.

4. Communication between the community and ward staff was poor, particularly in relation to Mr F's section 17 leave status, the decisions made in the ward round which did not filter through to the ward staff (such as the mid week review that should have been carried out by staff during Mr F's seven day leave which commenced on the 28/12/07).

5. The was a disparity in the decision to commence Mr F on a depot injection and the longer term planning in relation section 17 leave. This plan does not appear to have been communicated to all members of the medical team, hence Mr F was granted extended section 17 leave before commencement of his depot injection. Mr F was provided with a 7 day supply of oral antipsychotic medication (Risperidone) when he commenced extended section 17 leave on the 28/12/07.

6. Communication between the AOT and the ward was poor. There was little communication at the commencement of Mr F's section 17 leave between the two services and whilst the Care coordinator did inform the ward that Mr F did not attend his appointment with him there is no evidence that this was communicated to the medical team.

7. There was no communication with the family by the Care coordinator when Mr F failed to keep his appointment or at any other time to assess how the leave was progressing.

Documentation:

1. Mr F's risk assessment did not highlight the family as being at risk although it has been acknowledged that they were.

2. Mr F's care plan does not address his lack of engagement and whilst he had a long history of non compliance it is unclear what attempts were made to try and engage him when he was in the community. Other key areas not addressed within the care plan is his illicit drug use and the rationale for not referring to the Dual Diagnosis Service, and his cultural needs.

3. Mr F's admission care pathway for his final admission in an inpatient unit in Brent was not fully completed and key stages such as updating the risks for a CPA and updating the risk management plan have not been signed as completed. It is unclear from the clinical records that his risks changed during his inpatient stay or that they were updated to include his leave in the community.

4. The section 17 leave form completed on the 21/12/07 is unclear. There is an unsigned line drawn between the dates covering the period 28/12/07 – 28/01/08. The next date covers the period 04/01/08 – 28/02/08 but states only 4 times per month.

5. The depot prescription was incorrectly completed on the 04/01/08, stating the route of medication as oral, not as intra-muscular, this was not immediately corrected by staff on the ward, though subsequently Mr F continued to take oral medication on the ward, up until the time of his arrest.

Resources

1. Whilst AOT was an appropriate service for Mr F the service criteria was not applied in the delivery of his care. There appears to have been little attempt to engage Mr F, no communication with the family; little effective care and risk planning, no assessment of his social care needs, no evidence of acknowledgement of his cultural needs.

2. There is a discrepancy in the accounts of caseload sizes. The national guidance is 12, however the Care coordinator stated that case loads were between 20-25 and the Consultant stated that they were between 12-15.

3. There was little evidence of effective liaison between the inpatient services and community services such as AOT and the Dual Diagnosis Service (the latter to consider a way forward taking the staff view about referral to the Dual Diagnosis Service).

4. There is little evidence that Consultant ward round reviews were regularly attended by the Care coordinators.

Leadership

1. Whilst it is recognised by the External Panel that Mr F provided a very demanding challenge given his history and behaviour, it is not demonstrated that this was addressed by a clear leadership in both the inpatient and AOT services.

2. Leadership issues include; poor communication, poor liaison, poor documentation, poor care and risk management, lack of carer involvement, poor compliance with operational and clinical policies.

3. When staff suspected that Mr F was using cannabis on the ward there is clear action taken to address this.

4. There was no clear action taken when Mr F defaulted on his leave conditions, both when he failed to meet with his Care coordinator and when he failed to return from leave on the designated day.

5. Whilst there is an entry in the care plan about Mr F joining in Occupational Therapy activities there is no evidence that he was encouraged to do so on a day by day basis.

6. There is some evidence that Mr F's observation levels were considered but this is not consistently documented, particularly after an aggressive incident.

7. Clinical supervision for ward based staff and within the AOT service did take place however it is unclear how this impacted on the monitoring of high risk patients; robust contingency planning; clear risk plans; clear communication to all parties involved.

8. It is unclear how clinical supervision and other management meetings were used to address staff compliance with policies and procedures.

10. Root Causes/Causal factors

1. The NPSA determines a root cause as "a fundamental contributory factor which if removed would either prevent or reduce the chances of a similar type of incident happening in the future". Whilst there are several contributory or associated factors, which have been identified in section 10, the findings from the external investigation has determined that there is no fundamental contributory or causal factor. Mr F's evident risk behaviour was unpredictable and impulsive, therefore it could not have been predicted that he would have killed his father. The incident was of a different order in comparison with previous documented incidents of aggression.

11. Lessons Learned

1. The internal report identifies and makes recommendations in relation to:

- Compliance with Mr F's non-compliance and engagement
- The documentation and communication of risk information
- Communication and liaison between AOT and the inpatient ward
- Communication of decisions made within the Consultant ward review
- Management of illicit drug use
- Review of AOT working practices, interface with other services, and communication with service users and carers
- Management of detained patients who are absent without leave
- Involvement of carers

2. The recommendations were developed into an action plan (see section 9.1) and the panel was able to evidence progress against each recommendation (see section 9.2 and appendix 5)

3. The External Investigation Panel notes the progress on the action plan and adds the following points for consideration within the action plan:

4. Identified training should take account of all key staff and not just one group – for example - risk training for Care coordinators should apply to all staff involved in risk management.

5. An audit and/or process should have been included in the action plan to ensure compliance with each recommendation. Currently there is no clear monitoring process to ensure that each action is taken forward and that learning has taken place.

6. Recommendation 2 states in part that all users should be linked to the Dual Diagnosis Service. This should remain a clinical judgement and as such may not be appropriate for all service users who use illicit drugs. The recommendation could have included documenting a rationale for not linking to the Dual Diagnosis Service.

7. Recommendation 4 relates only to one inpatient setting which limits learning. All acute services within Brent and the Trust could have been included. The External Panel have received evidence that a process is in place across Brent to ensure wider learning.

8. Recommendation 5 is not specific. It should have included key areas of learning such as carer assessments, carer involvement in key decisions, carer involvement in CPAs, improved communication and liaison with carers.

9. The External Panel add the following areas which were not addressed as part of the internal investigation:

Leadership:

- The overall clinical and team leadership within both the AOT and the inpatient setting was not demonstrated as robust and effective. There is no evidence that compliance with policies, documentation, risk management and clinical interventions were monitored and where appropriate, challenged within a supervision or caseload management framework. The Trust has provided evidence that all clinical leaders could now access a leadership training programme.

Ethnicity and Culture:

- Mr F's ethnic and cultural needs were not addressed at any point. Mr F was Chilean and as such was in a small minority group. The Trust has provided evidence to the External Panel in relation to their strategic approach to address culture and ethnicity.

10. The External Panel would also like the Trust to take into account the follow:

Governance:

- The internal review took eleven months to complete and concerns were expressed by interviewees about the staff priority with regard to this. Although the Trust has now set up a much more robust process led by a Non Executive Director, and the Trust should ensure that post reconfiguration the action plan continues to be monitored.

- The Trust should gain clarity on the national status of the series of Policy Implementation Guidance documents (PIG). There is some confusion as to the current status of these.

Reconfiguration of services:

- Concern has been expressed by staff about the future of both the AOT and Dual Diagnosis Services following the Trust reconfiguring its clinical services into service lines. The Trust should have clear governance processes in place to ensure that clinical care is not compromised as an outcome of reconfiguration.

JADE - Electronic Care Record System:

- During the interviews staff welcomed the installation of JADE as an electronic care records system and its seems to be efficient. However some staff said that it was difficult to enter more qualitative and detailed information onto the system.

12. Post investigation Risk assessment

1. In light of the findings from the external investigation, the post investigation risk assessment remains at 15. Whilst it is recognised that there are many lessons to be learnt from this incident, due to the unpredictability of Mr F's risk behaviour, the incident in all probability could not have been predicted.

13. Recommendations

Internal Action Plan

1. The recommendations and action plan to be reviewed to take account of the external investigation additional findings.

2. The Trust to ensure that the action plan continues to be monitored and its progress reported upwards via its governance reporting systems.

Leadership

3. Leadership training and within this mentoring should continue to develop to ensure that all senior clinical leaders have access to leadership development.

Ethnicity and Culture

4. The Trust to continue its strategic approach to address carer involvement, culture, ethnicity and diversity and ensure via audits, monitoring and service user and carer involvement that culture, ethnicity and diversity are addressed.

Governance

5. The Trust to ensure that learning from External Panel findings is shared across its clinical services.

6. The Trust to seek clarity on the national status of the series of Policy Implementation Guidance documents (PIG) in relation to the optimum way of delivering care for people with an acute mental illness.

Reconfiguration of services:

7. The Trust to ensure that clear governance processes are in place to ensure that clinical care is not compromised as an outcome of reconfiguration.

JADE – Electronic Care Record System

8. The Trust to address the concerns raised by staff in relation to entering qualitative and detailed information onto the system.

13. Acknowledgements :

The External Investigation Panel would like to express their thanks to;

1. The family for taking the time to meet with the panel in what must have been very difficult circumstances
2. RETHINK – for their support to the family and their responsive liaison between the family and Panel members
3. The staff at Central North West London Mental Health Foundation Trust for their responsiveness and openness to this external investigation process
4. Brent PCT Commissioners
5. The General Practitioner
6. The Police
7. Brent County Council
8. The Consultant Psychiatrist and Social Worker currently involved with Mr F
9. The Coroner

Appendix 1

Independent Mental Health Investigation into the
Care and Treatment provided to Mr F

Terms of Reference

Commissioner

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.

Terms of Reference

The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr F 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 investigation;
- Involving the family of Mr F 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 Mr F and a review of the relevant documents;
- The extent to which Mr F's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies;
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs;
- The exercise of professional judgment and clinical decision making;
- The appropriateness and quality of risk assessments and care planning and interventions by the Assertive Outreach Service;
- Consider the effectiveness of interagency working with particular reference to the sharing of information between the Substance Misuse Service and the Mental Health Services;
- The level of support to staff, service users and the families of the victims and service users following the incident;
- 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.

Approach

The investigation team will conduct its work in private and will take as its starting point the Trust Internal Investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

The investigation team will follow established good practice in the conduct of interviews ensuring that the interviewees are offered the opportunity to be accompanied and given the opportunity to comment on the factual accuracy of the transcript of evidence.
If the investigation team identify a serious cause for concern then this will immediately be notified to the Manager, Homicide Investigations, NHS London.

The investigation team

The investigation team will consist of appropriate qualified senior professionals:

Consultant Psychiatrist Mental

Health Nurse Panel Chair

Project Manager

Appendix 2

Tabular time line of Mr F from 21/9/06 onwards.

Notes; MHA documentation; Trust Policies; National Policies in relation to CPA and Risk, Acute Care Forum Policy tion

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
lmission to nd ward	Disengaged on 27/06/06 had been arrested for punching a woman. Admitted under section 3 of MHA. On admission he admitted that he had not been compliant with medication No observation level noted in notes Section 17 leave form completed so that Mr F could attend A & E. Key information re risk not included	Risk assessment yes, but section on history of dropping out of contact not highlighted Section on family/carers scantily completed			Key risk information not documented inpatient care plan not completed observation levels not documented poor use of MHA Documentation Section 17 monitoring form
ction 17 ave agreed	Escorted leave to go to Asda, no evidence of risk assessment carried out.				Key risk information not documented

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
r F verbally gressive	Mr F verbally aggressive to staff when he was refused escorted leave due to staffing difficulties. Staff decision not to escort him out of ward whilst he was verbally aggressive		No observation levels noted		Observation levels not recorded.
en by Dr – cision to ant 1 hour 2 escorted ave	Had unescorted leave – no risk assessment carried out. Section 17 leave monitoring form not completed No care plan carried out to update plan of care	None completed			Risk assessment not implemented Inpatient care plan not implemented MHA Documentation Section 17 monitoring form not applied
lice visit	Mr F visited by Police – warrant out for his arrest. Police wished to be notified when he was discharged	None completed			Observation levels following visit not recorded
patient care an mmenced	Standard to be completed within 72 hours of admission – this was completed 10 days after admission	Yes – review date not noted.	No signature from patient		Inpatient care plan completed outside of stated standard of 72 hours

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
ilised ction 17 ave	Had Section 17 leave – no monitoring form completed				MHA Documentation - SECTION 17 monitoring form not applied
ilised ction 17 ave	Had Section 17 leave – no monitoring form completed	None updated			Mental Health Act Documentation - Section 17 monitoring form not applied
nescorted ction 17 ave creased to 4 urs	No risk assessment carried out to update response to increased leave	None updated			Mental Health Act Documentation - Section 17 monitoring form not applied. Risk status not recorded
ilised ction 17 ave	Had Section 17 leave – no monitoring form completed	None updated			MHA Documentation Section 17 monitoring form not applied
ilised ction 17 ave	Had Section 17 leave – no monitoring form completed	None updated			MHA Section 17 monitoring form not applied
pressing llusional eation re ians	Believes black Asians and Chinese are following him around – "beats them up in the back of his mind"	None updated	Unescorted leave not revoked		Risk status not reviewed in light of disclosure

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
rbally gressive to other tient	Became angry as Patient mis-pronounced Mr F name, Staff acted to remind Mr F that such threats were unacceptable. Staff in charge informed.	None updated	On-going management following this not set out in clinical notes.		Management following incident not recorded. Observation level not considered
ard round	Section 17 leave increased to 8 hours from the 16th September if no further incidents Forensic assessment referral carried out	No risk assessment carried out to update response to leave			Mental Health Act Section 17 monitoring form not applied Risk status not recorded
ilised ction 17 ave	Had Section 17 leave – no monitoring form completed	None updated			MHA Documentation Section 17 monitoring form not applied
r F phone ll to ward	Call to ward from Mr F to say that in flat and couldn't move. Feels over sedated. Ward staff offered to call cab. Mr F "suddenly found energy to move"		Section 17 monitoring form not used no clarity when leave commenced.		MHA Documentation Section 17 monitoring form not applied

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
r F late back om leave by 5 hours	Described in notes as over utilising his leave		Not noted that effort made to contact Mr F as per AWOL Policy. His care plan does not state what should happen if Mr F defaults on leave specification . AWOL monitoring form not completed		AWOL Policy not followed. Care Plan not current - does not address leave
lice ephoned ard	Police requiring to be informed 2 days before Mr F discharge re warrant out for his arrest				
ilised S17 ave	Had Section 17 leave – no monitoring form completed	None updated			MHA Documentation Section 17 monitoring form not applied

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
aluation of s care plan	Focused on how he was stabilising and alerting staff when he felt agitated.	Yes care plan update			17 days since last review of care plan
lephone ll from lice	Mr F in custody, arrested for sexual assault but too drunk to be interviewed or charged. Will be interviewed in the morning		Police requested that the ward not report him as missing		
ntact with lice	Ward telephoned Police who said case was dropped as victim unwilling to pursue matter	Risk assessment not carried out			Risk status not reviewed in light of incident
r F returned ward pm	Mr F said to staff that he was arrested for not attending court and released on bail. No evidence that the potential sexual assault was discussed with him	Risk Assessment not completed Care plan & Section 17 leave not reviewed			No review of treatment plan, or risk status

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
viewed by	Mr F stated was picked up by Police, stopped and searched, they found he had failed to appear in Court, was put in cells but released the next day. Also said that he was not bothered by Chinese or Indians. Dr rang police who said not charged with anything but on bail pending investigations . To report back to the Police on the 22/11/06	No risk review carried out.	Dr to discuss leave with RMO. Will let staff know decision		No review of Risk
utcome of scussion th RMO	Leave to continue at 8 hours per day				No contingency plan in place for Mr F should he default on leave
	More settled on ward	No risk review carried out during this time			No review of risk

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
nt on leave	Section 17 extended to overnight or longer to his home address at staff discretion 2 times per week from 27/09/06 – 27/11/06, however not written in clinical notes by medical staff until the 29th. No risk assessment updated				Clarity of information in the clinical notes, also no review of clinical risk
lice contact	The ward contacted the Police as requested to inform them that Mr F on leave.		Good follow up on part of the ward		
turned to ard	Mr F returned briefly to ward but wanted to go on leave again. Plan was for him to go on leave and return on the 27/11/06	N			Date incorrectly noted or Section 17 leave not correctly applied.
rensic sessment	Attended for assessment, not noted in notes if an assessment made about home leave	N			No updated assessment carried out. Review not carried out on the 30th as planned

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
ntact with ard	Clinical notes at 19.45 state that Mr F remains on leave with no contact. Beneath this there is a note saying that he attended pm to have his depot injection	N			Communication/sharing of information
ntact with ard	Arrived on ward, stayed for a while, played pool. Not noted how Mr F is at home.	N			No assessment carried out
ntact with ard	Arrived on ward, states feeling ok. Regular contact with parents	N			No contact with parents from staff to see how things are. When he was admitted the parents expressed concern about his aggression towards them
tended ave	Home leave extended to 2 weeks at a time. Whilst leave form completed, not noted in clinical notes	N			Poor documentation in clinical notes

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
tended ard round	Plan to refer to AOT and plan discharge on the 30/10/06	N			Late referral to AOT given the history re poor engagement
tended for pot	When Mr F attended for depot – noted by staff to be angry with staff. Left ward after a while. No assessment carried out	N			No assessment to establish mood and potential risk to others
scharged om ward d from ction 3 of HA . CPA rried out	Re-commenced on depot anti-psychotic medication. CPA carried out but CPA documentation not found in notes	Y			No evidence that formal documentation applied.
ome visit om mmunity orker	No access, left message for Mr F to contact him	N			
ome visit om mmunity orker	No access, not noted in notes any action by Community worker	N			No contingency plan should Mr F disengage

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
ntact with r F	Community worker spoke to Mr F on phone, he agreed to attend review on the 13/11/06	N			
view	Mr F attended review, appeared stable, accepting oral medication. On the 30/10/06 he had agreed to have a depot injection AOT referral to be chased up	N	In less than 2 weeks he defaulted on his agreement to have depot injection		Risk status not reviewed in light of depot refusal AOT had still not accepted referral, two weeks after formal discharge
ome visit	Seen at home by community worker. States continues to have regular contact with parents. No evidence of follow up to the parents	N			No follow up to parents to review their concerns expressed on the 22/08/06
ome visit	Seen at home, no concerns. Mr F in court on the 08/12/06 for assault charge	N			

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
ocated to OT	Arranged home visit for week of the 18th	N			AOT not engaged until 6 weeks after Mr F discharge No assessment evident in clinical notes
one call om Mr F	Phone call requesting depot. Worker agreed to phone him on 05/01/07 to arrange to meet that day	N			No immediate response to request, even though history of non-engagement
veral one calls to r F	Calls to landline and mobile – no response	N			
one call om Mr F	Several calls from Mr F stating he had just had a spliff, no longer wanted his depot and only wanted telephone contact	N			Had missed opportunity to engage on 02/01/07
view	Declining depot, contact to be made with GP to see if Mr F collecting medication	N	Not known from notes if plan followed up as no information		

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
A review	Relapse indicators completed but contingency plan and crisis plan not completed Next review 3 months. Mr F did not attend CPA review not documented in the care process notes	Y	Family were not on invite list of people to attend		Family not invited Key areas of CPA plan not completed No signature and date on plan
ntact from ousing fice	Asking if his care has been transferred to AOT. They will close case as receiving support from AOT. No evidence in clinical notes of AOT support received.				AOT support not documented.

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
OT entry in tes	No success in contacting Mr F despite numerous calls from the team. AOT to try and contact over next 2 months then consider discharge back to CMHT	N			No risk status considered at any time
tter questing HA sessment	Consultant wrote to duty team requesting assessment. Stated risk status to others, states no engagement with AOT, states keeping in touch via father.		Date stamped received 06/07/07		Action from letter not noted
llow up ter to cial rvices Duty rvice	Consultant updating on situation, regular contact with Mr F parents, over last 3 days Mr F has become withdrawn, not answering calls etc;				Not evident from clinical notes what response given.

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
tter to GP dating re ncern			Hand written on bottom of letter, that Mr F now arrested for assault and on remand awaiting psychiatric reports		
leased om prison	Mr F released from prison, currently with parents, very unwell hearing voices. Consultant contacted who stated that he was released on Monday and although family concerned he had been assessed by a Dr who felt he was fine to go.				

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
HA sessment	Assessed by Social worker and Section 12 approved Dr. Found not to be sectionable				In the assessment parents discussed feeling scared of Mr F
dmission to nd Ward	Having sustained a laceration to the right forearm. He was noted to be inappropriate and aggressive: Detained under Section 3. In the morning he was admitted to Pond ward, Park Royal. He was not seen on the AOT ward round that day: he was described as "too disturbed". Commenced on oral medication.	Risk tool completed Multi disciplinary Care plan completed (for evaluation on the 12/11/07) Nursing assessment carried out			Admission/discharge checklist audit tool not fully completed Risk event history tool not fully completed Alcohol screening tool not completed
r F agitated	Agitated and restless, given medication with good effect	not on day to be reviewed			
ard round view	Again very agitated, observed laughing to himself. Medication reviewed.	not on day to be reviewed			

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
re plan view	Mr F mental state unstable and behaviour unpredictable	Y - care plan	Next evaluation 20/11/07		Review had been planned for the 12/11/07
esentation ward	Pacing and agitated – very little sleep	not on day to be reviewed			
O review	Noted that Mr F presents extreme risks to others	not on day to be reviewed			
ard round view	Noted in review that no evidence of psychotic illness but behaviour problems	not on day to be reviewed	Evidence note entries as Mr F refused to come to ward round		
sited by rents	Observed that parents spent some time with him and he seemed "chuffed" to see them	not on day to be reviewed	Not noted if staff spoke with parents re view of Mr F		Carer involvement not apparent
esentation ward	Mr F informed staff that people seemed to know what he was about to do	not on day to be reviewed			

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
esentation ward	Mr F very agitated – shouting at staff and being threatening to staff, uttering racist comments	not on day to be reviewed	PRN medication appropriately administered		
esentation ward	Mr F accepted medication and persuasion. He told staff that if they continued to give him PRN medication he would be back with 2 spanners and that this was not a threat but a warning	not on day to be reviewed	Not documented if Mr F was held to account for his threatening behaviour to staff		No evidence of threatening behaviour being managed. No evidence of an updated risk assessment
esentation ward	Mr F observed to be pacing on the ward – not settled				
re plan aluation	Cited Mr F behaviour as agitated and unpredictable	Y	next review 27/11/07		
O review	Acknowledged Mr F behaviour and agitation. Commenced him on Clonazepam	not on day to be reviewed	Next review ward round on the 23/11/07		

ent	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
view of rsing mission d care plan	Note from staff member stating that named nurse responsibilities had not been done. Within 3 days of admission. Plan to complete admission and care and risk plans	not on day to be reviewed	Not clear what documentation was followed up on		Incomplete nursing assessment (pathway) and care plan
ard round view	Mr F left review, refused to cooperate. Medication reviewed	not on day to be reviewed			
esentation ward	Mr F informed staff that he was worried his father would go to his flat and take his cables. He had lent the cables to his father 10 years ago and Mr F had just taken them back.	not on day to be reviewed			
esentation ward	Noted that father and Mr F spent time on the ward together and that Mr F was very calm	not on day to be reviewed			

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
k essment	Risk screening completed by Consultant Psychiatrist with ward staff today as per admission pathway	Y	On the risk tool it asks if Mr F has children. This is ticked no whereas he has a child, not in contact.		Incorrect information on risk tool, risk to Child assessment tool should have been completed
iew	Reviewed by SpR, noted that no significant change to mental state.				
sentation ward	Mr F agitated and verbally abusive to pt, telling pt to go back to where he came from. Staff asked to go to his room to calm down, he refused. Informed by staff that his behaviour would not be tolerated. Was offered PRN medication, eventually took this, not restrained	not on day to be reviewed			Observation levels not documented.

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
D review	Noted that no overt psychotic symptoms noted but Mr F trying to keep control	not on day to be reviewed			
T meeting	Visited on the ward by member of AOT. Mr F stated that he would only receive a depot injection from a female CPN	not on day to be reviewed			
rd review	Noted that Mr F abusive on ward, medication reviewed, no leave granted				
e plan iew	Review noted mental state unstable – continue with current care plan	Y			
rd sentation	Mr F awake all night, pacing the corridors, staff smelt cannabis by Mr F, he denied using this	not on day to be reviewed			
rd sentation	Mr F awake refused medication, pacing corridors. Said job does not allow sleep, said he was a CID officer	not on day to be reviewed	persuaded to discuss with Drs before stopping medication		

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
rd sentation	Mr F settled but prone to aggressive outbursts	not on day to be reviewed			
rd review	Medication change, states on ward review record – if no reaction to Risperidone consider depot with possible Section 17 leave	not on day to be reviewed	Clinical notes states depot to be commenced in view of non compliance. Prescription was written up for oral Risperidone		Treatment plan not clearly communicated.
rd sentation	During this period Mr F much drowsier, sleeping a lot	not on day to be reviewed			
rd sentation	Mr F refused his clonazepam at 22.00hrs stating that it made him drowsy. He stated that he had done his research and that medication was bad. He walked up and down the corridor during the night.	not on day to be reviewed			

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
D review	Noted that Mr F was in good mood, no psychosis or agitation. No evidence of thought behaviour however "he thinks he might repeat the behaviour problems he has displayed so far".	not on day to be reviewed			
rd sentation	Mr F stated he did not believe he had a mental illness. Concerned medication is wrong. "you know I have been in and out of this place since 1997". Mr F wanted to go on and on but staff appropriately ended conversation.	not on day to be reviewed	Conversation disjointed Important as Mr F non compliant with medication in the community		
rd sentation	Mr F very calm on ward, no episode of aggressive behaviour	not on day to be reviewed			
rd sentation	Mr F shouting at another patient. Staff intervened and he calmed down	not on day to be reviewed			

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
rd review	Ward review led today by Specialist Registrar. Planned unescorted leave for 15 minutes x 2 per day plus 4 hours with family on 16/12/07 for his birthday. Section 17 leave appropriate for outing with family	not on day to be reviewed	previous ward round note 07/12/07 stated as a long term plan consider depot with possible section 17 leave.		Admission/discharge check list and audit tool MHA section 3.4 not completed.
rd sentation	Mr F did not sleep all night, pacing the corridors. Calm when approached	not on day to be reviewed			
e plan iew	Stated in care plan that Mr F had not displayed any aggressive behaviour in the last few days and yet had been shouting at a patient the day before	Next review 30/12/07			
t with ily	Went out with father and sister to celebrate his birthday. He had been appropriate in mood	not on day to be reviewed	Family not asked how leave went		Involvement of carers

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
rd sentation	Mr F remained in bed all morning and refused to engage with staff	not on day to be reviewed			
D review	Noted that Mr F seemed stable.	not on day to be reviewed			
rd sentation	Mr F complied with his medication, interacted well with staff and fellow patients	not on day to be reviewed			
rd sentation	Mr F refused his medication – stated that he wanted to be awake for the ward round	not on day to be reviewed			
rd review	Oral medication changed – still not on depot however Section 17 leave increased to 10 hours daily. Not noted in clinical notes that family informed	not on day to be reviewed			No communication noted to family as main carers
rd sentation	Mr F has been appropriate to staff, using his leave also appropriately.	not on day to be reviewed			

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
tion 17 ve increased	Section 17 leave applied from 24-26th December. states Mr F to reside at father's address. Not noted if discussed with family.	not on day to be reviewed	At interview with family they stated informed but not asked.		Poor communication noted with family
rd sentation	Mr F returned from leave – he stated that it went well. Not noted if discussed with family.	not on day to be reviewed	At interview with family they stated leave difficult		No communication noted with family
rd sentation	Good interaction on ward except with one patient he feels is following him	not on day to be reviewed			
rd sentation	Mr F has been awake all night.	not on day to be reviewed			
rd review	Section 17 leave extended. Noted in ward review that leave went well. This does not appear to have been confirmed with family. Family also not informed of extended leave to family home	not on day to be reviewed	Section 17 leave 28/12/07 to 28/01/08 crossed out without signature. Not noted on Section 17 form that this leave granted		No communication noted with family Section 17 leave paperwork incorrectly completed

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
med nurse ocation	New named nurse allocated to Mr F.	N	Care plan due for review not carried out as on leave. Review date not changed.		Care planning process not followed through
eting with T worker	Ward round record notes that Mr F due to meet with AOT worker at Mr F flat today.	N	AOT worker not at ward round. Appointment actually made for the 31st December		Communication between inpatient and AOT services not clear
eting with T worker	Visited Mr F flat as arranged. Mr F not there. AOT worker contacted ward but did not follow up with family.	N	AOT worker assumed ward staff would follow up with family. There was no follow up		Lack of communication with family. Mr F defaulted on monitoring arrangements, this not noted in clinical records, he was not recalled.

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
contact	Mr F remained on leave – no contact made with Mr F or family.	N			Lack of communication with family.
contact	Mr F failed to return. Stated in notes if no show to circulate, Mr F did not return, Police not informed	N	No contact made to AOT. Noted that unable to contact NOK.		Lack of communication with AOT service. Police not informed.
rd review	Mr F not returned, Consultant reviewed medication. Medication chart incorrectly completed. Stated route as oral, not IM.		Consultant noted that Mr F to return to ward, if not circulate to Police.		Medical instruction/plan not acted upon. Medication document error.
F contact	Staff did not recall as instructed. Leave papers showed Mr F had been granted leave from 04/01/08 overnight for 4 times.		Not noted in clinical notes if this was discussed with medical staff		Poor communication between medical and nursing staff with regard to care plan

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
F not urned	Discussion with ward staff re contacting AOT to get feedback from them.	N			No joint working across AOT and inpatient ward
F returned	Mr F returned, having overslept yesterday. Not detained. Depot not given as error not rectified. Instead, one day of oral medication was given to the patient who returned (home?) He was told to come back next day for TTOs	N	No updated risk assessment carried out Depot medication not given. TTO's not available.		Care plan not followed Medication plan not followed
F returned	Mr F returned to the ward, TTOs not given? availability. Mr F stated not aware of depot. To return am. He appeared calm, playing guitar for patients.		Prescription chart - Risperidone 4mg nocte 05/06 January. Risperdal Consta (depot) not commenced		Care plan regarding medication not followed through.

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
F return	Mr F attended as requested. Several days of medication were dispensed. Patient told to return for Ward Round on 11th January for CPA and discharge.	N	Mr F stated to staff that all was going well		
ice visit	Police attended Pond Ward, asking questions about Mr F. The Police informed ward staff that Mr F was a suspect in the death of Mr F senior, and warned staff that he might still be armed with a gun.		Staff made a clear plan in the event that Mr F came to the ward		
ice nmunication	Police informed staff that Mr F had been arrested in connection with the death of Mr F senior.		Communication plan set up by staff involved.		

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
ice nmunication	Police contacting to find out if there was another address for Mr F				
ice nmunication	Police contacted to confirm that Mr F was a Section 3 patient and to gain more information on Mr F.		They also confirmed the murder was on or around 22.00hrs. Later pathologist evidence showed Mr F senior had been murdered by a blunt instrument causing massive head trauma. Time of death was difficult to establish with accuracy		As no time of death established with accuracy it is very possible that Mr F visited the ward following the murder of Mr F senior

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
propriate lt issue	Staff contacted EDT but was informed that Brent will not provide an appropriate Adult outside of the borough as comes under Barnet.				
dication uest	Current list of medication to be faxed to Police. Did not include PRN medication or Depot as had not been given.				No evidence that a discussion took place with medical staff re what medication to include.
te entry	Acting ward manager set out her involvement re events of the 8th January				Clinical notes still not secured by Trust

nt	High level relevant information	Care Plan/Risk assessment plan Y/N	Other information if relevant	Notable Practice	Care or Service Delivery Problem
O rospective ry	Noted: SHO spoke to Mr F on Sunday, asked about any problems when on leave. Saw him briefly on the 7th when Mr F collected TTOs. Mr F appeared calm				
date from ice	Mr F in custody, not yet charged				
date from propriate ult	Mr F did not admit to killing Mr F senior but did admit to being in the house with his dead body. Remanded to Wormwood Scrubs until the 18th April				
charge from tion 3	Consultant discharged Mr F from Section 3, and from Pond ward.				
A letter	Mr F's mother invited to a CPA				communication poor.

Appendix 3

Chronology up to Mr F's last admission on the 09/11/07

1998	
January	cautioned
	Shoplifting. 12 month Conditional Discharge.
February	Fine for theft
March	Fine for failure to surrender
April	Admitted under section 2, had hit father on the nose
August	Charged for Shoplifting, given a conditional discharge
November	Charged for common assault, had attacked a stranger in the street, – section 37 Hospital order applied

2001	
February	Section 49/49 transfer from prison to hospital. Had attacked a man on the bus, said the man was staring at him, discharged August
November	Arrested for abusing bus driver – Admitted under section 3, Treated with oral and depot anti psychotics – referred for anger management, discharged in February 2002

2003	
January	Admitted under section 2, Random assaults on people of Asian origin. Hostile and guarded. Hit inpatient who he said was staring at him. Discharged July 2003
November	Punched female in the face. Two weeks previous had been arrested for hitting a woman. Had presented himself to A & E wanting to get admitted. Team thought he was avoiding people he owed money too. Exposed his penis to his mother and asked her for sex. No sign of mental illness during his admission. Discharged in December.
December	Arrested for assault, remanded to HMP Wandsworth

2004	
June	Arrested for assault, placed on section 37. Punched Japanese woman on tube, threatened his girlfriend, threatened any nurse who gave him an injection. Discharged in January 2005

2005	
October	Police called to parent's house following Mr F's aggressive behaviour. Placed on section 3. Punched charge nurse 3 times in the face. No psychotic symptoms noted. Discharged in February 2006

2006	
June	Arrested for punching a woman, placed on bail but stopped attending police station. Police took no action.
July	Arrested for Assault and bailed.
August	Found to be aggressive and agitated admitted under section 3, expressing persecutory ideas. During admission:
September	Police notice for arrest – Mr F visited whilst in hospital; Referral for forensic assessment; : Arrested for sexual assault whilst on section 17 leave, case dropped – victim unwilling to pursue; Expressed delusional ideation in relation to Asian people. Section 17 leave not revoked.
October	Forensic assessment and report. Report commented that "full consideration to his mental state should be given at the time of his offending. If there is little relationship between his mental state and his offending behaviour and there is no evidence to suggest he has a mental illness that required admission and detention it was his opinion that hospital disposal should not be sought" 30th October: discharged, had been referred to the AOT on the 14th October.
November	Home visit from Community Worker. No access, message left for Mr F to contact. 7th November: community worker spoke to Mr F on the phone, he agreed to attend review on the 13th November. 13th November Mr F attended the review, appeared stable accepting oral medication but not a depot which on the 30th October he had agreed to have. 28th November seen at home by the community worker, stating that he still had regular contact with his parents.
December	Seen at home, no concerns noted. In Court on the 8th December for assault charge. Allocated to AOT (6 weeks post discharge)

2007	
January	Phone call from Mr F requesting depot, worker agreed to meet with him on the 5th, no access on that day Several phone calls from Mr F stating he just wanted a spliff, no longer wanted his depot and only wanted telephone contact. Review carried out, Mr F declining depot contact to be made with the GP to see if he was collecting his medication.
March	Nothing noted in clinical notes from January - On the 26th March CPA review carried out. Family were not on the invite list. Relapse indicators completed but contingency plan and crisis plan not completed as part of updated risk assessment.
May	No success in contacting Mr F despite numerous calls from the team. Noted that AOT to try and contact over the next 2 months and then if no contact discharge back to CMHT.
June	Consultant wrote to Duty team requesting an assessment, stated in the letter that he had been keeping in contact via Mr F's father. Action from letter not noted Consultant updated Duty team on situation with Mr F's parents. Mr F had become withdrawn, not answering calls etc; Consultant letter to GP updating on concerns – Hand written at the bottom of the letter was that Mr F had now been arrested for assault and was on remand awaiting psychiatric reports. Mr F spent 3 months in prison

Appendix 4

Documents reviewed by the External Panel

Documents relating to the recommendations of the internal inquiry

Knowledge

- Memo to Lead Clinicians highlighting points from RCA from Mr F's internal inquiry
- Clinical Governance Meeting 29/04/09 re implementation of recommendations of Mr F's internal inquiry
- AOT Meeting Minutes 21/04/09 re implementation of recommendations of Mr F's internal inquiry
- Email re Training re risk and CPA
- BMHS Training database template 2009
- BMHS L&D Priorities
- Pond Ward results of risk audit January 2010
- AOT Business Case

Communication

- Memo detailing staff dedicated as resource to AOT inpatients
- Memo providing details of AOT senior practitioner roles – AOT/Park Royal
- Shift handover guidelines
- Memo introducing single consultant with responsibility for AOT/RASP patients at Park Royal from 19/04/10
- Proposal for AOT Team re-organisation
- Supervision form
- Ward managers meeting 22/04/09 - discussion re drug amending screening process
- Memo to staff re new drug screening process 28/04/09
- Updated internal record sheet for drug testing of patients
- Copy of updated ward round record showing weekly drug testing

Brent Assertive Outreach Service

- AWOL Policy awareness
- Proposal for introducing dedicated inpatients and community AOT Consultants
- Implementation of one consultant for AOT Community and one consultant for AOT inpatient
- Updated patient handover checklist
- Updated ward round patient checklist
- Review of practice in ward rounds
- Brent User Group Review
- Notes of meetings with AOT senior practitioners
- Action plans for AOT senior practitioners
- CPA Audit and action plan

Review by Brent User Group (BUG)

- Review document
- BUG AOT feedback
- Minutes of 02/06/09 meeting
- Survey of AOT and service users
- Cultural competence training course outline
- Recovery Approach course outline
- Overview of training available and taken within BMHS
- ToR for Care Quality Group (formerly Clinical Governance Group) 21/06/09
- Use of practical assistance when providing care
- Details of how to access services
- BMHS high level process map
- ToR for Brent interface meeting
- SDS Training attendance
- SDS course outline
- Direct Payments course outline
- CPA Policy document 04/2009
- Overview of work undertaken to improve AWOL Policy awareness
- Memo to staff re AWOL questionnaire
- AWOL questionnaire

Involvement of Carers

- Plan to run Carers group at Park Royal and other measures to raise awareness of Carers issues
- Dates for meetings of Carers Forum
- Article for Art Therapy
- SDS 09/02/10
- Carers Forum 19/03/10
- Information sharing with Carers
- Drug and Alcohol Awareness for Carers
- Art Therapy for Carers
- Carers Forum Christmas Lunch
- Brent MH Service Information for Carers
- Carers break leaflet

Additional documentation requested by the Panel

- Acute Care Forum Minutes [various]
- AWOL Policy
  - Brent local Protocol on Leave arrangements
  - Search Policy
  - Section 117 aftercare
  - Supervised discharge
- Admission and Discharge Policy 07/2009
  - Ward round action plan
  - Handover check list
  - MDT meetings ToR

- Review of ward rounds
- Observation and Engagement Policy and completed competency forms
- Training data
- AOT – final report
- Overview Report
- Operational Policy 04/2007
- Clinical supervision Policy
- Reflective practice for nurses
- Supervision monitoring form
- Carers Strategy
- Child protection and Safeguarding
- Protection of Vulnerable Adults in Brent
- Quality minutes various
- Clinical Governance Committee meetings various
- Mandatory training proforma
- Clinical Risk – Screening Form
- Management Plan
- Event History
- Substance Misuse
- Self harm/suicide
- Self neglect/vulnerability
- Violence/sexual assault
- Harm to Children

- CNWL
- Introduction
- Map
- Organogram
- Executive structure
- Overview of services
- Demographics
- Safeguarding
- Professions
- Board of Director Minutes various

- CPA – care plan form

- CRT - Operational Policy
- Brent Operational Policy

- Cultural Competence- manager's training statement
- Dual Diagnosis strategy 2003 - 2006 & 2010 – 2015
- various steering group minutes
- Bromley Screening Tool

- Needs Assessment Adult Health and Care

- Nurses - (senior) Away-day 05/01/11

- (senior) Away-day 0 5/01/11
- Nursing Conference Workshop

- Mr F - internal management inquiry report
  - staff statements
  - interview notes
  - independent medical report 09/2009
  - Action Plan
- Relapse Prevention Training
- Training – Attendance
  - Calendar (Brent]
  - Induction
  - CPA Training Attendance
  - Recovery Training Programme

- Vulnerability Stress Model (Flyer)

- Ward Rounds - 21/02/10
  - Records

- External organisations:
  - staff interview reports – Broadmoor and GP
  - Police Statement
  - Pathologist Police Report

- Family
  - Original questions posed to the Trust
  - Interview with External Panel members

Internal Investigation action plan/recommendations - current status

	Evidence	NHSLA Level
rists, ient or er	- Memo to lead clinicians and consultant - DICES risk assessment training. - CPA training included as part of mandatory training as a medium priority (March 2011) - In 2010 83 staff from Brent attended a 1 day CPA course, as part of corporate training for all Care coordinators – commenced 08/2009 - Effective risk management contingency and crisis management training (March 2011), as part of corporate training for all Care coordinators – commenced 08/2009. - Confirmed in interviews that now 2 levels of Risk training 1 level external and 1 level internal training.	Level 2
f risk ould	- Spot audit carried out on Shore Ward and Courtyard CMHT in March 2011. Audit sets out 5 key standards , one of which covered risks assessment reflected in care planning. Shore ward scored 100% compliance. - Pine Ward audit covering risk results in Sept 09 and Jan 2011 show 100% compliance re risk screening tool completed. - Risk screening tool RA1 - Risk management Plan RA3 - ACF Trust minutes Sept 2009 discuss introducing completion of risk assessments as a KPI - AOT minutes 21/04/09 refers to all new clients to have a risk assessment	Level 2

es eam s	- Induction of Computerised Clinical notes system JADE allows for risk information to be shared across services and staff groups. This was confirmed during interviews with staff. This is Trust wide. - Hand over guidelines developed post incident which addresses current risks. - Handover patient check list developed. - Ward round action plan included section on risk. This was updated in June 2008.	Level 2
w Ward d e a at ient ome. then ents and	- Trust wide Induction of Computerised Clinical notes system JADE allows for risk information to be shared across services and staff groups. This has been welcomed by staff however staff feedback is that it is difficult to enter qualitative and detailed information onto the system. - Evidence of handover communication - Handover guidelines developed - Review of ward round paper, not dated but refers to commencement of a pilot in Feb 2011. - Memo June 2008 – Senior Practitioner Responsibilities - ACF minutes from 11/06/10 onwards refers to new nursing practices to be reviewed in detail using the Royal College Standards - Paper on Review of ward rounds covers communication - Ward round action plan included section on risk. This was updated in June 2008. - Have single Consultant for AOT –achieved	Level 2 Level 2

Drug ent drug	- Ward meeting minutes cover this - Bromley screening tool May 2007 - Risk Screening Tool RA2.1 – for Substance Misuse concerns - Trust Dual diagnosis Steering Group TOR and minutes - Dual Diagnosis Strategy 2010-2015 - Dual Diagnosis training – 85% staff from Park Royal reported to be trained in 2010. - 5 day Pan London DD course available in 2010 - Routine Drug test Record Sheet used in –inpatient setting - Drug & Alcohol away day for carers 2010	Level 1
king with with	- AWOL Policy awareness - Proposal for introducing dedicated inpatients and community AOT Consultants - Implementation of one consultant for AOT Community and one consultant for AOT inpatient - Updated patient handover checklist - Updated ward round patient checklist - Review of practice in ward rounds - Brent User Group Review - Notes of meetings with AOT senior practitioners - Action plans for AOT senior practitioners - CPA Audit and action plan	Level 2

out the o be ave	- MHA Audit form includes AWOL - May 2009 – memo sent to all staff with a set of questions relating to the AWOL Policy - AWOL questions relating to above - Section 18 & 21 AWOL Policy – last reviewed 2010	Level 1
arers ne mend to rth	- Users/carers addressed in Brent ACF minutes 06/2010, - Trust ACF addresses user/carers. - Re training, involvement and approach. - Carers assessments carried out, part of corporate training . - Carers support meeting notes February 2008 - Training course for carers – Brent 2010 - As above September 2010 – my life as a carer - Carers Forum Lunch 2010, Carers forum invite March 2010 - Art therapy 2010 - Brent information resource for Carers - Admission process information for carers – Brent 2010 - Drug & Alcohol away day for carers 2010 - Notes for professionals working with carers - Information on Brent Training (3 day residential course) - Carers strategy 2010-2013	Level 2