An independent investigation into the care and treatment of AP

A report for NHS London

January 2010

NHS London

Contents

1. Introduction

1.1 On 19 October 2003 AP stabbed and killed her former boyfriend KZ at her home in Palmers Green in north London. She escaped from the scene and on 20 October 2003 stabbed and killed her maternal great-grandmother, MG, and then lit fires in her great-grandmother's home. AP was 24 at the time of the homicides.

1.2 On 14 September 2004 at the Old Bailey, AP was found not guilty of murder and arson due to insanity. The judge made the order committing AP to a hospital specified by the Secretary of State. He also made an order under section 41 of the Mental Health Act 1983; a restriction order without limit of time.

1.3 AP was known, in the two years leading up to the homicides, to a number of NHS organisations and other statutory and voluntary agencies across London.

1.4 Haringey Teaching Primary Care Trust (the tPCT) commissioned an internal investigation. It was carried out by the director of public health, a medical adviser and a public health consultant. All were employees of the tPCT. The terms of reference were dated November 2005. The report was dated February 2007.

1.5 *HSG (94)27 guidance on the discharge of mentally disordered people and their continuing care in the community (Department of Health, May 1994) and the updated paragraphs 33-36 issued in June 2005* state that in serious cases there must be an immediate investigation using structured investigation processes such as root cause analysis (RCA).

1.6 This report provides an independent investigation of AP's care and treatment from June 2001 to October 2003. It starts with a chronological overview of events and then evaluates the primary and secondary mental health care and treatment AP received and the communication between organisations about her care and treatment.

1.7 The investigation was led by Malcolm Barnard. He is a senior Verita consultant and a former senior NHS manager and area director of social services. David Watts was the supporting investigator. He has a background in mental health nursing. Dr Tim Woodman, a GP and former PCT medical director, acted as an expert adviser to the investigation team. Dr Douglas Gee, consultant psychiatrist and medical director of a mental health NHS trust, advised on matters concerning care and treatment provided by secondary mental health services.

Acknowledgements

1.8 We are particularly grateful to the mother and sister of KZ for their contributions. They agreed to be interviewed and provided valuable background information, views and perspectives.

1.9 We are conscious that the deaths of KZ and MG have deeply affected the lives of their families and friends. We offer them our deepest sympathy.

1.10 We were grateful for the opportunity to meet and interview AP. We offered to meet with AP's mother but she did not feel able to accept. We understand and respect her decision.

2. Terms of reference

2.1 To:

- evaluate the mental health care and treatment given to AP
- evaluate the communication about AP between agencies
- review the Haringey tPCT internal investigation report and assess the progress made on the implementation of its recommendations.

2.2 This is a standalone investigation. However the investigation team will work closely with the two investigation teams conducting equivalent investigations into the care and treatment of two patients who were also known to Barnet, Enfield & Haringey Mental Health NHS Trust (PT and ID). The reason for this approach is that the three investigations are expected to identify common themes and issues. The three investigation teams will provide specific and joint recommendations which will be consistent and thorough. The recommendations will be made to the relevant agencies and NHS London to help ensure future best practice in the provision of mental health care.

2.3 The investigation team will:

- investigate and review the range of mental health care and treatment provided to AP by primary and secondary care agencies with a particular examination of the care and treatment provided in the two years leading up to the offences.

- examine the extent and adequacy of collaboration and communication between the health, social care and housing agencies that were involved with AP.

- assess the adequacy with which AP's risk was assessed and actions consequent upon the assessment(s).

- complete a chronology of the events to assist in the identification of any care and service delivery problems leading up to the offences.

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

- review the Haringey tPCT internal investigation and assess the adequacy of its findings and recommendations and the progress made in their implementation.

- provide a written report including recommendations specific to the care and treatment of AP to NHS London and the agencies that were involved in her health and social care.

- simultaneously work with the two investigation teams conducting equivalent investigations into the care and treatment of two patients who were also known to Barnet, Enfield & Haringey Mental Health NHS Trust (PT and ID). Where common themes and issues are identified joint recommendations will be made. The aim of the recommendations will be to assist agencies in learning lessons from these adverse incidents and to help provide safer services to patients, the public and staff.

Approach

2.4 The investigation team will conduct its work in private and will take as its starting point the Haringey tPCT internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team. The investigation team will also seek to engage with AP and her family and also the family of KZ. This will assist in ensuring that the investigation and review achieve a thorough understanding of the incident from the perspective of those directly affected.

2.5 The investigation team will follow established good practice in the conduct of interviews e.g. offering interviewees the opportunity to be accompanied and to comment on the factual accuracy of the transcript of their evidence.

2.6 A list of documents reviewed and people interviewed are included at appendix A and appendix B.

2.7 If the investigation team identify a serious cause for concern then this will immediately be notified to NHS London and any other relevant organisation.

The investigation team

2.8 The investigation team will consist of an appropriately knowledgeable team leader and a Verita investigation manager as well as expert advisers with nursing, medical or other relevant experience.

Timetable

2.9 The investigation team will complete its investigation within six months of starting work. The six months will start once the team is appointed in full, written consent has been received for the release of AP's records (or other arrangements made for the release of the records) and sufficient documents are available to the team for interviews to start. The team leader of the independent investigation and the investigation manager will discuss any delay to the timetable with NHS London. A monthly progress report will be provided to NHS London and to Haringey Teaching Primary Care Trust (tPCT).

3. Executive summary and recommendations

Executive summary

3.1 On 19 October 2003 AP stabbed and killed her former boyfriend KZ. She escaped from the scene and on 20 October 2003 stabbed and killed her maternal great-grandmother MG. In September 2004, AP was found not guilty of murder and arson due to insanity. The judge made an order committing AP to a hospital specified by the Secretary of State. He also made an order under section 41 of the Mental Health Act 1983; a restriction order without limit of time.

3.2 AP was known to a number of NHS organisations and other statutory and voluntary agencies across London in the two years leading up to the homicides.

The internal investigation

3.3 An opportunity for swift implementation of serious untoward incident (SUI) procedures was lost immediately after AP's arrest in October 2003. GP1 (AP's GP at that time) was informed of the homicides but Haringey tPCT was not.

3.4 Barnet, Enfield and Haringey Mental Health NHS Trust (BEMHT) was unaware of the homicides until eleven months after they happened. It became aware following media coverage at the end of AP's trial and correspondence from the Zito Trust and KZ's mother, CZ.

3.5 Haringey tPCT commissioned an internal investigation. Work started in November 2005. It took the tPCT eighteen months to produce a draft report. This was explained partly by the unacceptably long delay in obtaining the records and partly because the first investigation team leader left the tPCT. Such a delay demonstrates poor practice in handling serious untoward incidents (SUI), a lost opportunity for early identification and learning of lessons, poor customer care and a lack of courtesy to CZ.

3.6 The terms of reference were agreed in November 2005 and the report was completed and agreed in February 2007.

3.7 The delays in starting and completing the internal investigation were avoidable with better management and are unacceptable.

3.8 Membership of the internal investigation panel was appropriate since most of AP's contacts were with GPs. However, advice should have been sought by Haringey tPCT from an independent consultant psychiatrist about AP's contacts with secondary mental health services.

3.9 The terms of reference were narrow, restricting the internal investigation to AP's contacts in Haringey and the *"north central sector"*.

3.10 The internal investigation's methodology made use of some root cause analysis tools. There was no list of documentation so it is not possible to confirm that all relevant policy and procedural documentation was adequately reviewed. The chronology in the internal investigation report covered all the main events between August 2001 and October 2003 but not all contacts were included. Findings did not follow on from presentation of evidence so the report was hard to read. The findings section included a mix of discussion, analysis, findings and conclusions. Findings were however presented covering most of the key issues in AP's care and treatment. Key causal factors for the absence of follow-up in AP's care and treatment were identified. Recommendations were relevant to the findings and identified causal factors.

3.11 Regular and formal monitoring of progress of the internal review took place in Haringey tPCT's serious incident group (SIG) from 2005 and, from 2006, also in the joint mental clinical services improvement group (JSIG) with representatives of both the tPCT and BEHMHT. The monitoring did not help to speed up the process of the internal review and did not improve either the quantity or quality of communication with CZ. Monitoring by the SIG and JSIG was, however, proactive in ensuring that work towards improving services and practice took place while the internal review continued.

3.12 The initial action plan developed in 2006 to support the implementation of recommendations of the internal review was of poor quality. From December 2007 the quality of the action plan improved considerably. Action plans have been regularly reviewed and updated since. The action planning process is now well integrated into the joint service improvement arrangements.

Primary care

3.13 AP received timely and appropriate care while registered (from November 2001 to March 2002) with the Herne Hill practice. Her depression was diagnosed and managed in accordance with accepted good practice and the GPs communicated well with other agencies. It is not explicitly stated but the practice appears to have recognised that AP was at risk. The first real crisis in AP's mental health coincided with her leaving this practice.

3.14 AP was a vulnerable adult. She was exploited and harmed by people close to her. She was suffering from depression, a mental illness, when she registered with GP1 in March 2002.

3.15 It is not clear whether or not GP1 read AP's previous notes, or if he did read them, felt that they contained nothing to give cause for concern. In any event, there is no evidence in AP's notes of any formal review of her antidepressant medication or of any reassessment of her mental state while she was registered with GP1. GP1's management of AP's depressive illness fell short of acceptable practice as defined in paragraphs two and three of the General Medical Council's (then current) good medical practice guidance 2001.

3.16 On two occasions GP1 considered referring AP for further assessment of her depression but failed to do so. GP1 saw and initialled the discharge note from North Middlesex Hospital in March 2003 but otherwise appears to have had no involvement with AP between January and October 2003.

3.17 A locum GP, GP2, working at GP1's practice, was the GP most involved with AP during the period of her psychotic episodes. The Haringey tPCT investigation failed to identify the locum GP. The central role of the (then unidentified) locum GP in AP's care and treatment was noted by the tPCT decision-making group as early as December 2004. This independent investigation was quickly able to identify the locum GP from documentation in AP's medical records as GP2, a GP practising in the Newham PCT area. Newham PCT has confirmed that GP2 was not a source of concern to them at the time of the homicides.

3.18 AP consulted GP2 three times in the period January to February 2003. On each occasion, despite issuing medical certificates and repeat prescriptions for paroxetine he (like GP1) did not appear to have assessed her mental health. AP saw GP2 twice in April 2003. He was aware of her admission to hospital and of the prescription of olanzepine. He was aware that a psychotic illness was a possibility and identified the need to exclude this diagnosis. The only way to do so would have been to refer AP for a formal psychiatric assessment. He failed to do so. Furthermore, although he knew that she had been prescribed olanzepine, he did not continue this, but prescribed stelazine (an older antipsychotic drug) instead.

3.19 We do not know why GP2 did not refer AP for psychiatric assessment. However, a formal psychiatric assessment in early 2003 could have revealed AP's abusive background, her history of poorly controlled depression and at least two (probably three) episodes of psychotic behaviour. Such a history, with a full mental state examination, might have resulted in AP receiving continuing care from secondary mental health services following the care programme approach (CPA). This was a crucial missed opportunity. Furthermore, AP had now experienced four encounters (in July/August 2002 and April 2003), with two GPs, when she may have been expecting referral to secondary care.

Secondary mental health services

3.20 AP engaged with secondary mental health services on three occasions:

- Assessment by a duty worker and a psychiatrist from West Norwood CMHT (South London and the Maudsley NHS Trust) on 1 March 2002.

- Overnight stay in the accident and emergency (A&E) department at North Middlesex Hospital on 13/14 March 2003 during which she was seen by a mental health liaison nurse from BEHMHT.

- Admission on 20 March 2003 to Stonelea Hospital (North East London Mental Health Trust) from where she was discharged the following day.

3.21 The assessment by members of West Norwood CMHT, while based on a brief interview with AP, considered her history and recent reported behaviour together with her observed speech, mood thoughts, perception, cognitive functioning and insight. AP had said she did not wish to engage further with the CMHT. The focus of the assessment seemed to be on 'degree of mental disorder' and how she presented on the day. A reported incident concerning AP's threat to bathe a fellow resident at a women's refuge in bleach was alarming as an indicator to suggest high risk. AP's religious ideas should have been explored further.

3.22 Further intervention and assessment should have followed. An attempt should have been made to persuade AP that a follow-up appointment was needed. The suggestion of a hypomanic episode (for which the notes show limited evidence), together with serious risk, as indicated by the bleach incident, should have made further follow-up by the CMHT necessary. Advice was given by the CMHT to the GP about future management.

3.23 There was no reference in the letter from the CMHT to the GP about AP's imminent move into new accommodation or of her housing needs, although the team had been made aware that she would have to leave the women's refuge. At this point there was an opportunity for AP's GP and the CMHT to recognise that she was a

vulnerable adult - she was living in a Women's Aid refuge, her behaviour had been reported as bizarre and she was to be evicted from her accommodation at the refuge. However, AP had moved home and registered with her new GP in Haringey a week after her assessment by the CMHT.

3.24 AP's care and treatment at A&E in March 2003 were in line with policy, custom and practice at the time. The records do not elaborate on the form her "*inappropriate behaviour*" took and there is no evidence that an adequate history was taken or sought from AP or her mother. The assessment by the mental health liaison nurse was based on AP's current mental state and not on historical information. There is no evidence that the mental health liaison nurse spoke to AP's mother. The senior house officer (SHO) in A&E and the mental health liaison nurse agreed that AP had settled overnight following her injection with haloperidol. The risk assessment was cursory but in line with policy at the time. The outcome of the mental health liaison nurse's assessment was faxed to the GP who appeared to have initialled it on 23 March 2003. The allegation that AP had been wielding a knife could have prompted the answer 'yes' to questions in the A&E nursing and assessment form and that in turn could have led to referral for psychiatric assessment.

3.25 The admission to Stonelea Hospital was for about 24 hours. It is unlikely that this was enough time fully to assess AP's mental state or to be sure that symptoms were not being masked. AP's mother and grandmother were interviewed by a psychiatric SHO as it was not possible to obtain a clear history from AP.

3.26 Given AP's history of disturbance and high risk factors, attempts were made, but not recorded, by consultant psychiatrist 1 to persuade her to stay in hospital informally. The focus during AP's short admission was on the presentation on the day rather than the history over time.

3.27 AP's care, treatment and discharge at Stonelea Hospital met the Bolam standard (in other words, they were in line with established practice at that time) but learning points arise from scrutiny of this episode in AP's care (see chapter 7). Given the circumstances of AP's admission and the recent history of her overnight stay in A&E, more attempts could have been made by doctors and nurses at Stonelea Hospital

to get to know her. The urgent referral letter faxed from Stonelea Hospital to Chase Farm Hospital on AP's discharge did not mention the history of AP allegedly having tried to strangle her mother.

3.28 The response from Chase Farm Hospital to the referral from Stonelea Hospital was prompt. It appears that AP's failure to attend was because Chase Farm Hospital was difficult to get to from her home. However, after AP's failure to keep her appointment on 28 March 2003, despite the urgency of the referral, Chase Farm Hospital made no attempt to engage her other than to offer a non-urgent appointment on 22 May 2003. An urgent problem appears to have become non-urgent when AP failed to attend. If the secondary mental health services had known AP well and it was clear that she had the capacity to make choices about her treatment, this might have been acceptable. However the services did not 'know' AP at this point and they down-graded to non-urgent someone with potentially high risk behaviour on the basis of an 'unknown' pathology. The decision not to offer AP a third outpatient appointment after her failure to keep appointments on 28 March 2003 and 22 May 2003 appeared to be in line with normal practice at Chase Farm Hospital at the time. Communication with the GP in this respect was adequate although there was a delay of almost four weeks before a letter was sent to the GP.

3.29 AP's contacts with secondary mental health services arose from at least two acute psychotic episodes. The psychotic symptoms of 13 March 2003 (admission to A&E) and 20 March 2003 (admission to Stonelea Hospital) both subsided overnight and in both episodes assessments the next day found no evidence of psychosis.

3.30 It is likely that the psychotic episode that led to the homicides developed in 2002 and 2003. Neither her GP nor the nurses and psychiatrists who saw her in secondary mental health services (from three mental health NHS trusts in London) noted this serious psychopathology. However, given AP's presentation, the lack of disclosure of full history and the swiftness of her recovery from psychotic symptoms, the mental health professionals involved in her care and treatment in secondary mental health services could not reasonably have foreseen or prevented these tragedies.

Learning the lessons

3.31 Haringey tPCT's incident management policy is now comprehensive and robust. However, there is a need to ensure that every general practice has a robust system for reporting all untoward incidents and near misses.

3.32 The appointments by the tPCT of the clinical specialist and nurse consultant in primary health care and the general practitioners with a special interest (GPwSIs - mental health) provide important investment in the development and improvement of primary care mental health services. There is, however, a need to review and evaluate the range and effectiveness of models for developing primary care mental health services across London. Joint work between Haringey tPCT and BEHMHT shows early promise in improving care pathways. It needs continued support and encouragement.

3.33 There are now clear links via terms of reference and common membership of groups and committees between the tPCT's performance management and serious untoward incident processes. A systematic approach to the performance management of independent contractors is now in place in the tPCT and increased management resources have been put in place to develop the interface with individual practices.

3.34 Haringey tPCT took a considered view of what to do about GP1 in the light of the homicides and the report of the internal investigation. It took external advice before concluding that GP1 should be assessed and supported in improving aspects of his practice rather than subject to disciplinary action or referral to the General Medical Council. The approach the tPCT took was appropriate in light of the evidence available to them at the time and of the evidence we have considered.

Recommendations

R1 The wider NHS should consider whether, when a patient leaves a GP's list, that GP should be informed of the patient's new GP. This would provide the opportunity to communicate any concerns the former GP may have about the patient which may not be apparent from the records.

R2 When a locum GP is engaged by a practice, formal arrangements should be in place to facilitate two-way discussion between the locum and other GPs at the practice regarding complex cases or patients giving cause for concern. Practices should try to integrate long-term locums into the practice team. Haringey tPCT should include in its clinical audit programme an annual audit to ensure implementation of this recommendation.

R3 Mental health NHS trusts should ensure that their clinical risk management arrangements require taking a longitudinal clinical history of previous episodes of mental disorder and risk indicators including, if necessary, informant history. Trusts should include in their clinical audit programmes an annual audit to ensure implementation of this recommendation.

R4 Mental health NHS trusts should remind clinicians of the need to examine both the nature and the degree of mental disorder in considering the possible use of the Mental Health Act 1983 to detain a patient in hospital.

R5 Mental health NHS trusts should be particularly careful when they discharge patients with serious risk indicators whose assessments are incomplete. They should try to actively re-engage such patients when appropriate.

R6 Haringey tPCT should ensure that there is a robust system in general practice for reporting all serious untoward incident and near misses including those related to mental health. The tPCT should include this in its audit programme to monitor the implementation of this recommendation.

R7 NHS London should identify the range of models in place in PCTs across London to improve and develop and improve primary care mental health services, evaluate their effectiveness and encourage all PCTs to build on best practice and outcomes.

R8 Haringey tPCT and BEHMHT should encourage the development and implementation of the work programme within the framework of the interface agreement. Particular attention should be given to the development of clear and

jointly agreed standards and expectations. The tPCT and BEHMHT should jointly review progress six months from the publication of this report.

R9 Haringey tPCT should ensure the dissemination to all GPs of the interface agreement.

R10 Haringey tPCT should continue to work with GP1 to specify the role, responsibilities, objectives and key tasks of the primary mental health worker in his practice. This should ensure that maximum benefit is obtained from the investment to improve the service in the practice for people with mental health problems.

DETAILS OF THE INVESTIGATION

4. Chronology of events in AP's care and treatment

4.1 In June 2001 AP moved into a hostel run by Lambeth Women's Aid. She was described as anxious and depressed when she moved in. Her case worker at Lambeth Women's Aid recorded that AP had been "*the victim of violence from former partner AS*".

4.2 By November 2001 AP had registered with a GP in Herne Hill. A letter from her previous GP said that she had been prescribed anti-depressants and had presented with distress and panic.

4.3 On 15 November 2001 AP was referred by Lambeth Women's Aid to the London Borough of Kensington and Chelsea for housing. The referral letter describes AP as "*extremely depressed and anxious when she arrived at the hostel*".

4.4 AP's GP prescribed paroxetine, an antidepressant, on 22 November 2001 and on 30 November the GP sent a completed medical assessment questionnaire to Kensington and Chelsea housing department. A medical certificate for six weeks was provided by the GP on 24 December 2001 when a further prescription for paroxetine was recorded along with a note indicating "*patient's condition stable*".

4.5 On 25 February 2002 the records from Lambeth Women's Aid stated that AP believed that God was telling her to run a bath for another resident and her child and to fill it with Jeyes Fluid to enable them to be with AP in everlasting life. The next day Lambeth Women's Aid contacted West Norwood community mental health team (CMHT), part of South London and the Maudsley NHS Trust, asking for a mental health assessment. The GP records confirm telephone contact on that day with the practice from Lambeth Women's Aid and the CMHT.

4.6 A mental health assessment was carried out on 1 March 2002 by a duty worker and SpR1, a specialist registrar in psychiatry. The psychiatrist telephoned the GP practice after the assessment to suggest withdrawing the antidepressant as AP may

have been experiencing hypomanic episodes, which this drug could have exacerbated. The CMHT were to make no further routine appointments at that stage. This episode in AP's care and treatment is discussed further in chapter 7.

4.7 Also on 1 March 2002 AP moved out of Lambeth Women's Aid and was accompanied by a member of staff to Kensington and Chelsea housing department and then on to her new flat in Haringey.

4.8 On 8 March 2002 AP registered with GP1, her new GP. Many entries appear in the GP notes between then and 4 July 2003. It appears from the records that AP was last seen by a locum GP on 11 April 2003. The primary health care and treatment AP received is discussed further in chapter 6.

4.9 In March 2002 AP wrote two letters to her landlord and Kensington and Chelsea housing department complaining about the state of her flat. One of the letters provided a detailed description of an infestation of mice. An entry in the GP notes on 1 May 2002 noted a change of address to Green Lanes.

4.10 On 13 March 2003 AP was taken by ambulance to the accident and emergency (A&E) department at North Middlesex Hospital, accompanied by her mother. She was reported to have been acting inappropriately at her friend's house and to have been wielding a knife. AP's mother reported that she had been attending religious sect meetings. An A&E senior house officer (SHO) noted AP's inappropriate behaviour and speech with loose associations and delusions but no hallucinations. Haloperidol 5mg was administered at 2am on 14 March 2003 in A&E. The SHO saw AP again at 6am when she appeared settled with no sign of the previous night's problems but she was emotional about the stress of university and a personal relationship. A mental health liaison nurse saw AP at 8.15am on 14 March 2003 and found no sign of "*psychotic behaviours*". He found her rational and oriented, with no thought disorder. He advised:

> *"Discharge when medically fit/will inform GP/informed mother who will come to collect her".*

4.11 AP later reported having visited a private GP some time after her discharge from A&E. The private doctor had prescribed trifluoperazine (an anti-psychotic medicine) 1mg twice daily. It has not been possible to identify this doctor. AP's recollection was that he was a family doctor based in Holloway and that she saw him only once.

4.12 On 19 March 2003 AP went to stay with her grandmother in Waltham Forest. Her mother and grandmother were encouraging her to take her medication. An argument followed on 20 March 2003. AP told us that during the argument her grandmother and her mother had threatened to have her admitted to hospital. The police were called and AP was admitted to Stonelea Hospital under section 136 of the Mental Health Act 1983. A psychiatric SHO assessed AP on admission. A consultant psychiatrist assessed her next day. The consultant found AP settled and noted that she denied all psychotic symptoms. The consultant's view was that the original section 136 was invalid. She did not appear to be detainable and she was keen to leave. She had no thoughts of harm to either herself or to other people. She had agreed to take medication and to receive psychiatric follow-up. Olanzapine 5mg was prescribed and a two-week supply provided. AP was discharged from Stonelea Hospital and the consultant wrote a referral letter dated 21 March 2003 to the consultant psychiatrist at the assessment unit, Chase Farm Hospital, Enfield, asking for urgent outpatient follow-up.

4.13 An outpatient appointment was offered to AP at Chase Farm Hospital for 28 March 2003 but she did not attend. A letter about her non-attendance and the date of the next appointment was sent by Chase Farm Hospital to the referring consultant (consultant at Stonelea hospital). A further appointment was offered for 23 May 2003.

4.14 AP saw a locum GP at GP1's surgery on 4 April 2003. The records state:

> "A*dmitted to hospital for mental illness and heard voices in her head. Did take actions of paranoid in nature. Pt was admitted in mental hosp and given olanzapine. Pt not sure if she should take these drugs. Implications explained. Med3 for one/12.*"

4.15 On 9 April 2003 a counsellor at Central St Martins College of Art and Design wrote to the locum GP about support for AP with particular reference to housing needs.

4.16 AP saw the same locum GP again on 11 April 2003. The record of the consultation said:

> *"Pt involved in a prayer in the church. Feels she has been controlled by the church. Felt the place was a cult. Pt feels scared now lives on her own. Not eating or drinking. Feels people from Cabbala Centre are walking around her flat. Has not been to cult since. Need to exclude acute psychosis. PX Stelazine 5mg and Seroxat 20mg."*

4.17 AP visited the locum GP again on 16 April 2003 to collect a letter for the housing department. She did not attend a further appointment with her GP on 12 May 2003.

4.18 Background information was recorded on a Barnet, Enfield and Haringey Mental Health NHS Trust outpatient record form dated 22 May 2003. It was completed by a staff grade psychiatrist and provided information drawn from the referral letter from Stonelea Hospital. The final sentence states: "*Pt DNA - no further Opa*" (outpatient appointment). The staff grade psychiatrist wrote to AP's GP on 18 June 2003 to tell him of the referral from Stonelea Hospital following her admission there under section 136 of the Mental Health Act. The letter said AP had not kept her appointment at Chase Farm Hospital on 22 May 2003 and that there were no plans to offer her a routine follow-up appointment. It ended by saying that the GP should not hesitate to re-refer her to the team at Chase Farm Hospital if he thought it appropriate.

4.19 On 18 June 2003 the GP records say "*repeat script given today*". A further entry to the GP notes on 27 June 2003 states "*came late*" and on 4 July 2003 there is a note that AP did not attend an appointment.

4.20 There is no record of AP having seen a health or social care professional between 16 April 2003 and the tragic events of 19 and 20 October 2003.

5. Review of the internal investigation

5.1 This section reviews the Haringey tPCT internal investigation and assesses the adequacy of its findings and recommendations and progress in implementing them. It also looks at the timeliness of the internal review and investigation and communication with the victim's relatives.

5.2 The internal investigation report is dated February 2007. The investigation was conducted by a public health consultant and a medical adviser to Haringey tPCT. They supported the director of public health who drafted the final report. External advice was provided by the head of 'healthcare advisers' a former GP who was at the time of the investigation an adviser to Haringey tPCT. There was no input from a consultant psychiatrist.

5.3 Terms of reference were provided and appended to the report, dated 22 November 2005. They were adequate but referred only to identifying the range and type of AP's contact with health services in Haringey and across the "*North Central sector"*. That appeared to exclude any investigation of AP's history before she moved to north London in March 2002. However, the chronology in the report did cover relevant aspects of AP's history from 1978 to October 2003.

5.4 The methodology included examination of medical records and use of some root cause analysis tools. Investigators sought information on trust and GP procedures from Barnet, Enfield and Haringey Mental Health NHS Trust, North East London Mental Health NHS Trust and GP1's practice. The internal investigation report did not, however, include a list of documents examined. Interviews were held with most of the key health professionals involved in AP's care and treatment.

5.5 The chronology in the report was detailed but did not include every episode of contact in the period between August 2001 and October 2003. All key events were covered.

5.6 Findings were reported under the following sub-headings:

- mental state of AP before the killings
- mental state of AP in 2001-03
- housing and AP vulnerability
- registration and contacts with Haringey GP
- GP and mental state assessment
- opportunities for referral and liaison with mental health services
- the letter of referral from Stonelea to CFH assessment unit
- AP's final attendances at Haringey practice
- care by mental health services while registered in Haringey.

5.7 The findings section of the report provided a commentary on the chronology and included references to evidence from interviews. The findings were not generally presented as following on from a review of documentary or verbal evidence, so the report was hard to read. It did not include a summary of findings or conclusions. However, key findings included:

- No contact with health services for three months before the homicides
- A number of psychotic episodes led to AP being seen by three different mental health services in London over 18 months
- Her symptoms settled quickly after each psychotic episode
- The degree of risk to AP and others was not regularly documented
- There were a number of opportunities to make a more detailed assessment and a number of opportunities to pursue mental health input more vigorously
- AP was a vulnerable adult
- No indication that GP1 or his locum had read AP's earlier health record
- No indication of mental state assessment when first registered with the Haringey practice
- There were further opportunities in July and August 2002 for referral from GP to psychiatry
- There was an opportunity for the GP to consider how serious AP's mental health condition was in March 2003 after her overnight stay in A&E

- The referral letter in March 2003 from the consultant psychiatrist at Stonelea Hospital to the assessment unit at Chase Farm Hospital was not copied to the GP
- AP's attendances at the GP surgery (in April 2003) included the expression of ideas that could be categorised as symptoms of psychosis. The locum GP was aware that AP had been prescribed olanzepine. The locum GP prescribed stelazine (an older antipsychotic medicine). The locum GP noted a need to exclude psychosis. There was no indication (in the notes) of any intention to refer to hospital
- There had been three contacts with mental health services while AP had been registered in Haringey
- The liaison service nurse at A&E at North Middlesex Hospital assessed AP to be well before her discharge. There had been no mention in the follow-up letter to the GP of AP allegedly carrying a knife
- On her admission six days later to Stonelea Hospital AP was settled by the time she saw the consultant (the next day). The consultant did not think she was detainable. She was discharged with a supply of olanzepine and the consultant referred her to Chase Farm Hospital for urgent outpatient follow-up
- Chase Farm Hospital's response was rapid but AP did not attend the appointment on 28 March 2003
- AP had no further contact with mental health services after 28 March 2003.

5.8 The report then examined "*key causal factors leading to absence of follow up*" and grouped them into five main areas (in fact, six were identified):

- communication across boundaries
- responsibility for follow-up
- individual practitioner
- diagnostic uncertainty
- prescribing
- patient factors - mobility, attendance, diagnosis.

5.9 These key factors appear to have been identified using some root cause analysis tools.

5.10 A sub-section was included for discussion of each factor. An additional factor "*pharmacological treatment issues*" also appeared at this stage of the report. In six of the seven sub-sections recommendations followed the narrative discussion. There were seventeen recommendations (although one recommendation referred to two earlier recommendations). In summary, they covered:

- communications between primary and secondary care
- ensuring that vulnerable people do not fall through the care net
- implementing protocols in the mental health trust for people who do not attend appointments (DNA)
- ensuring GPs understand their responsibilities for patients with possible serious mental illness
- developing an early intervention in psychosis service
- implementation by GPs of serious mental illness registers
- ensuring that GPs have systems to follow up diagnostic decision-making
- ensuring that GPs have systems to follow up letters from mental health services including integration with knowledge of patient's medical history
- providing information for GPs on who to contact, when and how for help in cases that are complex to manage in primary care
- ensuring good protocols for recruiting locums and handovers between GPs and locums and vice versa
- training programmes to improve GPs understanding and diagnostic approaches to acute psychosis
- ensuring GPs awareness of responsibilities at new registration regarding checking history
- training and updating GPs in mental-state assessments and risk assessments
- ensuring that GPs are aware of their responsibilities for QOF (quality and outcomes framework) when seeking recognition for mental illness (note: all elements of QOF are voluntary, including the mental health elements. Therefore a GP can *"opt out",* for example, of having a serious mental illness register).
- safety of prescribing practices

- operating of the mental health liaison service at North Middlesex Hospital within integrated clinical processes.

5.11 The report ends with the brief conclusion that AP could have been known to mental health services at the time of the homicides but she was not because there was no clarity of diagnosis or of who was responsible for her follow-up. There was no communication between North West London Mental Health NHS Trust and the GP and failed communication between Barnet, Enfield and Haringey Mental Health NHS Trust and the GP. AP's GP could have known her mental health state if he had actively followed up her case. The GP practice could have noted AP as needing proactive follow-up because she was a vulnerable patient, but this did not happen.

Conclusions

C1 There was an unacceptable delay between the homicides and agreement of terms of reference for the internal investigation. There was also an unacceptable delay between agreeing the terms of reference and the completion of the internal investigation report (see paragraphs 5.12 to 5.26 below).

C2 Membership of the panel was appropriate since most of AP's contacts were with GPs. Investigators should have sought advice from an independent consultant psychiatrist about AP's contacts with secondary mental health services.

C3 The terms of reference were narrow, restricting the investigation to AP's contacts in Haringey and the "*north west sector*".

C4 The methodology used some root cause analysis tools. There was no list of documentation so it is not possible to confirm that all relevant policy and procedural documentation was adequately reviewed.

C5 The chronology in the report covered all the main events between August 2001 and October 2003 but not all contacts were included.

C6 Findings did not follow on from presentation of evidence, so the report was hard to read. The findings section included a mix of discussion, analysis, findings and conclusions. However, findings covered most of the key issues in AP's care and treatment.

C7 Key causal factors for the absence of follow-up in AP's care and treatment were identified.

C8 Recommendations were relevant to the findings and identified causal factors.

C9 Conclusions of the internal investigation were appropriate based on the evidence.

Timeliness of the internal review and communication with the relatives of KZ

5.12 The police told GP1 about the homicides in the early hours after AP's arrest in October 2003. It appears, however, that the tPCT were not told and the opportunity for the immediate implementation of SUI procedures was lost.

5.13 On 20 September 2004, eleven months after the homicides and a week after the criminal trial ended, the Zito Trust wrote to Barnet, Enfield and Haringey Mental Health NHS Trust to request that an inquiry be held into AP's care and treatment. CZ, KZ's mother, wrote to the BEHMHT's chief executive on 29 September 2004 formally complaining about the care AP had received and requested an inquiry into her care and treatment.

5.14 The correspondence from the Zito Trust and CZ appears to have prompted BEHMHT to send a '24-hour' report to Haringey tPCT on 6 October 2004. The '24-hour' report was provided using a standard format in use by BEHMHT and which is to be sent to the serious incidents manager within 24 hours of such an incident. The report provided brief details of the events of 12 and 13 October 2003 and referred to national press coverage in September 2004. It referred to AP's admission to a unit in Leytonstone, East London on 20 March 2003 under section 136 of the Mental Health Act

and to her discharge the next day. It mentioned her referral to Enfield services and to the outpatient appointment on 28 March 2003 which she did not attend.

5.15 BEHMHT had not previously dealt with the incidents in October 2003 under their serious untoward incidents procedures. An email dated 6 October 2004 from BEHMHT's chief executive to colleagues at North Central London Strategic Health Authority and Enfield PCT confirmed that the trial verdict was "*the first we were aware of a homicide with a link to our services*". The email was not sent to Haringey tPCT although it pointed out that AP's GP was in Haringey.

5.16 The deputy director clinical of governance and service improvement for BEHMHT telephoned CZ during the week commencing 25 October 2004 to clarify some information about AP's admission in March 2003 to the Stonelea acute unit, which was part of the North East London Mental Health NHS Trust, and the subsequent outpatient appointment. BEHMHT wrote to CZ within a week of the telephone call confirming the information provided. Their letter said:

> *"This Trust considers an independent inquiry into these tragic events is necessary and will participate fully. I can confirm that we have written to the Strategic Health Authority to this effect. They will decide how this is taken forward and will liaise with all the relevant people."*

5.17 The letter was copied to the SHA chief executive, the Zito Trust and CZ's Member of Parliament.

5.18 On 16 November 2004 Haringey tPCT wrote to BEHMHT confirming receipt of the '24-hour' report and asking for an update on the action the mental health trust was taking.

5.19 Emails between the SHA, Haringey tPCT and BEHMHT after the '24-hour' report was circulated confirmed that the SHA had suggested the following way forward:

> *"The case would not come under the auspices of HSG 94/27 as she was not under the care of MH services and there are several gaps in this story. The court and police reports no doubt cover the pieces around the event but we need to know what role health played in all this, whether there had been any past manifestations of her illness and how had health responded.*
>
> *BEH(MHT) and Haringey tPCT need to work jointly on this, best led by Haringey tPCT (perhaps by a non- exec) as they commission services from yourselves (from BEHMHT) and from the GP. You would need to agree terms of reference together. The investigation will need to cover the GP involvement and GP records, information from the Leytonstone hospital (is this NE London MHT or a private service) and the referral to the BEH CMHT.*
>
> *Once the investigation is completed it should be clearer whether any further action or inquiry will be necessary."*

5.20 Some initial work on the internal investigation had started by 10 or 17 November 2004 (the note of the visit is not clear on which of the dates the visit was made) when the medical adviser to Haringey tPCT, visited GP1, AP's GP.

5.21 The tPCT's serious incident group (SIG) considered the case on 10 December 2004 and asked for an investigation to be led by the director of nursing, with a completion date of February 2005.

5.22 An email on 11 January 2005 from the tPCT's assistant director of governance said that the "*matter was taken up through the Reference Committee route with the GP*" and added "*following discussions between the (BEH)MHT and the SHA it was proposed that a joint investigation led by the HtPCT was the most appropriate way forward*".

5.23 There followed a period in which the tPCT were unable to access AP's medical records because she had not given her permission for their release for the purposes of the internal investigation. This was referred to in a letter from the tPCT to the Central Criminal Court on 2 June 2005. On 18 July 2005 the PCT's director of public health, in her role as Caldicott Guardian for the tPCT, asked the medical director of the West London Mental Health NHS Trust for his permission as the trust's Caldicott Guardian[1] to release the records to the tPCT on grounds of public interest. The medical director replied that he had asked AP's consultant forensic psychiatrist at Broadmoor to contact the tPCT. AP signed a consent form on 5 October 2005 after the intervention of the consultant forensic psychiatrist agreeing to the release of documents on file at Broadmoor Hospital relating to health issues in the community before her admission to Broadmoor.

5.24 By then the director of nursing had left the tPCT and responsibility for the investigation was transferred to another team. The medical adviser and public health consultant wrote a draft serious untoward incident report dated 20 June 2006.

5.25 The tPCT's director of corporate partnership and development met CZ, her sister and daughter on 31 May 2006 to discuss the family's concerns. On 8 September 2006 a meeting was attended by CZ, CZ's sister (KZ's aunt), the director of public health and the tPCT's director of corporate partnership and development. The director of public health appears to have raised questions not covered in the draft report. The next steps were noted as:

- *"finalise report (address all questions)*
- *take to SIG (serious incidents group) and include action plan (end of Sept 06)*
- *share with CZ in confidence*
- *? meet CH to discuss*
- *join the action plan with others re ID and make overall plan*

monitor actions/impact/outcomes

[1] Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.

5.26 Further work on the internal investigation continued. A meeting between the director of public health, the medical adviser and GP1 was held on 10 November 2006. An adviser to the tPCT provided further advice on matters related to AP's primary medical care on 9 January 2007. The final internal investigation report was dated February 2007. The minutes of the JSIG on 20 August 2007 refer to a further meeting between the director of public health, the tPCT's director of corporate partnership and development and CZ at which the action plan had been shared with CZ.

Conclusions

C10 An opportunity for swift implementation of SUI procedures was lost immediately after AP's arrest in October 2003. GP1 was told of the homicides but the tPCT was not.

C11 BEHMHT was unaware of the homicides until eleven months after they happened. It became aware following media coverage at the end of AP's trial and correspondence from the Zito Trust and CZ. AP had not been in touch with NHS services for six months before the homicides. Her contacts with secondary mental health services had been fleeting. Her only contact with BEHMHT was a letter offering an outpatient appointment in March 2003 and another in May 2003, neither of which she attended. It is therefore not surprising that BEHMHT were not aware sooner of the homicides.

C12 There was a two month delay before work on the internal investigation was started by the tPCT. By then it had been agreed by the SHA that the tPCT should lead a joint investigation with BEMHT. The decision for the tPCT to lead the investigation was appropriate as most of AP's care and treatment had been provided by her GP.

C13 The tPCT responded to CZ's letter three weeks after receiving it. There was then a delay of two years and ten months before the tPCT's director of public health met CZ to discuss the draft internal investigation report. CZ told us how the delay had affected her:

> *"Haringey PCT decided that an internal investigation is what would be the outcome. But they did not keep me updated. I had to constantly ring to find out if there was any progress, how things were going. Months would go by and I would hear nothing from them. I was left so frustrated and emotional."*

She added:

> *"I felt as though they* (the tPCT) *didn't care, as though they didn't want to have anything to do with it, and I felt as though left to them they would have happily swept it under the carpet and do nothing about it. That's how I felt about the PCT."*

C14 Delays in starting investigations sometimes happen when patients withhold permission for the release of records. In this case work on the internal investigation began within two months of the homicides being identified as a SUI. A further eight months passed before the tPCT asked the Caldicott Guardian at West London Mental Health NHS Trust to release the records in the public interest and then another three months before AP agreed. Better management would have avoided these delays. They are unacceptable.

C15 It took 18 months from November 2004 for the tPCT to produce the first draft report. This was partly due to the unacceptably long delay in obtaining the records and partly because the first investigation team leader left the tPCT. Such a delay demonstrates poor practice in handling SUIs, a lost opportunity for early identification and learning of lessons, poor customer care and a lack of courtesy to CZ.

Haringey tPCT's monitoring of the internal review

5.27 There is evidence that Haringey tPCT's serious incident group (SIG) received reports from January 2005 onwards about the internal investigation.

5.28 The minutes of the SIG meeting in March 2005 refer to contact with the tPCT by the mother of one of the victims (CZ) and her difficulty in trying to find out who was investigating the incident. A number of actions were agreed to address communication issues but this did not appear to improve the quality or regularity of future communication with CZ.

5.29 In January 2006 the SIG received a verbal report outlining some of the lessons emerging from the still incomplete internal investigation and agreed that an interim action plan should be drawn up. Reference was made to the action plan at the SIG meeting in March 2006 and suggestions were made to improve it. At the meeting in May 2006 an updated action plan was considered.

5.30 Minutes of SIG meetings confirm that while the internal investigation was continuing some actions were underway. For example, in January 2006 it was reported that a training event had been held for GPs, highlighting the (mental health) link worker service. A meeting had been held with the mental health trust to discuss shared care arrangements.

5.31 In July 2006 an overview of the draft report of the internal investigation was presented to the SIG. Concern was expressed by the SIG about the quality of the report and the clarity of the action plan. It was agreed that the director of public health would review the draft and present a revised version and action plan to the next meeting. However, the September meeting heard that the revised report was not yet complete.

5.32 The SIG minutes in October 2007 note that the case had been "*referred to the Reference Committee. A separate meeting would be held to discuss the issues*". This referral was to ensure that any performance issues concerning GP1's practice were considered. (See paragraphs 8.12 to 8.17).

5.33 From 2006 onwards in parallel with SIG consideration, reports on progress were also received at the joint mental health clinical services improvement group (JSIG) (Haringey tPCT and BEHMHT).

5.34 The JSIG approved the report of the internal investigation in May 2007.

Conclusions

C16 Regular and formal monitoring of progress of the internal review took place in Haringey tPCT's SIG from 2005 and, from 2006, also in the JSIG with representatives of both the tPCT and BEMHT. However the monitoring did not help to speed up the process of the internal review and did not improve either the quantity or quality of communication with CZ.

C17 Monitoring by the SIG and JSIG was proactive in ensuring that work towards improving services and practice took place while the internal review continued.

Implementation of the recommendations of the internal review

5.35 The SIG had expressed concerns in July 2006 about the quality of the action plan produced in response to the draft internal inquiry report. It was too general and actions were not adequately focused. In September 2006 the SIG agreed that further work was needed to revise the action plan. In February 2007 the JSIG further considered the recommendations of the internal tPCT investigation report and the action plan and approved the report subject to the reformulation of the action plan. The minutes of the May 2007 JSIG refer to the creation of an individual action plan for AP.

5.36 By December 2007 the quality of the action plan had improved. A new format was in use with:

- clear statements about what needed to be done
- clarity about which organisation and/or officer was leading each action
- a 'traffic light' colour-coded indication of progress on each action

- a description of assurance mechanisms
- performance indicators
- evidence of completion - with links to the evidence
- a 'traffic light' colour-coded risk assessment for each action.

5.37 It is a combined action plan with two other SUIs involving BEHMHT. However, the specific issues and actions arising from the internal investigation of AP's care and treatment are clearly identified and easy to follow.

5.38 The JSIG has since regularly reviewed and updated the action plan**.** The most recent version examined at the time of writing this report was dated October 2008. Eleven issues were identified concerning:

- primary care registration standards and assessment of newly registered patients
- support for primary care clinicians in managing patients with mental health problems
- assessment, diagnosis, prescribing, management and referral of patients with mental health problems in primary care
- clinical supervision
- systematic follow-up in primary care
- follow-up and referral
- crisis resolution home treatment patient pathway
- communication with locums in general practice
- communication between primary and secondary care
- vulnerable people in temporary accommodation
- dealing with poor performance.

5.39 A number of actions were set out for each issue. Progress had been made in all areas and actions were complete in a number of cases. For example, on support for primary care clinicians the action was for Haringey tPCT to establish a primary care mental health development team available to GPs for help. GPs were to be provided with information about "*who how and when to contact for help*". The action was coded green and described as complete. A source of evidence of completion was provided. A similar description of each action and progress to date was provided.

Seventeen actions specific to the internal review of AP's care and treatment were included.

Conclusion

C18 The initial action plan in 2006 was poor. From December 2007 the plan improved considerably. Action plans have been regularly reviewed and updated since. We heard verbal evidence that the action planning process is now well integrated into the joint service improvement arrangements and have seen documentary evidence, for example minutes of JSIG meetings, to support this.

6. Care and treatment in primary health care services

AP as a vulnerable adult

6.1 The Law Commission defined 'vulnerable adult' in 1995 as a person aged 18 or over "*who is or may be in need of community care services by reason of mental or other disability, age or illness and who is, or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation*". This definition was used in the 1999 consultation paper 'Who Decides' issued by the Lord Chancellor's department. It was also used in Department of Health and Home Office guidance 'No Secrets' published in March 2000.

6.2 In February 1987, AP was the subject of a non-accidental inquiry by Hackney social services into allegations of sexual abuse by a cousin. The allegations were found to be proved, but AP was not placed on the child protection register because contact with the cousin had been stopped.

6.3 In September 2001 a previous GP wrote a 'to whom it may concern' letter confirming that AP had consulted between March and September 2001 "*on several occasions*" saying she had been assaulted by her partner and had been diagnosed as suffering from clinical depression.

6.4 The sexual abuse allegation and the assaults were summarised as "*dormant problems*" in the computer record generated when AP left the Herne Hill general practice in May 2002. AP registered with GP1 in March 2002, but her notes were not requested until May 2002.

Comment

If GP1 had read these records when his practice received AP's notes, he might have linked the previous allegations of sexual abuse and physical assaults to her prescriptions for paroxetine and considered whether her situation had changed. The two events in her history, sexual assault and an abusive relationship, could both be interpreted as evidence that AP had been harmed or exploited in the past

and was therefore at risk of future harm or exploitation, thus fulfilling one part of the definition of a vulnerable adult.

6.5 A referral letter from Lambeth Women's Aid to Kensington & Chelsea housing department dated 15 November 2001 also refers to allegations of physical assaults. If the allegations were true this would have supported an assessment of AP as a victim of harm or exploitation. It is not clear whether this letter was also copied to the GP and thus included in the notes forwarded to GP1.

6.6 The Herne Hill practice prescribed AP paroxetine in November 2001. Consultations at this practice are recorded mainly on the practice computer and there is evidence of several consultations between November 2001 and February 2002 when her depressive symptoms were discussed and evaluated.

6.7 A letter from the West Norwood CMHT to the Herne Hill practice was dated 4 March 2002 (dictated 1 March) but received after AP had registered with GP1 (8 March 2002). It was filed in time to be included in the records sent to GP1 in May. The letter referred to a possible functional illness e.g. schizophrenia and paranoid ideation with possible hypomanic episodes. The letter also suggested withdrawing the paroxetine.

Comment

The focus of the assessment by the CMHT on 1 March 2002 seemed to be on degree of mental disorder and how she presented on the day and not on the nature of the disorder and how she had presented over time.

Further investigation and assessment by the CMHT should have followed (see chapter 7).

There was at least a suggestion in this letter that AP might have been suffering from a significant mental illness. She would therefore have fulfilled the second part of the definition of a vulnerable adult.

6.8 The acute deterioration in AP's mental state coincided with (and, indeed, precipitated) her move away from south east London and the Herne Hill practice. The Herne Hill practice was, therefore, unable to follow up her case.

Comment

When patients transfer away from a GP, the system does not inform the old GP of the new GP's details, so there is no opportunity for the two to communicate.

A review of AP's previous notes could have led to her new GP identifying her as a 'vulnerable adult'. This in turn could have led to closer and more proactive monitoring of her health and wellbeing and any possible need to refer her to secondary mental health services. There is conflicting evidence about whether such a review took place (see paragraphs 6.11 and 6.12 below).

New patient registration

6.9 According to the GP records, AP registered with GP1 on 8 March 2002. She failed to attend her first appointment on 14 March 2002, but saw GP1 on 26 March. The main purpose of this consultation was for back pain but AP requested a prescription for paroxetine. She was a new patient and GP1 did not have her records, so it would have been reasonable to expect him to have found out more about how long she had been taking this drug, why she was taking it and how she was now feeling. There is no evidence in the notes that he made any enquiries of this nature.

6.10 Furthermore, at the consultation on 26 March 2002, AP said that her back pain related to a kick she had received one and a half years earlier.

Comment

This was an unusual presentation of back pain in a young woman and one would expect a more detailed history to have been taken. It might have uncovered the allegations of assault. AP was referred for physiotherapy the same day.

6.11 By July 2002 GP1 should have received AP's previous GP notes. In his evidence to the internal tPCT investigation, GP1 said that he would not routinely have reviewed a patient's old records unless he had cause for concern.

6.12 GP1 told us that his policy was (and had been in 2002) to review all old records when he received them and that there was nothing in AP's records to cause concern.

Comment

A review of the notes might have revealed concerns that had not come to light during the short period AP was known to GP1 before the notes arrived.

GP1's recollection of his policy on reviewing records changed between his evidence to the internal review and independent investigation.

AP's primary health care and opportunities for referral to secondary mental health services

6.13 On 1 July 2002, AP consulted GP1 complaining of anxiety, tearfulness and insomnia following the death of a friend the previous week, allegedly by shooting. By this time, GP1 should have had her old records, which showed that she had started taking paroxetine in November 2001. GP1 noted that she was "*already on paroxetine*" and prescribed a sedative, zopiclone because she was not sleeping.

Comment

Insomnia is a recognised side-effect of paroxetine. GP1 could therefore have considered an alternative anti-depressant.

At this time, GP1 considered a psychiatric referral and counselling through MIND (the mental health charity) but no referral was made. MIND does not, and did not, provide formal psychiatric care. The record entry of 1 July clearly stated* "for psych ref + counselling (MIND)". *This implied two separate referrals. MIND accepts self-referral but a psychiatric referral would have required a letter or

telephone call from the GP to an appropriate consultant or team. There is no evidence that such a referral was made. The fact that the assessment by the CMHT in March 2002 had not led to further action by the secondary mental health services may have contributed to the lack of a re-referral. However, GP1 has said that no referral was made because he thought AP was planning to move out of the area. There is no mention in the notes until October 2002 of any intention by AP to move.

6.14 AP consulted her GP again on 6 August 2002. The notes describe her as depressed and "*could not pull herself* [together? – author's assumption]" (sic), there was no review of the antidepressant medication and the paroxetine was repeated. There is again a clearly expressed intention in the notes to refer AP for a psychiatric opinion: the notes stated "*d/w her*" – shorthand for 'discussed with her'.

Comment

There is no evidence that a referral for psychiatric opinion took place. We would expect GP1 to have read his earlier note regarding the need for referral and perhaps to have asked AP if she had been in contact with MIND.

There appears to have been no consideration of alternative medication, despite evidence that the paroxetine was not working.

A referral for a psychiatric opinion might have led to a formal mental state examination (assuming AP attended). GP1's failure to refer AP must be regarded as a missed opportunity.

6.15 AP failed to attend appointments with her GP on 30 August 2002 and 9 September 2002 and cancelled an appointment made for 11 October 2002. She attended on 21 October 2002, requesting help to move to either Walthamstow or Kensington. Her reason for moving was that "*she feels safe in those areas*". The implication is that she did not feel safe at her current address, but any reasons for this possible insecurity do not appear to have been explored at this attendance.

6.16 GP1 told this independent investigation that his main recollection of AP was of her repeated requests for help with housing problems. In fact, only two of her 12 attendances while she was registered with GP1 were recorded as having the specific intention of obtaining help with re-housing (and one of these was with a locum). The notes of six consultations refer explicitly to mental health issues (not including requests for repeats of paroxetine).

6.17 On 23 October 2002 AP completed a self-assessment form for re-housing purposes. This made reference to anxiety, depression and claustrophobia. It is not known however, if this form was copied to GP1.

6.18 On 14 January 2003 AP attended the surgery and was seen by GP2, a locum GP. (See paragraphs 6.26 and 6.27 below). In addition to physical problems, she complained of insomnia and was advised to take the paroxetine earlier in the day. As mentioned earlier, insomnia is a recognised side-effect of this drug – which AP had now been taking for more than a year with no documented evidence of a formal medication review or reassessment of her depressive illness. On 28 January 2003 AP requested and was given a further prescription for paroxetine by the same locum GP. GP2 did not record any enquiries regarding the earlier complaint of insomnia, or concerning the effectiveness or otherwise of taking the drug earlier.

6.19 AP saw GP2 again on 11 February 2003, saying she had been suffering from "*flu-like symptoms*", but had recovered. She was given a medical certificate for two months – no diagnosis was recorded at this consultation.

6.20 On 18 February 2003, AP cancelled an appointment and on 25 February 2003 she failed to attend.

6.21 Her next consultation, with the same locum GP, GP2, was on 3 April 2003. The notes for this consultation were out of order. The locum appears to have used an old blank Lloyd George[2] record card with AP's previous London SE24 address. The entry in the notes on this date states that AP had been admitted to hospital with a mental

[2] 'Lloyd George' record cards were used in a manual system for keeping patient records in GP practices.

illness. In fact, she had by this time contacted secondary mental health services twice. The discharge form from North Middlesex Hospital should have been in her notes by this time but the discharge form and letter from Stonelea Hospital would not (see chapter 7). GP2 discussed with AP the implications of her not taking her medication because he was not sure whether or not she had been taking her olanzepine. She was given another med3 (sickness) certificate for one month. Again, despite the requirements of the certificate (that the certifying GP has 'seen and examined' the patient) there is no record of a mental state examination.

6.22 AP consulted GP2 again on 11 April 2003. The entry in the notes follows that of 7 April 2003 (a repeat of E45 cream). It was at this consultation that the Kabbalah centre was first mentioned and the possibility of an acute psychosis was raised. GP2 clearly stated in the notes that there was a need to exclude acute psychosis.

Comment

The only way for GP2 to exclude acute psychosis would have been to refer AP for a full assessment by a psychiatrist but referral is not mentioned in the notes. The locum prescribed stelazine (trifluoperazine) and repeated the paroxetine. He does not seem to have considered whether to continue the olanzepine, but did not repeat the prescription. The fact that this is an anti-psychotic drug, usually begun in secondary care, should have served as a further reminder that a psychotic illness was a possible diagnosis. This primary care consultation took place in the absence of up-to-date information from secondary mental health services.

6.23 GP2 had received a letter dated 9 April 2003 from a counsellor at AP's college expressing concern about AP's mood.

6.24 On 16 April 2003, AP consulted GP2 again – this time for a letter for the housing department. This was only five days after the possibility of an acute psychosis had been raised but the notes contain no mention of any mental health issues and no assessment of AP's mental state appears to have been made.

6.25 GP2's recollections when interviewed for this review were not surprisingly unclear after five years. He confirmed that he worked as a locum at GP1's practice in March and April 2003, having been employed by an agency. He had not previously known GP1.

6.26 GP2 recalled that while he worked at the practice he met GP1 daily or a few times a week. The meetings were mostly ad hoc but some were arranged to discuss different patients and to give GP1 feedback. He could not remember whether any locum information pack or information on practice policies and procedures had been provided when he started work there but thought probably not.

6.27 GP2 confirmed that entries in the notes were in his handwriting but could not remember AP. Nor could he remember seeing any discharge letter from a mental health hospital around April 2003. He had no recollection of AP having mentioned the Kabbalah centre.

6.28 When referred to the section of the notes on 11 April that stated "*need too exclude an acute psychosis*", GP2 said that from the history given he would normally have referred to a mental hospital or to one of his colleagues but he could not recall what he did at the time. Nor could he remember why he prescribed stelazine instead of olanzepine.

6.29 Although he could not recall the consultation on 16 April 2003, GP2 thought the absence of any follow up of mental health concerns in the notes may have been because she looked much better and she had come specifically to collect the letter she needed for the housing department.

6.30 GP2 could not remember whether or not he discussed AP with GP1. He felt he might have and probably did.

Comment

The absence of follow-up on AP's mental health problems in the consultation on 16 April 2003 was extraordinary, as this entry was written on the back of a Lloyd George card. Inspection of the original record confirmed that this was the card bearing the notes of the consultation on 11 April. As 11 April 2003 was a Friday, and the 16 April was the following Wednesday, it would not be unreasonable to expect the locum to have remembered AP and to have followed up his concerns about possible acute psychosis.

In May 2004, at the request of her solicitors and while she was awaiting trial, AP was assessed by Professor NE. In his report of his interview with AP, Professor NE described the failure to refer AP for further assessment as 'noteworthy'. We agree with that conclusion.

Interviewees for this independent investigation from secondary mental health care services emphasised the rapid onset and florid nature of AP's psychotic symptoms and their equally rapid resolution. But Professor NE believed from the records available that the psychotic episode developed throughout 2002 and into 2003 (during AP's registration with GP1). We acknowledge Professor NE's considerable experience and suggest that AP's increasingly disturbed mental state might have been suspected sooner if management of her depression had been more systematic and follow-up had been pursued more rigorously in secondary mental health services (see chapter 7).

6.31 AP did not see her GP again before the tragic events of 19 and 20 October 2003. An appointment was made for 27 June 2003 but she apparently arrived late at the surgery. GP1 said she would have been given the option of waiting until the end of surgery or booking another appointment. Another appointment was booked for 4 July 2003 but she did not attend.

6.32 We asked GP1 about the employment of locums in his practice. He said the tPCT provided funding for a long-term locum to work concurrently (though not necessarily at the same surgery) with him in order to provide extra capacity. GP1 was

aware of the need for continuity and said the locum agency was asked to provide the same locum whenever possible. When we asked him if he communicated with his locums, GP1 said that the locum would tell him if he had any concerns about patients, and vice versa. The handwriting in the GP notes suggested that the same locum saw AP in both January and April 2003.

6.33 The internal Haringey tPCT investigation did not identify GP2 as the locum GP. A letter dated 9 April 2003 from a counsellor at AP's college to GP2 should have been in AP's GP records because it is marked 'file' and dated 11 April 2003. The wording of the letter suggests that GP2 was the locum seeing AP at that time. The director of public health has informed us that the letter was not in the GP practice notes she had or in any copies of notes shared by Broadmoor Hospital.

6.34 This letter from the counsellor was available to Professor NE in 2004, and his report clearly states that it was included in the GP notes.

6.35 GP1 subsequently (June 2008) confirmed that the locum was GP2.

Conclusions

C19 AP was a 'vulnerable adult' as defined by the Law Commission. Several interviewees commented on her 'bright personality' but this may have been her coping mechanism. She had been exploited and harmed by people close to her and was suffering from depression, a mental illness, when she registered with GP1.

C20 AP received timely and appropriate care while registered with the Herne Hill practice. Her depression was diagnosed and managed in accordance with accepted good practice and the GPs communicated well with other agencies. It is not explicitly stated but the practice appears to have recognised that AP was at risk. The first real crisis in her mental health coincided with her leaving this practice.

C21 It is not known if GP1 read AP's previous notes or if he did read them but felt that they contained nothing to cause concern. In any event, there is no evidence in AP's notes of any formal review of her antidepressant medication or of any reassessment of her mental state while she was registered with GP1.

C22 GP1's management of AP's depressive illness fell short of acceptable practice as defined in the General Medical Council's good medical practice guidance 2001. Faced with evidence that the antidepressant (paroxetine) was either not working or giving rise to side-effects such as insomnia, GP1 did not assess the need to change either the drug or the dose. On two occasions GP1 considered referring AP for further assessment of her depression but failed to do so. His reason for not referring AP (that she was considering moving) is disputed – particularly as he agreed to keep her on his list when she was living outside his practice area because, in his words, he felt she was vulnerable.

C23 GP1 saw and initialled the discharge note from North Middlesex Hospital in March 2003 but otherwise appears to have had no involvement with AP between January and October 2003.

C24 The GP most involved with AP during the period of her psychotic episodes was a locum, GP2, working at GP1's practice. The Haringey tPCT investigation failed to identify the locum GP. This should not have been difficult because their investigation took place much nearer the event, when memories were fresher and there were a limited number of agencies that could have provided the locum. The tPCT placed the onus for identifying the locum on GP1, saying (according to their decision-making group) that GP1 was responsible for him. In fact, following the introduction of the new performers' list regulations in 2002, locums were responsible for their own actions and subject to the same sanctions from their PCT as GP principals[3].

[3] Primary Care Trusts are required to keep lists of medical, dental and optometric performers. It is expected, but not mandatory, that a performer will be included in the list of the PCT in which he carries out the majority of his work. PCTs have an obligation to ensure that all medical performers undergo an annual appraisal and have the power to suspend, contingently remove or remove from their list(s) any performer whose clinical performance or conduct gives rise to serious concern. Admission to a performers' list is at the discretion of the PCT, following an approved application process, and may be refused, granted, or granted with conditions.

C25 The tPCT decision-making group identified the central role of the locum GP in AP's care and treatment as early as December 2004. This doctor would have been included in the performers' list of another PCT and Haringey tPCT should have made more strenuous and timely efforts to identify him in order that his 'home' PCT could be informed of their concerns. The 'home' PCT may have had concerns of their own about this GP and intelligence from that PCT could have had a bearing on any action they might take with regard to his continued status on their performers' list.

C26 This independent investigation was quickly able to identify the locum GP as GP2, a GP practising in the Newham PCT area, from documentation in AP's medical record. Newham PCT has confirmed that, at the time of the homicides, GP2 was not a source of concern.

C27 AP consulted GP2 three times in January and February 2003. On each occasion, despite issuing medical certificates and repeat prescriptions for paroxetine he (like GP1) does not appear to have assessed her mental health. She saw GP2 twice in April 2003. He was aware of her admission to hospital and of the prescription of olanzepine. He was aware that a psychotic illness was a possibility and identified the need to exclude this diagnosis. The only way to do that would have been to refer AP for a formal psychiatric assessment. He failed to do so. Furthermore, although he knew that she had been prescribed olanzepine, he did not continue this, but prescribed stelazine (an older anti-psychotic drug) instead.

C28 It is not known why GP2 did not refer AP for psychiatric assessment. Formal psychiatric assessment in early 2003 might have revealed AP's abusive background, her history of poorly controlled depression and at least two (probably three) episodes of psychotic behaviour. Such a history, with a full mental state examination, might have resulted in AP receiving continuing care from secondary mental health services following the CPA. It is unreasonable to speculate on whether this would have prevented the homicides, but this was a crucial missed opportunity. Furthermore, AP had now experienced four encounters, with two GPs, when she may have been expecting referral to secondary care (July/August 2002 and April 2003).

Recommendations

R1 The wider NHS should consider whether, when a patient leaves a GP's list, that GP should be informed of the patient's new GP. This would provide the opportunity to communicate any concerns the former GP may have about the patient which may not be apparent from the records.

R2 When a locum GP is engaged by a practice, formal arrangements should be in place to facilitate two-way discussion between the locum and other GPs at the practice regarding complex cases or patients giving cause for concern. Practices should try to integrate long-term locums into the practice team. Haringey tPCT should include in its clinical audit programme an annual audit to ensure implementation of this recommendation.

7. Care and treatment in secondary mental health services

7.1 AP received care and treatment from secondary mental health services on three occasions before the homicides in October 2003. All the interventions were brief.

7.2 The first was an assessment by a duty worker and a psychiatrist from West Norwood CMHT on 1 March 2002.

7.3 The second was as a result of her overnight stay in the A&E department on 13/14 March 2003 at North Middlesex Hospital when she was seen by a mental health liaison nurse.

7.4 The last followed her admission on 20 March 2003 to Stonelea Hospital from where she was discharged next day.

1 March 2002 assessment by Norwood CMHT

7.5 Staff from Lambeth Women's Aid contacted West Norwood CMHT on 26 February 2002 to request a mental health assessment for AP. Records from Lambeth Women's Aid note that a CMHT member had telephoned them the next day to arrange to visit her. A member of staff from Lambeth Women's Aid explained to AP that she could no longer stay at the refuge because of the danger she was posing to one resident.

7.6 The records from Lambeth Women's Aid included a further entry on 28 February 2002 indicating that CMHT members would visit the next day.

7.7 On 1 March 2002 (although the records state 29 February 2002) Lambeth Women's Aid told AP she was being evicted from the refuge for harassment. Lambeth Women's Aid had previously been in contact with the London Borough of Kensington and Chelsea housing department to discuss the situation and to refer AP to them for housing.

7.8 AP was assessed on 1 March 2002 by a duty worker and a specialist registrar to the consultant psychiatrist from West Norwood CMHT. A letter from the CMHT to AP's GP at the time, was dictated on 1 March 2002 and dated 4 March 2002. It said they were only able to see AP for about 10 minutes. AP was in the shower when they arrived and she stayed there for 20 to 25 minutes. Most of the details of AP's history were obtained from her key worker from Lambeth Women's Aid. This included reporting that AP "*talks constantly about the church and the need for her to help people because she says He [God] is speaking to her. There was another incident where AP apparently tried to drag a woman into a bath full of industrial bleach in an attempt to cleanse her.*" Generally, however AP was described as a "*friendly person within the hostel*".

7.9 The report of the mental state examination described AP as "*calm and cooperative and pleasant throughout the interview. Her manner was sometimes flippant and dismissive about some of the concerns that I relayed to her. She was however never aggressive or hostile*". No evidence was found of delusional thoughts and no obsessive ritualistic thoughts were identified. There were no depressive cognitions and no suicidal ideation or ideas of harming others. No abnormal perceptions were noted at the time of the assessment, although the history suggested significant mental illness. AP was reported in the letter as believing that she had psychological problems which she had been trying to address through counselling from her key worker at the hostel and by taking antidepressants. She denied the stories about wanting to cleanse people or having a special relationship with God. She was not keen to have further contact with the CMHT but was happy to liaise with her GP. The impression from the assessment was that:

> "*the history from the hostel workers certainly suggests that there might be a paranoid illness with an affective component. It sounds as if there have been possible hypomanic episodes. This may be a functional illness, although drug abuse has not been ruled out".*

7.10 The letter dated 4 March 2002 informed the GP that the CMHT would not make any further routine appointments to see AP. Reference was made to a telephone conversation on 1 March 2002 between the specialist registrar and the GP in which it had been suggested that the antidepressants be withdrawn because they might have been exacerbating hypomania and that a urine drug screen may be worth doing. Advice had been offered by the CMHT to the hostel to call the police if staff or residents felt threatened by AP. The police would then be able to decide whether to take her to a psychiatric hospital when she was exhibiting symptoms. The letter ended by restating that there had been little abnormality in her mental state examination and that the CMHT would certainly not be able to enforce treatment.

Conclusions

C29 The assessment by members of West Norwood CMHT, while based on a brief interview with AP, considered her history and recent reported behaviour together with her observed speech, mood thoughts, perception, cognitive functioning and insight. AP had said she did not wish to engage further with the CMHT.

- The focus of the assessment seemed to be on 'degree of mental disorder' and how she presented on the day.

- The bleach incident was alarming as an indicator to suggest high risk.

- The religious ideas should have been explored further. Part of the definition of delusions is to be out of keeping with someone's cultural and spiritual background. There was insufficient knowledge of AP's background to make this determination.

- In light of this, further intervention and assessment should have followed. An attempt should have been made to persuade AP that a follow-up appointment was needed.

- The suggestion of a hypomanic episode (for which the notes show limited evidence), together with serious risk, as indicated by the bleach incident, should have made further follow-up by the CMHT essential.

- Advice was given by the CMHT to the GP about future management.

C30 There was no reference in the letter from the CMHT to the GP about AP's imminent move into new accommodation or of her housing needs, although the team knew she would have to leave the refuge. At this point there was an opportunity for AP's GP and the CMHT to recognise that she was a vulnerable adult - she was living in a Women's Aid refuge, her behaviour had been reported as bizarre and she was to be evicted from her accommodation at the refuge. However, AP then moved home and registered with her new GP in Haringey a week after her assessment by the CMHT.

13/14 March 2003 overnight stay in A&E at North Middlesex Hospital

7.11 AP had no further contact with secondary mental health services for a year. By then she had moved into a flat in Haringey with support from Lambeth Women's Aid and registered with her new GP, GP1. She had moved again to another flat in north London in May 2002.

7.12 On 13 March 2003 AP was taken by ambulance to A&E at North Middlesex Hospital. The time of triage at A&E was recorded as 11.10pm. She had been reported to have been behaving inappropriately at a friend's house. Her mother accompanied her to hospital. It was alleged that AP had been wielding a knife. Her mother reported that AP had been attending religious meetings.

7.13 AP was seen in A&E by SHO1 who recorded that there was "*no direct Hx (history) of mental illness - although she is on SSRI (anti depressant)*". Her mental status was recorded as *"orientated to person, time and place. Inappropriate behaviour and speech at times some loss association and delusions, no obvious hallucinations reported or objectively visible."* The A&E record shows that AP was given intramuscular haloperidol 5mg (an antipsychotic drug) at 12.20am on 14 March 2003. She was seen again by SHO1 at 6.00am. The record states: *"Pt well, fully*

responsive, rational -no sign of last night's problems. Pt has vague memory of incident emotion++ -stress- university- relationship."

7.14 A mental health liaison nurse saw AP at 8.15am on 14 March 2003. He found no evidence of psychotic behaviours and recorded that she was rational and oriented with no thought disorder. His advice was: *"discharge when medically fit/will inform GP/informed mother who will come to collect her"*.

7.15 We interviewed the mental health liaison nurse. He could not remember AP. He confirmed that his assessment would have been recorded on the A&E nursing and assessment form in standard use at the time. The form included a brief section on risk assessment. In AP's case all risk boxes were answered *"No"*. Normal practice was to fax to the GP. He also confirmed that a more detailed risk assessment would not have taken place at that time unless he considered it necessary. In cases, for example, where he considered referral to the psychiatric assessment centre at St Ann's Hospital was needed, the (Barnet, Enfield and Haringey) mental health trust's standard risk assessment tool would have been used. The mental health liaison nurse could not recall details of AP's assessment and therefore had no recollection of a knife being mentioned. He said allegations about patients having weapons, including knives were not unusual in A&E. Usually weapons were brought into A&E with the police after incidents. He noted from the record that no knife was brought in by or with AP and that the reference to a knife was unsubstantiated.

7.16 AP was discharged from A&E that morning.

Conclusions

C31 AP's care and treatment at A&E were in line with policy, custom and practice at the time. The records do not elaborate on the form her *"inappropriate behaviour"* took and there is no evidence that an adequate history was taken or sought from AP or her mother. The assessment by the mental health liaison nurse was based on AP's current mental state and not on historical information.

C32 The SHO and the mental health liaison nurse agreed that AP had settled overnight following her injection with haloperidol. The risk assessment was cursory but in line with policy at the time. The outcome of the mental health liaison nurse's assessment was faxed to the GP who appeared to have initialled it on 23 March 2003. The allegation that AP had been wielding a knife could have prompted the answer 'yes' to questions about risk in the A&E nursing and assessment form and that in turn could have led to referral for psychiatric assessment.

20/21 March 2003 admission to and discharge from Stonelea Hospital and arrangements for follow up

7.17 AP was admitted to Stonelea Hospital on the evening of 20 March 2003. The police had been called to her grandmother's house. Her mother and grandmother had been keen to ensure that AP took her antipsychotic medication. This led to an argument as AP maintained that she had taken it. When the police arrived they found AP sitting on her mother on the lounge floor. AP was extremely abusive to the police who decided to place her under section 136 of the Mental Health Act 1983 and take her to Stonelea Hospital.

7.18 AP was initially assessed on admission by SHO2. SHO2's notes described AP as "*extremely agitated, verbally abusive, not in a position to give any information except telling that she was in an altercation with mother and grandmother*". The completed initial assessment form included a history of presenting difficulties, family background, personal background and current medications. The notes of the mental state examination included references to *"Kept on talking about being poisoned by gas and kept on spitting on hand and rubbing her nose on it, saying it would stop her from inhaling the gas. Rapport could not be established. Would make but not maintain eye contact. Distractible. (?High) psychomotor activity. Verbally abused staff*". No formal thought disorder or hallucinatory behaviour was found. The impression formed was of an acute psychotic episode - possibly manic. Lorezepam 2mg and haloperidol 5mg were administered and AP was to be reviewed the next morning.

7.19 On 21 March 2003 AP was seen by SHO3, SHO to consultant psychiatrist 1. SHO3 recorded detailed admission documentation. The clinical notes stated "*tried to strangulate mother (pt denies this)"* and recorded an "*uneventful childhood*". SHO3 recorded that AP responded appropriately to questions and that she was neither suspicious nor guarded. No formal thought disorder was found and AP denied any delusions. She also denied that anyone was poisoning her with gases. She said she had experienced thought echo[4] a few times two weeks earlier, but that was no longer the case. She denied having hallucinations and no evidence that she was responding to hallucinations was noted. AP said that she was more religious nowadays. She reported being stressed. The impression formed from the examination was of an acute psychotic episode secondary to stresses. The plan was to discuss with consultant psychiatrist 1 and formulate a management plan.

7.20 Consultant psychiatrist 1 saw AP on the afternoon of 21 March 2003. Consultant psychiatrist 1 told us that based on feedback he had received earlier in the day from SHO2 and SHO3 he expected that AP would need to be admitted to hospital. However, he recalled being surprised at the way she presented - fairly 'together' given her presentation the previous evening. She was pleasant, polite and fairly warm in manner. She was assertive in saying that she wanted to go home in spite of consultant psychiatrist 1's attempts to persuade her to remain in hospital informally. Consultant psychiatrist 1 said AP had persuaded him that the incident the previous evening had been a domestic argument between herself and her mother over whether she had been taking the stelazine prescribed by a private doctor. He was aware that AP had expressed psychotic ideas the previous evening. He found that she admitted recent psychotic experiences but these seemed to have subsided overnight. She was denied having auditory hallucinations, smelling gas or feeling *"unduly"* paranoid. She admitted that she still felt vaguely suspicious about things generally but seemed to have got herself together very substantially over night.

7.21 AP was discharged from Stonelea Hospital on 21 March 2003. Consultant psychiatrist 1 told us that he did not regard AP as detainable. On the same day consultant psychiatrist 1 wrote to the consultant psychiatrist at the assessment unit at

[4] Thought echo is a form of auditory hallucination in which the patient hears her thoughts spoken aloud.

Chase Farm Hospital (in AP's catchment area). The letter was marked *"urgent – by fax and post"*. AP's name was misspelt in the letter. Consultant psychiatrist 1 explained that this was the spelling on the section 136 form and that spelling was continued thereafter. The letter requested urgent outpatient follow-up for AP. It pointed out that the admission under section 136 of the Mental Health Act 1983 was illegal because the police had removed AP from her grandmother's house specifically to place her on section 136. Details of her recent history were provided together with a description of the events leading up to her admission. The letter ended:

> *"During her time at Stonelea she has actually been extremely settled. She denies all psychotic symptoms at present and is keen to leave. She does not appear to be detainable at the present time and has no thoughts of harm either to herself or other people. She is keen to return to her own flat, not her grandmother's and has agreed to take medication and to receive psychiatric follow up. I have prescribed for her olanzapine 5mg which she has agreed to take and will issue her today with two weeks supply. We do not plan any further follow up by our service but would appreciate it if she could be seen by your team, ideally within the next few days."*

7.22 It appears that consultant psychiatrist 1's letter was not copied to AP's GP. There was no indication on the letter that a copy had been sent to the GP and there was no copy in the GP records. Consultant psychiatrist 1 said his secretary nearly always sent copies of such letters to the patient's GP unless he told her not to. His secretary could not recall this case, not surprisingly in view of the time elapsed and as she had only typed the letter. SHO2 misspelt the GP's name in the records when AP was admitted. Consultant psychiatrist 1's secretary might therefore have seen a name she did not recognise. If she had tried to find out where the GP was she would not have succeeded because the name was spelt incorrectly. GP1 soon became aware that a referral had been made to the mental health unit at Chase Farm Hospital. The team manager of South Southgate community mental health team sent the GP a copy of a letter to AP dated 23 March 2003 offering an outpatient appointment at the mental health unit. AP confirmed her admission at her consultation with GP2 on 3 April 2003.

7.23 Chase Farm Hospital responded promptly to consultant psychiatrist 1's referral. A letter was sent to AP on 25 March 2003 with an appointment on 28 March 2003. We wondered whether such short notice of an appointment meant that AP had not received the letter in time. AP remembered receiving letters from Chase Farm Hospital. She said it was difficult to get to there from home.

7.24 AP did not keep the follow-up outpatient appointment at Chase Farm on 28 March 2003. A further appointment was made for 22 May 2003 which again AP did not attend. A copy of the letter to AP with the new appointment date was sent to the GP. The records show that the staff grade psychiatrist at Chase Farm Hospital, had noted a brief history in preparation for AP's appointment. The note also records AP's failure to attend and a decision –"*no further opa (outpatient appointment)"*. The staff grade psychiatrist wrote to AP's GP on 18 June 2003. The letter confirmed that consultant psychiatrist 1 had made a referral after AP's admission to Stonelea. It told the GP that AP had not attended her appointment on 22 May 2003 and that there were no plans to offer another routine follow-up appointment. The letter ended with an opportunity offered to the GP to re-refer AP if the GP thought fit.

7.25 We discussed the decision not to offer AP a further appointment with the staff grade psychiatrist. He could not recall details of the case. The staff grade psychiatrist did not think there was a written policy about what to do if a patient had not attended two outpatient appointments. He said it was a kind of 'common knowledge' that if a patient did not attend twice the likelihood was that they would not attend a third appointment. Therefore the policy was to inform the GP. If the GP felt it was urgent, arrangements would be made to visit the patient, usually with the GP. In a telephone interview with the independent investigation leader, the South Southgate CMHT manager confirmed that discharge after two failures to attend was probably in line with policy and practice at the time. It would also have been usual practice to notify the GP and offer the opportunity to re-refer.

7.26 AP had no further contact with secondary mental health services before the tragic events of 19 and 20 October 2003.

Conclusions

C33 SHO3 provided a detailed record of his assessment.

C34 The admission to Stonelea Hospital was for about 24 hours. It was unlikely that this was enough time fully to assess AP's mental state or to be sure that symptoms were not being masked.

C35 SHO2 interviewed AP's mother and grandmother at the time of her admission to Stonelea Hospital as it was not possible to obtain a clear history from AP.

C36 Professor NE felt that the use of the Mental Health Act 1983 to detain AP in hospital was not appropriate but a different view is also legitimate. The focus during AP's short admission was on how she presented on the day rather than on her history over time.

C37 AP's care and treatment were within the Bolam standard (a test for medical negligence) but learning points arise from scrutiny of this episode in AP's care:

- the need to focus on both current presentation and history including if necessary informant history
- the need to examine both the nature and the degree of mental disorder in considering the possible use of the Mental Health Act 1983 to detain a patient in hospital.

C38 The recorded history does not indicate that any detailed information about AP's childhood background was obtained. There is no reference in the clinical notes of AP or her relatives reporting her previous residence at Lambeth Women's Aid or to problems AP was experiencing at college. A fuller history of previous behaviour might have led to further consideration of the possibility of more prolonged psychotic symptoms.

C39 The urgent referral letter faxed by consultant psychiatrist 1 to Chase Farm Hospital did not mention the history of AP's alleged attempt to strangle her mother.

C40 Consultant psychiatrist 1's decision to discharge AP and to make a referral to Chase Farm Hospital for urgent outpatient follow-up was reasonable light of her history and presentation at the three assessments by SHO2, SHO3 and consultant psychiatrist 1. However, there are lessons to be learned from this review of her care, treatment and discharge from Stonelea Hospital (see C37 above).

C41 The GP's name was misspelt in the records of admission to Stonelea Hospital. The names of GP1 and AP are also misspelt elsewhere in the records. In the letter from consultant psychiatrist 1 to Chase Farm Hospital AP's name appears to have been misspelt.

C42 Chase Farm Hospital responded promptly to consultant psychiatrist 1's referral. It appears that AP's failure to attend was because Chase Farm Hospital was difficult to get to from her home. However, after AP's failure to keep her appointment on 28 March 2003, despite the urgency of the referral, Chase Farm Hospital did not try to engage her beyond offering a non-urgent appointment on 22 May 2003. An urgent problem appears to have become non-urgent when she did not attend. This might have been acceptable if the secondary mental health services had known AP well and it was clear that she had the capacity to make choices about her treatment. However, the services did not 'know' AP at this point and they were therefore downgrading to non-urgent someone with potentially high risk on the basis of unknown pathology.

C43 The decision not to offer AP a third outpatient appointment after her failure to keep appointments on 28 March 2003 and 22 May 2003 was in line with normal practice at Chase Farm Hospital at the time. Communication with the GP in this respect was adequate, although there was a delay of almost four weeks before the letter was sent to the GP.

C44 AP's contacts with secondary mental health services arose from at least two acute psychotic episodes. Her psychotic symptoms of 13 March 2003 (admission to A&E) and 20 March 2003 (admission to Stonelea Hospital) both subsided overnight and in both episodes assessments next day found no evidence of psychosis.

C45 We agree with Professor NE that it is likely that the psychotic episode that led to the homicides developed in 2002 and into 2003. This serious psychopathology was not noted either by her GP or by the nurses and psychiatrists who saw her in secondary mental health services. However, given AP's presentation and the swiftness of her recovery from psychotic symptoms the mental health professionals involved in her care and treatment in secondary mental health services could not reasonably have foreseen or prevented these tragedies.

Recommendations

R3 Mental health NHS trusts should ensure that their clinical risk management arrangements require taking a longitudinal clinical history of previous episodes of mental disorder and risk indicators including, if necessary, informant history. Trusts should include in their clinical audit programmes an annual audit to ensure implementation of this recommendation.

R4 Mental health trusts should remind clinicians of the need to examine both the nature and the degree of mental disorder in considering the possible use of the Mental Health Act 1983 to detain a patient in hospital.

R5 Mental health trusts should be particularly careful when they discharge patients with serious risk indicators whose assessments are incomplete. They should try actively to re-engage such patients when appropriate.

8. Learning the lessons

The lessons to be learned from AP's care and treatment in primary health care services are discussed in chapter 6. The lessons for secondary mental health services are discussed in chapter 7. This chapter looks at progress in implementing the recommendations of the internal inquiry and more widely at the lessons learned from these tragic events and whether services have developed and improved since.

Governance and serious untoward incidents

8.1 Haringey tPCT's incident management policy was published in 2002 and last updated in January 2007. The policy covers all incidents that occur in the context of the tPCT's activities. It requires that every incident is reported, no matter how minor. It makes clear that the tPCT also has responsibilities for developing incident management processes within independent contractor groups as part of its broader remit to ensure high-quality care for NHS patients or part of more specific contract management responsibilities. The policy sets out the responsibility of the tPCT to respond quickly and positively when incidents are reported. A clear definition of a serious untoward incident (SUI) is included and a procedure for notification of SUIs is provided. Responsibilities of directors and other senior managers are set out. The process for investigating SUIs is described, including the responsibilities of the tPCT's serious incident group and the use of root cause analysis (RCA). Processes for input to and accessing information from the TCPT's incident data base are included in the policy and a section covers communicating with and supporting staff, patients, carers and others affected by incidents. The policy also includes sections on working with other organisations and commissioned services.

8.2 The joint mental health clinical services improvement group was established by the tPCT and BEHMHT. Ensuring that SUIs and near misses of which GPs are aware are reported to the tPCT has been a key issue for the group. We heard from the clinical specialist and consultant nurse that not all GPs would necessarily see it as their responsibility to report a mental health near miss. Some GPs may still consider such reporting to be the business of the mental health trust.

Recommendation

R6 Haringey tPCT should ensure that there is a robust system in general practice for reporting all serious untoward incident and near misses including those related to mental health. The tPCT should include this in its audit programme to monitor the implementation of this recommendation.

Development of primary care mental health services

8.3 In September 2006 Haringey tPCT appointed a clinical specialist and nurse consultant in primary mental health care. In summary, the two key roles of that post are:

- Development of strategy including developing the local enhanced service (LES) specification for Haringey.

- Management of the graduate mental health service in the tPCT under which 11 primary care mental health workers have been recruited in the last three years as part of the programme for improving access to psychological therapies (IAPT) (see paragraph 8.6 below).

8.4 The clinical specialist and nurse consultant works closely with four GPs with a special interest (GPwSIs) in mental health appointed since 2006. The GPwSI's take a lead on training and development in each of the practice-based collaboratives in the tPCT. One of the GPwSIs leads on local analysis of output and outcome data on mental health from all GPs.

8.5 The GPwSIs and the clinical specialist and nurse consultant work on a one-to-one basis with practices and individual practitioners and the clinical directors of each PBC to develop and promote good practice. A variety of mental health training events are held across the tPCT. We were told that 120 GPs attended the sessions in 2007.

Recommendation

R7 NHS London should identify the range of models in place in PCTs across London to improve and develop and improve primary care mental health services, evaluate their effectiveness and encourage all PCTs to build on best practice and outcomes.

8.6 The tPCT is introducing a programme for improving accesses to psychological therapies (IAPT) with a particular emphasis on the more deprived east of the borough (where GP1's practice is situated).

8.7 The implementation by BEHMHT of a single point of entry to secondary mental health services was reported as having improved the referral pathway from general practice.

8.8 In 2007 the tPCT published a set of clinical guidelines, '*primary care guidelines for common mental illness*'. They are clear and comprehensive. Easy access is provided via a PowerPoint presentation to guidance by diagnosis. Flow charts are included for each illness to guide practitioners through assessment, diagnosis, and primary care management and referral options. Drug treatment guidance is provided.

8.9 The '*quality and outcomes framework*' (QOF) is the Department of Health recommended annual review process for general practice. The tPCT is working on linking the QOF process into mental health systems. The primary care committee of the local implementation team (mental health) (LIT) in Haringey supports and oversees this process. The membership of the committee includes BEHMHT staff, managers and clinicians, including psychiatrists, a GPwSI, staff from public health and the tPCT. It is chaired by the tPCT's clinical specialist and nurse consultant. The committee is responsible for analysing QOF data and its use to develop service plans and influence the work plans of the clinical specialist and GPwSIs. The use of QOF data also provides a focus for engaging GPs in improving the quality of primary care mental health services in their practices.

8.10 An interface agreement dated August 2007 between the tPCT and BEHMHT provides a platform for work to improve and ensure clear pathways between primary and secondary care mental health services. For example, joint work has been done on the process and quality of referrals. The need for further work has been identified by the JSIG, for example on the management of patients who do not attend appointments, the quality of referrals from general practice, the management of patients discharged back to primary care and information requirements.

Recommendations

R8 Haringey tPCT and BEHMHT should encourage the development and implementation of the work programme within the framework of the interface agreement. Particular attention should be given to the development of clear and jointly agreed standards and expectations. The tPCT and BEHMHT should jointly review progress six months from the publication of this report.

R9 Haringey tPCT should ensure the dissemination to all GPs of the interface agreement.

8.11 We heard that GP1 has funding in 2008/2009 to deploy a primary mental health worker. This development is to be commended, as it would provide added expertise and develop a multi-disciplinary approach to delivering services. It is, however, important that the role and responsibilities of the worker are clear and agreed by the tPCT.

Recommendation

R10 Haringey tPCT should continue to work with GP1 to specify the role, responsibilities, objectives and key tasks of the primary mental health worker in his practice. This should ensure that maximum benefit is obtained from the investment to improve the service in the practice for people with mental health problems.

Conclusions

C46 The tPCT's incident management policy is now comprehensive and robust. Every general practice must have a robust system for reporting all untoward incidents and near misses (see R3 above).

C47 The appointments by the tPCT of the clinical specialist and nurse consultant in primary health care and the GPwSIs (mental health) provide important investment in the development and improvement of primary care mental health services.

C48 There is a need to review and evaluate the range and effectiveness of models for developing primary care mental health services across London (see R4 above).

C49 Joint work between the tPCT and BEMHT shows early promise in improving care pathways. Its continued development needs continued support and encouragement.

Managing performance

8.12 Performance management of primary care contracting in the tPCT has been the responsibility of the director of performance and primary care since 2007. He is a member of the tPCT's serious incident group and reference committee (see paragraph 8.14 below).

8.13 The assistant director of practice performance works across both Haringey tPCT and Enfield PCT. She is responsible for practitioner performance, including the management of processes when there are serious concerns about individual practitioners.

8.14 A reference committee in Haringey tPCT considers the need for disciplinary procedures to be taken following complaints or serious incidents involving individual practitioners. Its focus is on serious, potentially disciplinary issues. The processes of inquiry and investigation are supported by a head of healthcare services advice (who also works across the two PCTs), a former GP. The roles of medical director and director of public health in the tPCT were held by one person until May 2007. Since

then the tPCT has appointed a part-time medical director who is a practising GP and who works with the head of healthcare services on serious concerns about practice or performance.

8.15 Performance management processes in the tPCT include the use of a 'balanced scorecard' published quarterly and provided to each general practice as key information on practice performance. This data, together with information from QOF is used to identify areas where there appear to be anomalies in practice. For example, low prevalence of an illness but high prescribing or vice versa. Such information then generates visits to practices to discuss issues and to encourage and support improvement. It also facilitates focused monitoring and review. Two senior managers in the tPCT support the director as heads of primary care for east and west Haringey respectively.

8.16 There were no reported concerns about the performance of GP1's practice before the tPCT became aware in October 2004 of the homicides a year earlier. The tPCT's reference committee were aware of these serious incidents by 13 October 2004. The tPCT's adviser (now head of healthcare services advice) medical adviser and visited GP1 as part of the internal investigation. We have seen the minutes of meetings of the reference committee between 13 October 2003 and January 2008 which provide evidence of the consideration, assessment and review of GP1's performance in the light of the homicides. The minutes also contain evidence of the debate and decisions about the need or otherwise to recommend disciplinary action and the need or otherwise to refer the case to the General Medical Council (GMC).

8.17 Verbal evidence from the assistant director of practice performance, who had attended most of the reference committee meetings, confirmed that the reference committee took advice from the National Clinical Assessment Service. There was then internal debate before the committee took the view that GP1 was a GP about whom there had been no previous concerns, working single-handed and therefore somewhat isolated and who needed more support and assessment. The tPCT therefore took the decision not to pursue a disciplinary route.

Conclusions

C50 There are clear links via terms of reference and common membership of groups and committees between the tPCT's performance management and serious untoward incident processes.

C51 A systematic approach to the performance management of independent contractors is now in place in the tPCT and increased management resources have been put in place to develop the interface with individual practices.

C52 The tPCT took a considered view of what action to take in respect of GP1 in the light of the homicides and the report of the internal investigation. It took external advice before concluding that GP1 should be assessed and supported in improving aspects of his practice rather than subject to disciplinary action or referral to the GMC. The approach taken by the tPCT was appropriate and proportionate in the light of the evidence available to them at the time and the evidence we have considered.

Secondary mental health services

8.18 The lessons to be learned from AP's care and treatment in secondary mental health services are discussed in chapter 7 above and the conclusions and recommendations in that chapter.

Appendix A

Documents reviewed

GP records	Herne Hill practice	1998 - March 2002
Lambeth Women's Aid records		February/March 2002
GP records	GP1's practice	March 2002 – July 2003
CMHT records	SLAM NHS Trust	March 2002
A&E records	North Middlesex University Hospital NHS Trust	March 2003
Mental health liaison records	BEHMHT	March 2003
NELMHT records	NELMHT	March -June 2003
Psychiatric report	Professor NE	May 2004
Shared care and interface agreement	Haringey tPCT/BEHMHT	August 2007
Complaints policy	Haringey tPCT	September 2006
Incident management policy	Haringey tPCT	January 2007
Health records management policy	Haringey tPCT	May 2007
Primary care guidelines for common mental illness	BEHMHT	September 2007
Working alone in safety policy	Haringey tPCT	September 2005
Policy on matters of conduct	Haringey tPCT	February 2007
Risk management strategy and procedure	Haringey tPCT	July 2006
Joint mental health clinical services improvement group (including SUI's): ToRs, reports, minutes and action plans	Haringey tPCT and BEHMHT	2006/2007/2008
Serious untoward incident - multiple stabbings - AP investigation report (The internal investigation report)	Haringey tPCT	February 2007
Sentencing remarks	Central Criminal Court	September 2004
Serious incident group - minutes	Haringey tPCT	2005/2006/2007
Non attendance policy	BEHMHT	January 2006
Post incident clinical records	North London forensic service/west London Mental Health NHS Trust	October 2003 -2007

Decision making group and reference committee -minutes	Haringey tPCT	October 2004-December 2007
Inter agency procedure for the assessment of people detained under section 136 of the Mental Health Act	North East London Mental Health NHS Trust	October 2007
good medical practice guidance	General Medical Council	2001
HSG(94)27 & updated paragraphs	Department of Health	May 1994 & June 2005

Appendix B

List of people interviewed

[name deleted]	Clinical specialist - primary care mental health -Haringey tPCT
[name deleted]	Former assistant head of governance (now head of strategy) - Haringey tPCT
[name deleted]	Director of corporate services and partnerships - Haringey tPCT
[name deleted]	Assistant director of practitioner performance - Haringey tPCT/Enfield PCT
[name deleted]	CMHT manager - BEHMHT
[name deleted]	Director of performance and primary care - Haringey tPCT
consultant psychiatrist 1	Consultant psychiatrist - North East London Mental Health NHS Trust
CZ- accompanied by victim's aunt	KZ's mother
AP	Perpetrator
GP1	General practitioner
GP2	(former) Locum general practitioner
GP3	General practitioner
Mental health liaison nurse	(former) Mental health liaison nurse - BEHMHT
Staff grade psychiatrist	(then) Staff grade psychiatrist - BEHMHT