BOARD PAPER HA06/025

Report of the Independent Inquiry into the Treatment and Care of Mr. E

Executive summary:

On 1st August 2004, Mr. D was with a friend in a park in Chesham. Mr. E (a community patient of Buckinghamshire Mental Health NHS Trust) came into the park and stabbed Mr. D a number of times in the neck, shoulder and back with a large knife. Despite attempts at resuscitation, Mr. D died at the scene. Mr. E was subsequently arrested and charged with murder. At his trial he pleaded not guilty to murder, and was convicted of manslaughter on grounds of diminished responsibility. He is currently detained at a medium secure psychiatric unit.

Following an internal review by Buckinghamshire Mental Health NHS Trust, Thames valley Strategic Health Authority commissioned an Independent Inquiry in accordance with HSG 94(27). The attached paper sets out the background to the case, summarises the key findings and recommendations of the inquiry, and recommends the next steps. The full inquiry report is to be found at Appendix One.

Actions requested:

- To note the contents of report and its recommendations
- To agree that NHS South Central take a role in the performance management of the resultant action plan
- To agree the process for publication of the independent inquiry report

Aim(s)/objective(s) supported by this paper:

In accordance with amended national guidance HSG94 (27) which was updated and published in June 2005, the Thames Valley Strategic Health Authority proceeded to a further stage of review by commissioning an independent inquiry into the treatment and care of Mr. E.

The aim of such inquiries is to better understand why such events occurred, whether they could have been predicted or prevented and to learn the lessons in order to improve practice and reduce the risk of such events happening again.

Author(s) of paper:

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Lead Directors responsible for this area of work:

Simon Tanner – Director of Public Health

Date of paper:

September 2006

On 1st August 2004, Mr. D was with a friend in a park in Chesham. Mr. E (a patient of Buckinghamshire Mental Health NHS Trust) came into the park and stabbed Mr. D a number of times in the neck, shoulder and back with a large knife. Despite attempts at resuscitation, Mr. D died at the scene. Mr. E was subsequently arrested and charged with murder. At his trial he pleaded not guilty to murder, and was convicted of manslaughter on grounds of diminished responsibility. He is currently detained at a medium secure psychiatric unit.

The Thames Valley Strategic Health Authority Board was advised of this case during 2004 and 2005. An independently chaired internal review carried out by the Trust reported in October 2005. Following that report and its submission to the Thames Valley Strategic Health Authority (SHA) the SHA then commissioned an Independent Inquiry into the Care and Treatment of Mr. E.

Since the commissioning of the inquiry, Buckinghamshire Mental Health NHS Trust has been dissolved and a new organisation, Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust (OBMH) has been created. The new Trust came into being on 1st April 2006. OBMH will be responsible for implementing an action plan following the recommendations from the report.

NHS South Central, which came into being on 1st July, has now taken the responsibility for receiving the independent inquiry report, originally commissioned by its predecessor organisation Thames Valley SHA. The decision to proceed to an Independent Inquiry was based on Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community, HSG (94) 27/LASSL (94)4, and the additional guidance (replacement paragraphs 33-36) published in July 2005 concerning the conduct of independent investigation into mental health services.

In this case an independent investigation was undertaken because a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event. The SHA is responsible for commissioning independent investigations and consequently the reports generated are the property of the SHA. Commissioning in this context refers to determining when an independent investigation is necessary, appointing an independent investigation team, agreeing terms of reference, publishing and distributing the resultant report and ensuring a process for subsequent action to address issues raised.

Thames Valley SHA appointed Lynda Winchcombe of GW Management Limited to co-ordinate and manage the inquiry. The panel was made up as follows:

Ted Unsworth (Chairman) - Former Director of Social Services
Ros Ramsay - Consultant Psychiatrist (South London & Maudsley NHS Trust)
Don Campbell – Former Director of Nursing (Gloucestershire Partnership NHS Trust)

The investigation was conducted adopting the principles of Root Cause Analysis (RCA), an investigative approach that aims to identify the causes of problems and to reach an understanding of how and why these problems happen. This approach is considered as best practice by the National Patient Safety Agency.

Key findings from the review

- That the murder of Mr. D by Mr. E was neither predictable nor preventable
- That primary care intervention with Mr. E should be commended
- Timescales for responses to referral need to be improved, and a system for tracking referrals should be implemented
- Risk assessment should become an integral part of care planning and management and should be audited by the Trust
- A DNA management policy should be introduced to ensure effective follow-up for those patients who DNA
- More active management of substance misuse issues within inpatient settings
- Care plans must include clear contingency plans that are regularly audited by the Trust
- The role of care co-ordinator be carefully recorded in the notes and that professionals understand this role clearly
- That eligibility criteria for the Assertive Outreach service be reviewed

The above is a summary of the key points, and some of these actions have already been actioned following the internal Trust review. The independent inquiry makes comment on those recommendations (all of which it endorses). The full report and recommendations can be found at Appendix One.

Board action required

The Board is asked to approve the recommendations in the independent inquiry report

- To instruct OBMH to complete an action plan to demonstrate how it will implement the recommendations, and to agree that the SHA will performance manage the implementation of that action plan with OBMH

- To agree to publish the Inquiry Report, and circulate to other NHS South Central Trusts and PCTs. To distribute the report to the nine other English SHAs for them to disseminate to their organisations to ensure wider learning from this case

In conclusion

Whilst very sad and rare events unfortunately cases such as this do happen in the mental health field. Making sure that as an NHS we are responsible, keen to learn and not apportioning blame is critical in learning the lessons that help to reduce the likelihood of reoccurrence of such incidents.

Steve Appleton
Head of Delivery and Service Improvement
September 2006

Independent Mental Health Inquiry

Into the

Care and Treatment Received By

Mr E

Commissioned by

Thames Valley Strategic Health Authority

July 2006

CONTENTS PAGE

Acknowledgements

Members of the Independent Inquiry Panel extend their deepest sympathy to the family of Mr D and are grateful to them for the assistance that they gave to the inquiry.

The inquiry panel also thanks Mr E and his family who provided valuable information about the circumstances surrounding his own care and treatment.

Inquiry Panel Members are in addition grateful to all those who provided the inquiry with information and the way in which those professionals cooperated in an open and frank manner.

It is acknowledged how stressful Independent Inquiries can be and the inquiry panel appreciate the willingness of the agencies to provide information and support to the staff through this difficult process.

Executive Summary

Introduction

On the afternoon of the 8th August 2004 near a bandstand at a park in Chesham, Buckinghamshire Mr E approached an acquaintance, Mr D, and fatally stabbed him.

They had previously shared accommodation for approximately three months earlier in the year.

Mr E had been in receipt of local mental health services provided by the Buckinghamshire Mental Health NHS Trust since 2003.

He pleaded guilty to and was subsequently convicted of manslaughter with diminished responsibility, and detained by the Court on a restriction order under the Mental Health Action 1983. He is currently being treated in a medium secure unit.

The Buckinghamshire Mental Health NHS Trust together with Buckinghamshire County Council Social Services established an independently chaired Internal Investigation, which reported its findings and recommendations to the boards of the relevant agencies.

An Independent Mental Health Inquiry was subsequently appointed on 9th January 2006 by the Thames Valley Strategic Health Authority as required by National Health Service Guidance HSG (94) 27 and the 2005 Addendum and undertaken using the Terms of Reference in Section 3. Following the publication of Commissioning a Patient Led NHS, and a subsequent consultation, Thames Valley Strategic Health Authority has been merged with Hampshire and Isle of Wight Strategic Health Authority. On 1st July 2006 those two bodies were replaced by NHS South Central.

The purpose of an inquiry is to thoroughly review and analyse the patient's care and treatment in order to identify any learning points minimise the possibility of a recurrence of similar events, and to make recommendations for the future delivery of mental health services.

This inquiry has been undertaken by an Inquiry Panel and Manager independent of the local mental health service provided by Buckinghamshire Mental Health NHS Trust.

The inquiry panel identified the written documentation it required and evidence was received from twenty-five individual witnesses both orally and in writing, over a period of five days during March, April and June 2006 from which a chronology of events was compiled.

The inquiry panel has considered the way in which mental health services were organised in the period February 2003 through to August 2004. Since early in 2004 the Buckinghamshire Mental Health NHS Trust (BMHT) had been working with Oxfordshire Mental Healthcare NHS Trust to bring together their management teams into a single team, in recognition of BMHT's size and inability to provide all the functions to the desired standard.

The two Trust Boards formally decided to apply to become a single Trust at their meeting in May 2005 and this received ministerial approval in March 2006. The Buckinghamshire Mental Health NHS Trust was dissolved on 31st March 2006 and its services combined with the Oxfordshire Mental Health NHS Trust to form a new organisation.

This report has been drafted to include a brief history of Mr E, detailed consideration of key periods in his care and treatment and the inquiry panel's findings and recommendations.

Chronology

A summary chronology of the events is as follows: -

- Mr E was born in 1982 and grew up in Great Missenden, Buckinghamshire. His mother managed as a lone parent for 2 ½ years until she remarried. Mr E has a younger half-brother. It was reported that following the birth of his natural son, Mr E's stepfather became physically abusive towards him. The marriage eventually broke down when Mr E was 9 or 10 years old (1991 or 1992?).

- In 1990 the family GP referred Mr E aged eight years, for a psychological assessment as his mother was concerned about his behaviour and the deteriorating relationship with his stepfather. Mr E attended several treatment sessions both alone and together with other family members during the next six years as a result of re-referrals to the service including a referral in 1995. In 1996, when Mr E was 14 years old, these sessions were discontinued as he was becoming difficult to engage. His case was closed in 1997.

- In 1999 when he was seventeen years old, Mr E's mother reported to their GP that he had started to use cannabis and was occasionally angry and depressed.

- He obtained work as a barman in Amersham in 2000 and sometime during this year left home to live in lodgings in the town staying at this accommodation for approximately three years. It is reported that at the end of this period Mr E was

asked to leave the lodgings by his landlady as he had 'gone berserk' and that the other residents were 'terrified of him'.

- Mr E was first referred to mental health services in February 2003 by the GP's as he was reported as experiencing mood swings, with some aggressive behaviour and possible paranoia. His GP prescribed oral risperidone, 1 mg twice daily. The following week Mr E was referred to the mental health services.

- In June Mr E again visited his GP as he had not yet received an appointment with the mental health services. The GP made a second referral on the 22nd June 2003. The practice carried on prescribing oral risperidone.

- Mr E saw a locum Consultant Psychiatrist with the CMHT on the 8th July and was provisionally diagnosed as suffering an "acute predominately delusional psychotic disorder". His risperidone was increased to 4mgs at night. A further review was arranged for 5th August 2003.

- There is no record that Mr E attended this outpatient appointment as during the summer he took a temporary vocation job in the Scilly Isles where he attended the A & E department of the local hospital on 1st October. He presented with abdominal pain and admitted overnight. The admission assessment form recorded that the "the local people had noted inappropriate and strange behaviours".

- Early in October Mr E returned from the Scilly Isles and is reported to have lived in a tent in local woods for a short period before moving back home with his mother and brother.

- On 28th October Mr E saw his GP who re-referred him to the mental health services as he had been non-compliant with his medication and presented as tearful and depressed. An outpatient appointment was subsequently arranged for 13th November with the locum Consultant Psychiatrist.

- On the 1st November Mr E's mother contacted the Social Services Emergency Duty Team. She was profoundly concerned as her son appeared to be experiencing strong paranoid ideas in relation to his half brother and had broken his computer and thought that his half brother's thoughts were "destroying" him. Mrs E was advised to contact the GP 'out of hours service' and was advised by the doctor there to give Mr E two extra risperidone tablets and to contact them again if the situation deteriorated.

- Mr E was then assessed following a re-referral by his GP to the Community Psychiatric Nurse (CPN) linked with the family GP practice on the 3rd November. The CPN recorded that Mr E believed his half brother was tampering with his thoughts and playing mind games with him. Mr E denied hearing voices and did not wish to be admitted to hospital but did eventually agree to do so and was admitted to Frith Ward, Haleacre Unit, Amersham.

- It was reported that Mr E tested positive for cannabinoids and he brought into the ward cannabis and alcohol which he knew to be in contravention of ward policy. During this admission his medication was changed to depot risperidone 25 mgs two weekly by intramuscular injection.

- It was not possible to identify the precise time and date when Mr E was discharged but it is assumed this followed a CPA review meeting, which took place on Frith Ward on Friday 9th January 2004.

- The accommodation arranged for him only contained a fridge. His mother provided a mattress and some bedding for the unfurnished bed-sit. Arrangements were made for the care manager to visit him weekly for the first month; for the rehabilitation officer to visit weekly and for the CPN to administer his depot injection on a 2 weekly basis.

- Between January and April 2004 there was minimal contact with Mr E despite the numerous attempts by the three professionals involved in his care. It appeared that he was actively avoiding contact. Mr E's mother was aware of the situation and tried to encourage him to meet staff and comply with his treatment plan.

- The CPN referred Mr E to the Crisis Team on the 4th March, requesting that he be assessed for admission to hospital but this did not take place. On the 24th March the CPN made a referral to the Assertive Outreach Team after discussing her inability to contact Mr E with his locum Consultant Psychiatrist. They eventually replied that he did not meet their eligibility criteria.

- On the 14th April Mr E's mother accompanied him to his GP as he had smashed up his room, appeared distressed, not eating or sleeping and was smoking cannabis and using alcohol.

- A Mental Health Act 1983 assessment was arranged for the following day attended by Mr E's GP, the locum Consultant Psychiatrist and an Approved Social Worker. Mr E did not meet the criteria for detention under the Mental Health Act 1983 and he was unwilling to be admitted voluntarily.

- Mr E's GP contacted the Crisis Team on the 1st May and asked them to contact Mr E's mother to discuss arrangements for their assessment of her son. In the event Mr E did not answer his mother's telephone calls.

- On the 4th May the locum Consultant Psychiatrist considered that Mr E should have a Mental Health Act assessment as he had again smashed up his room, been drinking heavily and had run out of money. The Crisis team were contacted to assess Mr E but were unable to contact him and his CPN agreed a care plan with him to avoid a hospital admission.

- It was decided later by the Crisis Team that he did not meet their criteria so did not assess him. During this period Mr E had also been prescribed oral medication instead of by intramuscular injection.

- During June Mr E's pattern of non-engagement continued. On the 30th June Paradigm Housing contacted the Care Manager as they had concerns about Mr E's personal hygiene. It was reported that he was unkempt, wearing dirty clothes and generally dishevelled.

- Throughout July there were concerns expressed by Paradigm Housing in regard to Mr E's hygiene, they contacted the care manager three times reporting that Mr E was unkempt and smelt of faeces and was known to be in debt.

- On 23rd July the Care Manager recommended that the CPN re-refer Mr E to the Assertive Outreach Team again. The Care Manager and the CPN agreed that if Mr E continued to disengage then a case conference would be arranged. On the 27th a planned CPA meeting was cancelled and rescheduled for the 10th August 2004.

- On the 1st August Mr E was arrested and charged with the murder of Mr D.

Findings and Recommendations

Mr E's pattern of engagement with the services, with the exception of his GP, was that he was unlikely to attend for appointments and comply with specific interventions. Throughout his contact with the services it is clear that he was seen as someone who had a substance misuse problem and not regarded as someone with a severe mental illness with the exception of the locum Consultant Psychiatrist and

CPN. The primary concern related to his substance misuse and the short term effect that it had on his mental health although no formal attempt was made to treat his substance misuse.

The discharge summary from the hospital stated that he could pose a risk to others if he became paranoid about them but there is no reason to interpret this as sufficient to predict that Mr E would have killed that person. It is the consideration of the inquiry panel that the killing of Mr D was neither preventable or predictable.

However the inquiry panel did find that there were system failures that need addressing and would improve the service provision, these are outlined below.

Childhood and Adolescence

The inquiry panel found no evidence that Mr E's contact with the Child and adolescent mental health service during his early years was taken into consideration during his contact with the adult mental health services.

Recommendation one

It is recommended that previous contacts with other services are included in assessments undertaken by the adult services, taking into account full background information about the person's previous psychiatric history and social circumstances.

General Practitioner Service

The inquiry panel were impressed with the treatment and continuous support provided by Mr E's family GP and the practice as a whole. Their knowledge of mental illness and how they dealt with it should be commended and made a positive contribution to Mr E's care.

Initial Referral to Mental Health Services

The initial referral from the GP to mental health services in February 2003 appeared to have been 'mislaid'. The referral letter had clearly been written as a copy was found in both Mr E's GP and mental health records, however we were unable to substantiate when it arrived, who saw it and what action was taken. A gap of five months occurred

between the original referral, re-referral and eventual outpatient appointment for assessment.

Recommendation two

In line with good practice a timescale of response to referrals should be agreed between primary and secondary care and the referring agency should develop a system for tracking when referrals are made and the response received.

Evidence was available at the time of Mr E's first assessment by the mental health service that he was capable of "going berserk" and following his hospital admission the SHO there identified the risk to others. It was found that there was not a systematic review of his risk assessment nor management. At no time was consideration given regarding a risk he might have posed to others.

Recommendation three

It is recommended that risk assessment and management becomes an integral part of care planning and management and is regularly audited by the Trust.

Mr E did not appear to have attended his second outpatient appointment and the inquiry panel could find no evidence that an attempt was made to contact him. In the event he had to be re-referred by his GP for a further assessment as his mental state had deteriorated.

Recommendation four

It is recommended that the Trust develop a Policy on Managing DNA or Cancelled Appointments as detailed on the internal review's recommendation to ensure that there is an effective follow up of people who do not attend for appointments. It is further recommended that once the Policy is implemented that its operation and effectiveness is audited.

Admission to hospital

The panel considers that the admission to hospital in November 2003 was the right course of action. It acknowledged the pressure that the Trust inpatient staff were under in managing a busy acute admission unit whilst short staffed and relying heavily on agency staff. This may account in some degree for the fact that there is little evidence of any therapeutic activities or investigation to understand this young man's

mental health problems. This was reflected in the manner of his treatment and discharge by:

- Insufficient consideration in regard to his substance misuse and the reasons why he was continuing to use it
- The fact that he was seen as an intimidating and disruptive young man, not the vulnerable person that he was seen to be by the Locum Consultant Psychiatrist
- Staff were not mindful of the contribution that Mr E's mother could have made so that she might have been more fully engaged in his care plan and also provide a fuller history of his mental problems
- A failure to engage in discharge planning early in his admission to ensure that the most appropriate housing and support was available

Recommendation five

The inquiry panel recommends that the inpatient unit review their processes to ensure that:

- Where a person continues to misuse substances then a more active management of these problems should be undertaken either by a referral to specialist services or through the adult service with support from the specialist service
- The contribution of carers is recognised and encouraged
- Preparation for discharge is commenced on admission including the identification of appropriate housing needs where relevant
- Meaningful therapeutic activities are available within the unit

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Discharge from Hospital

The inquiry panel could not identify from the evidence received the actual date that Mr E was discharged from hospital. It is known that a CPA review took place on the 9th January 2004 (a Friday) with a view to discharge him on the 12th January, and that Mr E was insistent that he was discharged, despite the only available accommodation being an unfurnished bedsit. However discharge documentation records show that he was discharged on the 12th January 2004.

No attempt was made by the services to obtain an adequate range of furniture and domestic equipment for Mr E and up until the incident it is understood that his room remained sparsely furnished and equipped.

A care plan was agreed but this did not include an adequate contingency or crisis plan.

Recommendation six

It is recommended that where patients are discharged to unfurnished accommodation staff support clients to obtain adequate furniture and domestic equipment.

Recommendation seven

It is recommended that Care Plans contain full information on contingency and crisis plans and that the Trust audits this on a regular basis.

Contact with the Community Mental Health Services

Mr E is not an untypical patient in terms of his use of illicit substances. People like Mr E will tend to dis-engage from services if they feel under pressure or unwell.

It is the inquiry panel's view that none of the professionals involved in his care (with the exception of his GP), had an opportunity to develop a therapeutic relationship with him thus making it much harder to identify when his mental state was deteriorating.

The inquiry panel has concerns that a care coordinator was never clearly nominated with both the CPN and care manager considering that the other had this role. This led to a lack of case accountability.

Referrals to the Crisis and Assertive Outreach Teams were unsuccessful and the inquiry panel were concerned that the CPN was unable to obtain the help and support necessary for this complex case.

Conflicting evidence was provided in relation to the eligibility criteria for the service provided by the Assertive Outreach Team. A senior manager assured the inquiry panel that this had been reviewed and the six month rule no longer existed. However we received both written and oral evidence which stated that an individual must have been disengaging with the mental health services for at least six months before considered for eligibility for the Assertive Outreach Team.

Recommendation eight

It is recommended that the allocation of a care coordinator is carefully recorded and that the professional and their role is

clearly understood by his/her colleagues, the patient, carer and other relevant agencies.

Recommendation nine

It is recommended that the eligibility criteria for access to the Assertive Outreach Team is reviewed and that if the six month guidance remains then professionals seeking support for their patients/clients who are not accepted should be able to have an opportunity to discuss the case with the team, and mechanism and for dealing with unresolved referrals between the teams should be developed.

Communication between and within Teams

Systems for sharing and using information were inconsistent in this case. The inquiry panel had detailed information relating to Mr E that was not shared with other members of the team. For example:

- Inadequate case recording systems and processes in place
- Notes being kept separately by each member of the team with no integration of records
- Allocated team members working different duty rotas and therefore not being able to liaise with each other on a face to face basis

Recommendation ten

The inquiry panel understands that the Trust, together with its partner agencies, is reviewing and developing an electronic data system, which can be used by the multi-disciplinary team.

It is further recommended that the Trust:

- Reviews the implementation of integrated records to ensure that the transition to this new system is in place as soon as possible.
- Take into consideration duty rotas when allocating a team of professionals to one individual patient/client.

Leadership and Clinical Accountability

The situation within the local services during the period of Mr E's care indicates that there was inadequate leadership and accountability for both clinical and management arrangements.

The reorganisation and future of the BMHT must have impacted on both senior management and the operational teams. More specifically it is considered that there was a lack of nursing leadership; that a significant number of medical posts did not have substantive Consultant Psychiatrists in those positions; that regular supervision and appraisal were not available to the medical team and locums were working to a degree in isolation.

Recommendation eleven

It is recommended that the Trust ensures appropriate professional support and supervision structures are in place for all clinical staff and that this is monitored.

Dual Diagnosis

The inquiry panel found that training for all staff on dual diagnosis work was insufficient and led in some cases to a belief that a person with a history of substance misuse was less deserving of treatment.

Recommendation twelve

It is recommended that staff are provided with training on the impact that substance misuse can have on a person with a mental illness and that local Dual Diagnosis Strategies are developed and implemented.

Carers

It is the responsibility of secondary care services to ensure that carers' needs are met and that a Carers' Assessment is offered and undertaken if accepted.

Mr E's mother, although actively involved with her son, was found to be marginalized; was not informed or involved with compiling a care package for her son and felt that her views were not taken into consideration.

Recommendation thirteen

It is recommended that the following is taken into account and audited by the Trust: -

- The assessment process must include information gained from carers without compromising the individual's right to confidentiality.
- That carers are offered a Carers Assessment and that their support needs are recognised.
- That the services should establish better links with the organisations in Buckinghamshire Carers

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Support provided to families after the homicide

The inquiry panel found that both families had been contacted after the homicide and invited to participate in the Trust's internal review. However the Trust did not offer informal or formal support or keep them informed of the actions being taken following their investigation

Recommendation fourteen

It is recommended that the Trust should identify a senior manager to coordinate both informal and formal support to families after a homicide as set out in the "Building Bridges" and the National Patient Safety Agency guidance for "Supporting Families".

Concluding Comments

The value of an independent inquiry is in identifying issues that can be resolved by achievable recommendations. We therefore submit this report to NHS South Centreal and its Board and trust that the findings and recommendations are considered fully and put together into an action plan, the progress of which will be reviewed regularly.

1. Introduction

On the afternoon of the 8th August 2004 near a bandstand at a park in Chesham, Buckinghamshire Mr E approached an acquaintance, Mr D and fatally stabbed him.

They had shared accommodation for approximately three months earlier in the year. Mr E had started to harbour "ill feelings" towards Mr D and at Mr E's trial there were reports of three unprovoked attacks by Mr E towards Mr D both in their lodgings and at their local public house.

Mr E had been in receipt of local mental health services provided by the Buckinghamshire Mental Health NHS Trust since 2003.

Mr E pleaded guilty to and was subsequently convicted of manslaughter with diminished responsibility, and detained by the Court on a Restriction Order under the Mental Health Act 1983. He is currently being treated in a medium secure unit.

The Buckinghamshire Mental Health NHS Trust together with Buckinghamshire County Council Social Services established an independently chaired Internal Investigation, which reported its findings and recommendations to the Boards of the relevant agencies.

An Independent Mental Health Inquiry was subsequently appointed on 9th January 2006 by the Thames Valley Strategic Health Authority as required by National Health Service Guidance HSG (94) 27 and the 2005 Addendum. Following the publication of Commissioning a Patient Led NHS, and a subsequent consultation, Thames Valley Strategic Health Authority has been merged with Hampshire and Isle of Wight Strategic Health Authority. On 1st July 2006 those two bodies were replaced by NHS South Central. The Guidance requires that an independent inquiry is undertaken when a person who has been in receipt of mental health services for the past six months commits a homicide.

It is important to note that since these tragic circumstances under review occurred, local services have undergone a period of significant reorganisation and more improvements continue to be implemented at the time of writing this report.

2. Purpose of the Inquiry

The purpose of an Inquiry is to thoroughly review and analyse the patient's care and treatment in order to identify any learning points, minimise the possibility of a similar event occurring, and make recommendations for the future delivery of mental health services.

The role of the inquiry panel is to establish a full picture of what was known, or should have been known, at the time by the clinicians and to form a view of the practice and decisions made based on that knowledge.

The process is intended to be constructive, serving the individuals involved, their employing agencies and service commissioners together with the wider public interest. It is important that those who have been bereaved are fully informed of the individual circumstances and are assured that the case has been fully investigated by an impartial and independent inquiry panel.

To safeguard those involved, the Independent Inquiry Report has been anonymised.

The Terms of Reference for this Inquiry are set out on the following two pages.

3. Terms of Reference

1. To examine all circumstances surrounding the care and treatment of Mr E in particular:

   - The quality and scope of his health, social care and risk assessment

   - The circumstances relating to treatment, and to comment upon:

     - The suitability of the care in view of Mr E's assessed health and social care needs, and clinical diagnosis
     - The clinical and operational organisation, and the quality of care provided in the community
     - Assessment of the needs of carers and his family

   - The suitability of his treatment, care and supervision in respect of:

     - His assessed health and social care needs
     - His assessed risk of potential harm to himself or others
     - Any previous psychiatric history, including drug and alcohol abuse
     - Previous forensic history
     - How the service met his health and social care needs

   - The extent to which Mr E's care corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health and local operational policies: the extent to which his prescribed care plans were:

     - Effectively delivered
     - Complied with by Mr E
     - Monitored by the relevant agency

   - The history of Mr E's treatment, care and compliance with the service provided

   - The independently chaired Internal Investigation completed by the Buckinghamshire Mental Health NHS Trust and Buckinghamshire Social Services and the actions that arose from this.

- Consider such other matters relating to the said matter as the public interest may require.

2. To consider the adequacy of both the risk assessment procedures applicable to Mr E and the relevant competencies and supervision provided for all staff involved in Mr E's care.

3. To examine the adequacy of the collaboration and communication between all the agencies involved in the care of Mr E, or in the provision of services to them, including housing, substance misuse, Buckinghamshire Mental Health NHS Trust, GP services and the voluntary sector.

4. To prepare an independent report for the Thames Valley Strategic Health Authority, its successor body being South Central Health Authority and make recommendations to the local health and social care communities.

4. Panel Membership

This Inquiry has been undertaken by the following panel of professionals who are all independent of the mental health services provided by the Buckinghamshire Mental Health NHS Trust.

Panel Chair

Ted Unsworth	-	A former Director of Social Services and national mental health charity Chief Executive, currently managing director of a specialist consultancy company and in service with the Mental Health Review Tribunal

Panel Members

Ros Ramsay	-	General Adult Consultant Psychiatrist, South London and Maudsley NHS Trust, London
Don Campbell	-	Former Director of Nursing Practice and Development, Gloucestershire Partnership NHS Trust

Inquiry Manager

Lynda Winchcombe	-	Director, GW Management Consultants Ltd, (a company specialising in undertaking Inquiries and Investigations)

5. Methodology

5.1 How the Independent Inquiry was undertaken

The Thames Valley Strategic Health Authority commissioned the Independent Inquiry under the Terms of Reference in Section 3.

An initial briefing between the Inquiry Manager, a representative of the Strategic Health Authority, and the family of Mr D was held to explain the purpose of the Independent Inquiry; how it was set up; the National Health Service guidance that the Strategic Health Authority was following and the timescale within which the Independent Inquiry would complete its report.

The inquiry panel identified the written documentation it required. As each document was received it was indexed and paginated. A chronology of critical events was compiled and is contained within this report, (section 7).

Presentations were received from senior managers in the Oxfordshire Mental Healthcare NHS Trust, Buckinghamshire Social Services, Buckinghamshire Mental Health NHS Trust and the Vale of Aylesbury Primary Care Trust. The purpose of these presentations was for the inquiry panel to gain an understanding of the services provided by the respective statutory bodies and their partners and to learn about their plans for future service development, together with providing an opportunity for all those present to meet the inquiry panel and discuss the Independent Inquiry process.

An informal meeting was also offered to the staff involved in Mr E's care to meet the inquiry panel and discuss how the Independent Inquiry would proceed. Due to an administrative error by the Trust this meeting did not happen.

A full list of the documentation considered by the inquiry panel can be found in Appendix 1 and this was provided to the Inquiry in a timely manner. However, although several individuals indicated whilst providing evidence that the community team recorded discussions regarding individual clients in a diary, despite several requests for a copy of any relevant pages relating to Mr E the inquiry panel did not see them.

Evidence was received from 24 individual witnesses both orally and in writing, over a period of five days during March and April 2006. Those identified for interview had either had direct contact with Mr E or undertook managerial responsibility for the local mental health service.

Representatives from related agencies such as housing were also seen. Each interview was recorded and the individuals were given an opportunity to correct the transcript for accuracy and to add any other information that might be of further help to the Inquiry. A further individual, who no longer worked within the local services was finally seen in June 2006 by two members of the inquiry panel. This person had played a pivotal role in the care of Mr E.

The inquiry panel made a visit to Frith Ward in the Haleacre Unit, Amersham, to gain a fuller understanding of the inpatient experience for Mr E and the working environment for the staff.

Mr E, his solicitor and current staff team were interviewed at the start of the Independent Inquiry.

The families of Mr D and E were interviewed by the inquiry panel at the start of the process so that their viewpoint could be understood and also that any concerns they had regarding Mr E's care could be investigated.

This report has been drafted to include a brief history of Mr E, detailed consideration of key periods in his care and treatment and the inquiry panel's findings and recommendations.

6. Profile of the Services

6.1 Mental Health Services

Since early 2004 the Buckinghamshire Mental Health NHS Trust (BMHT) had been working with Oxfordshire Mental Healthcare NHS Trust to bring together their management teams into a single team, in recognition of BMHT's size and inability to provide all the functions to the desired standard. The introduction of a single senior team was gradually introduced from March 2004 with the agreement to share a Chief Executive. Other Directors were appointed in July (Finance), September (Medical) and November (Clinical Governance) with the rest of the team in place by May 2005.

The two Trust Boards formally decided to apply to become a single Trust at their meeting in May 2005 and this received ministerial approval in March 2006. The Buckinghamshire Mental Health NHS Trust was dissolved on 31st March 2006 and its services combined with the Oxfordshire Mental Health NHS Trust to form a new organisation.

The new Trust now operates across both non-metropolitan counties of Oxfordshire and Buckinghamshire. Health and social care services are delivered through an integrated management structure.

The mental health services received by Mr E were delivered by the BMHT. With the exclusion of the Milton Keynes area, BMHT provided mental health services to the county of Buckinghamshire, which has a population of 495,000. The following is a summary of the relevant mental heath services provided to that local population at the time of writing. During the time of Mr E's contact with services, and subsequently, there have been many ongoing changes to both the community and inpatient services. This includes a Service Review as well as the establishment of new services such as an Early Intervention Service.

6.1.1 Inpatient care

The BMHT provided inpatient care at sites across the county totalling 82 acute beds, 10 of which were intensive care. The following units provide the Acute Adult Services: Haleacre Unit at Amersham Hospital, Amersham for the South Buckinghamshire inpatient service; the Tindal Centre and Manor House in Aylesbury for the North and Aylesbury areas of Buckinghamshire.

6.1.2 Community Mental Health Teams

There were six community mental health teams (CMHTs) operating in Buckinghamshire. The Chiltern CMHT covered the Chesham and Amersham areas and was linked into the local GP practice. Mr E lived within its catchment area.

The Chiltern community mental health team provided care for people with severe enduring mental illness and includes:

- community psychiatric nurses
- social workers
- psychiatrists
- psychologists
- and other related mental health care professionals

6.1.3 Assertive Outreach Service

The Assertive Outreach Service supports people who are severely mentally ill, have other care needs and who find it difficult to engage with mental health services. Care and support is provided to these people either in their homes or in other community settings as appropriate. The service was set up in the latter part of 2003.

6.1.4 Crisis Resolution and Home Treatment

This service provides intensive support to people in their homes during a period of acute illness and is available 24 hours a day, 365 days a year. A main part of the team's role is assessing people with a mental illness for admission as an inpatient, both informally and as a compulsory detention under the Mental Health Act. It was originally set up in 2003 but due to recruitment problems and capacity issues was dissolved and then re-launched at the end of 2004. The service also works closely with the newly reconfigured acute day hospital which provides daytime treatment and support seven days a week to people with a mental illness who would otherwise be admitted to hospital.

6.2 Recent Service Developments

6.2.1 Primary Care Mental Health Teams

In January 2006 three new Primary Care Mental Health Teams were launched which are being managed out of the Primary Care Trusts, (PCT's) for the Vale of Aylesbury, Chiltern and South Buckinghamshire and Wycombe.

The purpose of this new service is to provide help for people with mild and moderate mental health difficulties whilst at the same time underpinning delivery of the broader mental health prevention and social inclusion agenda.

6.2.2 Early Intervention Service

The Early Intervention for Psychosis Service was set up in 2005. This provides a specialist service for young adults, up to the age of 35, who present with a first episode of psychosis. The aim is to reduce the duration of untreated psychosis and focus on social inclusion, employment and family support.

6.3 Future Development of the Mental Health Services in Buckinghamshire

In September 2005, the three Primary Care Trusts (commissioners of the services) together with the BMHT launched a Public Consultation Document which set out a series of proposals for the development of mental health services in Buckinghamshire.

The main proposal was for a review of inpatient beds and the development of a purpose built inpatient unit in Aylesbury, which would incorporate the two units already in existence there. To balance the reduced number of inpatient beds the proposal includes a higher investment into home and community treatments.

Other service developments include a reduction in inpatient rehabilitation beds as a direct result of a recent increase in community based services; the development of community based services for older people who have been in receipt of long term inpatient care; a different way of providing services for younger people suffering from Alzheimer's disease and alternative daytime activities to older people in North Buckinghamshire to replace the day service there.

6.4 Housing

In 1988 the District Council transferred the management and maintenance of its housing stock to Chiltern Hundreds Housing Association (now known as Paradigm Housing). The Council continues to have responsibility for determining the housing strategy and policies on eligibility criteria (including those for people requiring supported accommodation); these are then administered on its behalf by Paradigm Housing.

Social housing is allocated in accordance with the Council's Housing Allocation Policy. When an application is made by an individual suffering with a mental illness as well as going through the normal allocation process, Paradigm Housing consults with the relevant agencies involved with that individual to assess their priority of need and the type of housing required. Further consultation takes place prior to the housing offer, once available, to ensure it is the most appropriate.

Currently there are three properties in the Chiltern district, Mr E's local area, which offer temporary accommodation:

- A block of 20 self contained bed-sits and flats
- Two houses of six bedsits each with a shared bathroom and kitchen facilities in each house.

7. Chronology

7.1 Background- Early Years

Mr E was born in 1982 and grew up in Great Missenden, Buckinghamshire. His mother managed as a lone parent for 2 ½ years until she remarried. Mr E has a younger half-brother.

When Mr E was five years old his mother fell down the stairs and sustained a broken neck. Mr E became very anxious and concerned about his mother following the accident. It was also reported that following the birth of his natural son, Mr E's stepfather became physically abusive towards him. The marriage eventually broke down when Mr E was 9 or 10 years old and Mr E's mother left her husband taking both boys with her. Mr E has not been in contact with his stepfather since that time.

In 1990 the family GP referred Mr E aged seven years for a psychological assessment as his mother was concerned about his behaviour and the deteriorating relationship with his stepfather. Mr E attended several treatment sessions both alone and together with other family members during the next six years as a result of re-referrals to the service including a referral in 1995. However in 1996, when Mr E was 14 years old, these sessions were discontinued as he was becoming difficult to engage. The Department of Child Mental Health finally closed his case in 1997.

No formal psychiatric diagnosis was made but there was a recognition of his difficulties and his need for intervention from Child and Adolescent Mental Health Services.

During his school years it was reported that he had been bullied at school and was an anxious and agitated child. He attained six GCSEs and commenced his A-levels at school. The school authorities excluded him after he hit a fellow pupil. He then completed a two-year Btech National Diploma in Performing Arts at Amersham College.

In 1999 when he was 17 years old, Mr E's mother reported to their GP that he had started to use cannabis and was occasionally angry and depressed.

He obtained work as a barman in Amersham in 2000 and sometime during this year left home to live in lodgings in the town staying at this accommodation for approximately three years. It is reported that at the end of this period Mr E was asked to leave the lodgings by his landlady as he had 'gone berserk' and that the other residents were 'terrified of him'.

In 2003 Mr E moved to a hostel for the homeless in High Wycombe.

7.2 Referral to Mental Health Services

2003

Mr E was first referred to mental health services in February 2003 by one of the GPs in the practice as he was reported to be experiencing mood swings, with some aggressive behaviour and possible paranoia. The GP prescribed oral risperidone 1 mg twice daily (an anti-psychotic medication), which was dispensed during February to April. The following week Mr E was seen by his own GP who referred him to the mental health services.

In June Mr E again visited his GP. Mr E had not received an appointment with the mental health service so the GP made a second referral on 22nd June 2003. He reported that Mr E had become non-compliant with medication and his mental state had deteriorated. The practice carried on prescribing oral risperidone.

An appointment was arranged for Mr E to see a locum Consultant Psychiatrist with the CMHT on 8th July. At that appointment Mr E was provisionally diagnosed as suffering from an "acute predominately delusional psychotic disorder". (ICD10 F23.3). The psychiatrist advised an increase in the risperidone to 4 mg at night. A letter sent by the locum Consultant Psychiatrist to Mr E's GP noted that Mr E had a wide range of persecutory delusions and auditory hallucinations. A further review was arranged for 5th August 2003. Mr E's GP prescribed his risperidone in June, July and September. Nothing was noted for August in the GP records.

There is no record that Mr E attended this outpatient appointment as during the summer he took a temporary job in the Scilly Isles where he attended the A & E department of the local hospital on 1st October. He presented with abdominal pain and admitted overnight. The admission assessment form recorded that the "the local people had noted inappropriate and strange behaviours". He was discharged from hospital after one night's stay and asked to see his own GP if he had any further problems. It was also reported that he believed a girl was controlling his emotions and feelings.

Soon after this admission, Mr E returned from the Scilly Isles to Buckinghamshire. Mr E is reported to have lived in a tent in local woods for a short period before moving back home with his mother and brother. During this time he believed that "James" was inside his head controlling him.

On 28th October Mr E saw his GP who re-referred him to the mental health service as he had been non-compliant with his medication and presented as tearful and depressed. His GP agreed to continue monitoring Mr E until the outpatient appointment took place and he restarted treatment with risperidone. The outpatient appointment was subsequently arranged for 13th November with the locum Consultant Psychiatrist.

However, on the 1st November Mr E's mother contacted the Social Services Emergency Duty Team. She was profoundly concerned as her son appeared to be experiencing strong paranoid ideas in relation to his half brother and had broken his computer and thought that his half brother's thoughts were "destroying" him. Mrs E was advised to contact the GP 'out of hours service' and was advised by the doctor there to give Mr E two extra risperidone tablets and to contact them again if the situation deteriorated.

Mr E's GP re-referred him to the mental health service and he was assessed by the Community Psychiatric Nurse (CPN) linked with the practice on the 3rd November. The CPN recorded that Mr E believed his half brother was tampering with his thoughts and playing mind games with him. Mr E denied hearing voices and did not wish to be admitted to a psychiatric hospital but did eventually agree to do so.

Following the assessment, arrangements were made for an informal admission to Firth Ward, Haleacre Unit at Amersham Hospital. On the ward it was reported that Mr E tested positive for cannabinoids and he brought into the ward cannabis and alcohol which he knew to be in contravention of ward policy. During this admission his medication was changed to depot risperidone 25 mg two weekly by intramuscular injection.

From the records to which we had access, it was not possible to identify the precise time and date when Mr E was discharged but it is assumed this followed a CPA meeting, which took place on Frith Ward on Friday 9th January 2004. The meeting was attended by a care manager, rehabilitation officer, Mr E and his mother, the locum Consultant Psychiatrist and other ward staff. The referral from the SHO to the CMHT stated that "identified needs are lack of insight, so risk of stopping meds and becoming unwell, also other difficulties causing stress, including lack of employment and financial difficulties and no accommodation. Needs CPN for support and to help insight". The referral was identified as "semi high priority".

It is reported that Mr E was insistent that he left the ward that day despite the fact that the accommodation arranged for him was an unfurnished bedsit with only a fridge. His mother provided a mattress and some bedding for him. Arrangements were made for the care manager to visit him weekly for the first month; for the rehabilitation

officer to visit weekly and for the CPN to administer his depot injection on a two weekly basis.

The discharge date is recorded in the records as 12th January and the discharge summary states that "Mr E can become deceptively unwell and become significantly paranoid about others. This poses a risk of harm to those he is paranoid about. He is no risk of harm to self". It was also recorded in the records by the care manager/coordinator that "when/if Mr E feels he is becoming unwell, he or his mum will make contact with services, e.g. GP/Out of Hours/CPN/Consultant Psychiatrist/Crisis Team. Mr E is aware of the contact numbers".

January – April 2004

During this four-month period there was minimal contact with Mr E despite the numerous attempts by the three professionals involved in his care. The CPN appeared to be the only person who did manage to see him but this was spasmodic although she did manage to administer his medication on 22nd of January and 5th February. He was due for a further injection on 19th February but was not contactable. It appeared that he was actively avoiding contact. Mr E's mother was aware of the situation and tried to encourage him to meet staff and comply with his treatment plan.

The CPN referred Mr E to the Crisis Team on 4th March, requesting that he be assessed for admission to hospital. It was agreed that this would take place the next day.

On 24th March the CPN made a referral to the Assertive Outreach Team after discussing her inability to contact Mr E with his locum Consultant Psychiatrist.

On 5th April Mr E's mother reported to the GP that Mr E was feeling suicidal and a home assessment was arranged for the Crisis Team, but it did not take place as it was not possible to contact Mr E.

On 14th April Mr E's mother accompanied him to his GP as he had smashed up his room, appeared distressed, not eating or sleeping and was smoking cannabis and using alcohol.

A Mental Health Act assessment was arranged for the following day attended by Mr E's GP, the locum Consultant Psychiatrist and an Approved Social Worker. Mr E did not meet the criteria for detention under the Mental Health Act 1983 and he was unwilling to be admitted informally. It was noted that at the time of the assessment he was intoxicated with alcohol.

The CPN made a referral to the Crisis Team but they were unable to establish contact with him throughout the remainder of the month. Also

at this time, his mother reported to the care manager that he had started to smoke cannabis again.

On 26th April a CPA review, attended by Mr E and his mother, the CPN, GP, Care Manager, Rehabilitation Officer, and locum Consultant Psychiatrist took place. He reported that he felt fine and denied any paranoia. His care plan was updated by the CPN and set out the following:

- Mr E to continue to attend his outpatient appointments.
- his mother to administer his medication on a weekly basis.
- The Care Manager to continue to provide support.
- The Rehabilitation Officer to visit fortnightly and help with shopping, budgeting and home management.
- The CPN to visit fortnightly to provide support, monitor his mental state, and the side effects of his medication.
- Mr E to reduce his consumption of alcohol and to be aware of the dangers of cannabis use.

May 2004

Mr E's GP contacted the Crisis Team on 1st May and asked them to contact Mr E's mother who was going to discuss arrangements for their assessment of her son. In the event Mr E did not answer his mother's telephone calls and she was therefore unable to help set up a meeting for him with the Crisis Team.

On 4th May the locum Consultant Psychiatrist considered that Mr E should have a Mental Health Act assessment as he had again smashed up his room, been drinking heavily and had run out of money. The Crisis Team were contacted to assess Mr E for a hospital admission. The Crisis Team were unable to contact Mr E and his CPN agreed a care plan with him to avoid a hospital admission. It was arranged that the Crisis Team would visit Mr E on 6th May.

The Crisis Team were unable to meet Mr E as arranged on 6th May as they had another priority but did agree to see him later that evening. It was decided later by the Crisis Team that he did not meet their criteria so they were unable to assess him. The CPN protested at this decision and again the Crisis Team agreed to assess Mr E.

Also on 6th May the CPN received a letter from the Assertive Outreach Team stating that following consideration of the referral made in March, Mr E did not meet their criteria as he had not been disengaging with services for a period of six months or more.

It was discovered by the CPN on 10th May, that Mr E still had not been assessed by the Crisis Team. During this period Mr E had also been

prescribed oral medication instead of an intramuscular injection (depot).

On 13th May Mr E was seen by the CPN. He reported that he felt low and lonely but he had been offered a job at a petrol station.

On 17th May Mr E attended the MARES community project with the CPN. He reported having enjoyed his session there but was unable to attend again as the scheme was discontinued.

On 21st May Mr E was cautioned by the police for shoplifting. Mental health services were not informed of this at the time. On 24th May the CPN visited him and he appeared well and more relaxed. On 25th May Mr E was seen by the locum Consultant Psychiatrist in outpatients with a plan to review him again on 19th August 2004.

June 2004

During June Mr E's pattern of non-engagement continued. The CPN did manage to meet him once during the month and he visited his GP on the 18th. He reported feeling calmer and was taking his medication. However he did not keep his appointments with the CPN on 9th and 22nd June.

The Care Manager wrote to Mr E on the 22nd June expressing concern about her lack of communication and inability to establish contact with him. On 30th June Paradigm Housing contacted the Care Manager as they had concerns about Mr E's personal hygiene. It was reported that he was unkempt, wearing dirty clothes and generally dishevelled.

July 2004

The CPN made contact with Mr E on the 1st when he reported feeling 'okay' but she noted that his bedsit was 'dishevelled'.

Throughout July there were concerns expressed by Paradigm Housing in regard to Mr E's hygiene; they contacted the care manager three times reporting that Mr E was unkempt and smelt of faeces and was known to be in debt.

A replacement microwave was provided as the door on the original one had been broken. Mr E was reported as forgetting that he had put food on to cook and that it was getting burnt.

On 23rd July the Care Manager recommended that the CPN re-refer Mr E to the Assertive Outreach Team. The Care Manager and the CPN agreed that if Mr E continued to disengage then a case conference would be arranged. On the 27th a planned CPA meeting was cancelled (by Trust) and rescheduled for 10th August 2004.

August 2004

On the 1st August Mr E was arrested and charged with the murder of Mr D.

8. Analysis of the Evidence

8.1 Childhood and Adolescence

As a child Mr E was described as anxious and sensitive. The relationship with his stepfather broke down once his half-brother was born. It was reported that up until this time Mr E and his stepfather had a caring, loving relationship. However after the birth of his half-brother Mr E's mother was unwell and most of the caring for the baby fell to his stepfather.

This apparently had a profound effect on the family relationships and the stepfather became physically abusive towards Mr E. His mother became concerned about Mr E's behaviour and this deteriorating relationship and asked the family GP for help. Mr E was referred for a psychological assessment when aged seven and both he and his family attended various family therapy sessions together and separately until the marriage broke down and Mr E's mother and stepfather separated. The sessions continued intermittently until Mr E was 14 years old when it was agreed that further individual sessions would not be offered to him and the case was formally closed the following year.

There was no diagnosis made during this period except that Mr E remained an overanxious, sensitive child who was prone to be bullied by his peers and seen as a "loner". It was reported that Mr E started to use cannabis aged 17 years old but how much or how frequently is not known.

Throughout this extended period of intermittent contact with services there seems to have been good interagency working together. There was a thoughtful analysis of Mr E's problems and although the Child and Adolescent mental health professionals did not reach a psychiatric diagnosis they did recognise his needs and attempted to facilitate understanding and offer support to Mr E and his family. Mr E's GP played a pivotal note in these service contacts.

8.2 Initial Referral to Adult Mental Health

When Mr E, accompanied by his mother, visited the GP in February 2003 complaining of mood swings, aggressive outbursts and possible paranoid behaviour the GP was concerned enough to make a referral to the mental health services and prescribe risperidone 2 mg, an anti-psychotic medication. It was known at the time that Mr E was using cannabis and drinking alcohol and that he had been asked to leave his lodgings in Amersham as he had reportedly "gone berserk" and the other residents were "terrified" of him.

It was considered by the inquiry panel that the GP's assessment and diagnosis of a possible schizophrenic illness was accurate as was his prescription of risperidone. It was entirely appropriate for a referral to have been made to the mental health services. In addition, without specifically stating that Mr E posed a risk, the GP gave a warning in his referral to the mental health services in which he referred to an "aggressive outburst".

In June 2003 Mr E again visited his GP. He had stopped taking his medication and it was observed that his mental state had deteriorated in the intervening months. He had not had any contact with the mental health services.

The family GP re-referred Mr E, as an urgent referral, to the mental health services. He was offered an appointment with a locum Consultant Psychiatrist in July 2003. This was five months after the original referral. It is unclear as to what happened to this initial referral. None of those interviewed from the local mental health services were aware of the referral. A copy of the referral letter was found in Mr E's GP notes but not in his mental health records and it has to be assumed that without further evidence to the contrary that the mental health services never received this referral.

With further exploration the inquiry panel found that in his letter to the GP, dated 10th July 2003, following Mr E's first appointment, the locum Consultant Psychiatrist implied that he had had a copy of the February 2003 referral letter but it is not clear when this letter was received by the Trust and what action was taken following its receipt.

On exploring the system used when referrals were sent to the mental health services, the inquiry panel were informed that the CMHT had a system whereby each referral that came in was entered into a referral book and then discussed and allocated to the appropriate professional at a weekly meeting. Despite repeated requests the inquiry panel were not able to access these documents and therefore it was not possible to ascertain whether the letter had been seen or not.

When Mr E was seen by the locum Consultant Psychiatrist on the 8th July 2003 he reported that he was leaving his accommodation because his friends there were "winding him up and making him angry. They were discussing him and saying nasty things about him". He also reported that after moving to High Wycombe he could hear people talking about him through the walls.

This report should have alerted the professionals that he could pose a risk to others. At the time no-one explored the statement that he had "gone berserk".

In that same outpatient assessment the locum Consultant Psychiatrist diagnosed Mr E as suffering from an "acute predominately delusional psychotic disorder". (ICD10 F23.3) His risperidone medication was increased to 4 mg daily.

The letter from the locum Consultant Psychiatrist to the GP also noted that Mr E had presented with a wide range of persecutory delusions and auditory hallucinations. He denied use of alcohol or illicit drugs. The locum Consultant Psychiatrist referred him for a drug screen and other tests including liver function tests. These were subsequently found to be normal.

A further review appointment was arranged for four weeks time on 5th August 2003. There was no plan for a referral to the CMHT at this time.

The inquiry panel were unable to establish in the records provided whether, or not, Mr E did attend the appointment. Although it is known that Mr E took a summer job in the Scilly Isles, the inquiry panel were unable to identify the exact dates that he went and returned. Little is known about this period in Mr E's life. Neither his mother nor Mr E can recall where he went in the Scilly Isles, what he did there nor the date he returned to the mainland. It has to be assumed that he did not attend his outpatient appointment on 5th August.

It does appear that during this period he disappeared from the service radar. There is no record of him taking his medication or of any follow up from either a GP or mental health services in the Scilly Isles. No information from the Scilly Isles was given to the GP, and it has to be queried whether Mr E informed the Scilly Isles' services of his illness and medication requirements. In addition there is no evidence that the mental health services in Buckinghamshire sought to find him during this period.

On questioning by the inquiry panel the locum Consultant Psychiatrist who saw him in July 2003 expressed surprise on hearing that Mr E had left Buckinghamshire later that summer and it appears to the panel that no health professionals were aware of his re-location.

Mr E was reported to have returned to Buckinghamshire in early October where he lived in a tent for several weeks in woods before returning to live with his mother and half brother. His mother reported that at this time he appeared unwell and that she took him home as he needed looking after.

At the end of October 2003 the family GP again referred him to the mental health service for an assessment as he had stopped taking his medication at some point since being seen by the locum Consultant Psychiatrist on the 8th July 2003 and he was tearful and depressed.

His GP continued to monitor his mental state until his outpatient appointment with the locum Consultant Psychiatrist on the 13th November 2003. The GP restarted risperidone 1 mg, increasing to 1 mg twice daily and also saw him with his mother at several of these appointments.

In the event Mr E's mother contacted the emergency duty team (EDT) on 1st November 2003 as he was experiencing paranoid ideas about his half brother and had threatened him. It doesn't appear that the EDT took into account his previous contact with the service and the staff advised his mother to contact the out of hours GP service.

The out of hours doctor advised Mr E's mother to give him two extra risperidone tablets and to contact them again if the situation deteriorated. At the time of writing, the Crisis Team would now be contacted for emergencies and involved in any Mental Health Act assessments.

Two days later Mr E was assessed by the CPN linked to the family GP practice at the request of the GP and he was admitted as an informal patient to the Haleacre Unit at Amersham Hospital.

8.3 Admission to hospital

Mr E was an inpatient for approximately 10 weeks during which time the overriding impression given by those interviewed was that Mr E was seen as a complex young man who was rather troublesome to manage. It was reported that he could be intimidating to ward staff, often standing close to them or blocking doorways. (Mr E was over six feet tall with long hair and a beard). Whilst an inpatient, Mr E continued to take illicit street drugs and alcohol to excess (in contravention of explicit ward policy) at times bringing these onto the ward from his contacts in the community. The clinical team were preoccupied by the behavioural effects of Mr E's substance misuse rather than – and perhaps at the expense of – his underlying mental illness.

During Mr E's stay, he was found positive for cannabis on three occasions following drug screening. Only once did he test negative. On 9th November he went missing from the ward and on his return did test positive for cannabis. Twice he was found to be alcohol intoxicated, 27th November 2003 and 26th December 2004. He was also found to be providing other patients with cannabis and using it in the ward garden.

Due to his continued use of cannabis and alcohol, the staff approached the locum Consultant Psychiatrist to discuss an early discharge as per their zero tolerance policy on illicit drugs on the ward. The locum

Consultant Psychiatrist, on discussing this with the inquiry panel, stated that he considered Mr E to be vulnerable and in need of treatment as a inpatient and was not prepared to discharge him at that time.

Mr E's mother reported that she was not consulted about her son's treatment and care plan, even though he had indicated that this information could be shared with her. There is no record of any in-depth discussions with Mr E's mother who had throughout made a significant contribution to her son's life.

The inquiry panel acknowledge that there is a tension that staff have to manage between a patient's right to confidentiality and discussion with family members. However the balance was not struck on this occasion and an opportunity lost to gain a better insight into Mr E's condition and background from his mother.

During the period of Mr E's treatment, inpatient services seemed to be lacking in structure, both for the inpatients and staff. The Multi-disciplinary team working was not well developed with only doctors and nurses essentially having input to the patient's treatment. It was identified that at the time of Mr E's admission, the ward was experiencing staff shortages and were using agency nurses to fill in the duty rotas.

There were very few therapeutic activities available on the ward and the impression gained by the inquiry panel was that patients were left to their own devices. There was little indication of any effective engagement between Mr E and the ward staff, although several of those interviewed remembered him well. The inquiry panel also heard that staff training was limited due to the general staffing difficulties.

Of concern to the inquiry panel was that while Mr E was an inpatient the Senior House Officer (SHO) on the ward referred in writing to his diagnosis as one of paranoid schizophrenia, and his discharge summary dated 12th January 2004 refers to his diagnosis as paranoid schizophrenia ICD10 F23.0. In relation to a risk assessment the SHO stated on discharge that Mr E "can become deceptively unwell and become significantly paranoid about others. This poses a risk of harm to those he is paranoid about. He is no risk of harm to self". This clearly indicates that there could be a risk of harm to those he is paranoid about and does not appear to have been considered during his contact with the community services.

8.4 Discharge from hospital

From the records available to the inquiry panel it was not possible to establish the exact date that Mr E was discharged from Frith Ward, Haleacre Unit as both the 9th and 12th of January 2004 are recorded.

It is however known that a CPA review took place on Friday 9th January 2004 with a view to discharge Mr E on 12th January 2004. The CPA review meeting was attended by ward staff, Mr E and his mother, the locum Consultant Psychiatrist, a care manager and rehabilitation officer. The CPN, to whom he was allocated, was not present as she was on leave at the time. Evidence provided to the inquiry panel indicated that Mr E insisted on being discharged at that meeting. There had been some discussions prior to the CPA review meeting in relation to Mr E's homeless state and an unfurnished bedsit had been found for him to move into. However his insistence in moving in on that day resulted in him being discharged to an unfurnished bedsit that only contained a fridge. His mother provided him with a mattress and bedding. Over the next few days he begged and borrowed some other items but the bedsit remained very sparsely furnished throughout the time he lived there.

It is accepted that Mr E rushed through his discharge and that it was difficult to obtain furniture on a Friday afternoon. However it is not clear whether any attempt was made after the weekend or subsequently to obtain additional furniture and furnishing for the bedsit other than a microwave, which was later obtained by the care manager.

The inquiry panel were informed that there were several schemes in operation at that time that would have been able to help furnish the bedsit.

Discharge planning should commence as soon after admission as possible. A care plan early in his admission, 28th November 2003, stated that he had been informed that he was no longer welcome to reside at his mother's address and that a care manager was being appointed to identify accommodation appropriate to his needs. A subsequent record of a meeting held on 12th December 2003 noted *"chase ASW. Needs housing".* It is the view of the inquiry panel that adequate preparations were not made for his eventual discharge.

At the CPA review on 9th January 2004 a care plan was agreed whereby the care manager was to visit Mr E weekly for a month, the rehabilitation officer to visit once a week and for the CPN to administer the depot injection on a 2 weekly basis. The inquiry panel were informed that these three professionals were allocated to meet Mr E's perceived care needs. There was no mention of a contingency plan if

these arrangements were not met, with the exception of a note that "Mr E can also contact his GP during the evening or weekend".

It is clear from the evidence received that there was a lack of clarity in relation to the allocation of a care coordinator with both the CPN and Care Manager assuming they had this role. Without adequate supervision and liaison between the professionals these issues were never identified or addressed.

8.5 Contact with the Community Mental Health Services

January – May 2004

From the time of Mr E's discharge from hospital there were difficulties with engagement. The CPN was often unable to give him his depot injections as he failed to keep appointments. Mr E's mother tried to help the community team by acting as an intermediary and setting up meetings, keeping the team informed of Mr E's mental state by telephone and via her GP.

The CPN had little contact with Mr E after she saw him on 5th February 2004 and he had had his second and last depot treatment in the community. She took several steps to contact him but had continuing difficulty engaging with him. In April she discussed these difficulties with the locum Consultant Psychiatrist and it was agreed to refer him to the Assertive Outreach Team and the Crisis Team.

There were a number of attempts by the CPN to gain additional support for Mr E. On 5th April 2004 the CPN referred him to the Crisis Team asking for him to be assessed for admission to hospital but due to reasons we were unable to discover he was not assessed by the Crisis Team on that date.

Further attempts by the Crisis Team to assess Mr E also failed as they were unable to establish contact with him even when he was reported as feeling suicidal by his mother. The Assertive Outreach Team, did not assess Mr E, because they determined he didn't meet their criteria as he had not been difficult to engage for a period of at least six months.

New teams such as the Assertive Outreach, Crisis and Home Treatment and Early Intervention have been developed in response to the needs of people who use services and in the growing awareness of evidence based practice. While the local development of these newer services is endorsed and required by national policy, care needs to be taken in the way newer models of care and treatment complement each other and are integrated with the more traditional services.

The inquiry panel considers that Mr E and those working with him were not appropriately supported by either the Assertive Outreach or by the Crisis Teams. The Assertive Outreach Team declined the referral of Mr E because he did not meet one of their criteria, that people referred should have been in contact with a CMHT for at least six months. Whilst the inquiry panel recognise concerns that this relatively new team might have become overwhelmed by the volume of referrals, the inquiry panel feel that this response showed a lack of flexibility and disregarded the main issue, that Mr E was not engaging with his CMHT workers and was not concordant with his prescribed anti-psychotic medication. Similarly the Crisis Team did not carry out an assessment of Mr E although they had originally agreed to do so.

A Mental Health Act assessment took place on 15th April at the request of the family GP. Mr E had been seen by the GP on the proceeding day, when accompanied by his mother, it was reported that he had smashed up his room, appeared distressed, was not eating or sleeping and was smoking cannabis. At interview he was intoxicated and denied that he was ill. His feet were "smelly and dirty". He "agreed to take his medication and give access to the professionals". His mother was willing to give him his medication. There were a number of risk factors identified but they did not include risk to others.

Given this information it would not have been possible to proceed with admission under the Mental Health Act and Mr E was not willing to consider admission as an informal patient. It was decided that he did not meet the criteria for a compulsory admission.

Mr E attended a CPA review on 26th April 2004 along with his mother, the locum Consultant Psychiatrist, the CPN and Care Manager. He was not paranoid at the time, but was noted to have problems with excessive alcohol intake and drug intake. It was agreed that he would continue on treatment with risperidone 4 mg at night.

Four weeks later the locum Consultant Psychiatrist wrote to the GP that he had seen Mr E in the clinic on 25th May 2004 when he attended with his mother. He reported taking his medication (risperidone 4 mg) regularly and that "things have improved". According to both his mother and Mr E, when he was unwell he abused Cannabis; when he was not taking Cannabis, his mood was "fine" and he did not have any psychotic symptoms. The locum Consultant Psychiatrist agreed to reconsider Mr E's diagnosis at the request of Mr E and his mother. This was now recorded as a mental and behavioural disorder due to use of cannabinoids (schizophrenia-like) ICD10 F12.IX.50. He admitted using Cannabis two weeks previously, and agreed not to in the future. A follow up appointment was made for August 2004.

During May there appeared to be a mix of engagement and non-engagement. It was also during this period that he was cautioned by

the police for shoplifting. The services were not informed of this incident. When seen by the CPN a few days later she reported that he appeared relaxed and well.

June – July 2004

During this period there were concerns expressed about Mr E from various sources although the reports remained inconsistent. His mother was stated as being particularly worried as she considered he was not taking his medication.

- He failed to keep three appointments with his CPN and when she did manage to see him he assured her that he was taking his medication.

- 18th June he saw his GP and reported feeling calmer, taking his medication and seeing the CPN.

- 22nd June the Care Manager wrote to Mr E regarding his lack of communication and her inability to meet with him.

- The housing association complained to the Care Manager about Mr E's lack of personal hygiene, that he was unkempt and smelt of faeces in June and July. There is no record of the Care Manager following this up although he was reassessed by the CPN who reported that his bedsit was unkempt.

There appeared to be an escalation of concerns expressed about Mr E during the latter part of July. It was reported by the housing association that he was putting food on to cook and then forgetting it, that he was finding food in bins outside fast food restaurants and bringing this back to his room. His non-engagement with the mental health services continued.

At this time those involved in his care decided that if the non-engagement continued then they would hold a case conference and also consider re-referring him to the Assertive Outreach Team.

It does seem apparent that the services were now concerned about Mr E's deteriorating condition and that the CPN, in particular, was attempting to gain additional support for him.

However a planned CPA review for 27th July was cancelled and rescheduled for the 10th August 2004 by which time Mr E had been arrested and charged with the murder of Mr D.

During this period his presentation varied at times, for example when he was seen by the CPN or Care Manager, his mental state seemed relatively stable and he reported taking his medication. At other times

he was chaotic, not keeping appointments and damaging his flat in addition to using illicit drugs and taking alcohol.

It is the view of the inquiry panel that one of the difficulties regarding Mr E's care was that staff struggled to develop a therapeutic relationship with him which made it harder to identify when his mental state was deteriorating. It is also considered that staff did not engage as fully as possible with Mr E's mother.

8.6 Diagnosis and Management Plan

In February 2003, when Mr E was seen in primary care, no formal diagnosis was made, but the two GPs who saw him found features of a psychotic illness and started treatment with anti-psychotic medication and at the same time referred him to secondary care mental health services. It appears that Mr E was very troubled by symptoms which could be seen as suggestive of a serious mental illness.

During the week prior to the homicide the community team were beginning to have concerns in relation to Mr E and the treatment plan. The scheduled CPA review which was cancelled might have enabled the team to review his care and plan a different treatment plan. However the homicide took place before this could occur.

A diagnosis of paranoid schizophrenia was established during the ten week admission in hospital which was complicated by his use of illicit substances. His treatment with risperidone was appropriate. However there were difficulties in administrating the depot injection and when he was placed on oral medication it was not possible to assess how compliant he was in taking this.

No consideration was given to a psychological intervention for his schizophrenia nor a more active approach taken for his substance misuse, but the inquiry panel do recognise that he might have been difficult to engage in such processes if they had been offered.

The locum Consultant Psychiatrist revised the diagnosis in May 2004, at the request of Mr E's mother, in an attempt to engage better with Mr E and his mother. Neither of them was comfortable with a diagnosis of paranoid schizophrenia and the locum Consultant Psychiatrist considered that it was reasonable to change his diagnosis if it led to better engagement with the mental health services and to continue with the same treatment plan. The inquiry panel acknowledge this attempt by the locum Consultant Psychiatrist to listen to his patient and his carer.

8.7 Communication between and within Teams

Within the CMHT there was a single manager for the team but the different professionals within that team were situated in separate rooms. They met together at a weekly team meeting.

The patient/client records were not integrated at the time of Mr E's care and different electronic systems for the separate services were in place which were not totally compatible. Indeed the inquiry panel found it difficult to align the records provided to them and it must be queried how the staff kept themselves up to date with the contacts made with Mr E by their colleagues.

The inquiry panel were also informed that the three professionals allocated to provide Mr E's care all worked different rotas and were not working on the same days as each other which further complicated communication.

The difficulties experienced by the CPN in requesting assessment and support from both the Crisis and Assertive Outreach Teams seemed to be compounded by the lack of a process to discuss the referrals. Whilst the inquiry panel recognises that individuals do not always fit the criteria for services they were concerned that the CPN requested help from these two specialist teams to deal with someone with complex needs, but this input was refused without any recourse to further discussion.

8.8 Leadership and Clinical Accountability

From the evidence provided to the inquiry panel it became apparent that at the time of Mr E's contact with the mental health services the clinical and management leadership in the local service was not strong.

The difficulties in the interaction of the teams with the practical communication shortfall, the problems relating to separate notes are both systems issues and problems for individual professionals.

The inquiry panel considers that there were failures in nurse leadership. Mr E's CPN recognised that Mr E was not engaging with her and that he was not regularly accepting his anti-psychotic medication. She was not adequately supported in her attempts to provide Mr E with a more intensive service through the Assertive Outreach and Crisis Teams.

In addition it was evident that the CPN was not supported after the homicide and was understandably distressed at the events that took place.

The inquiry panel is aware that the Trust has been through structural changes as detailed earlier and was likely to become part of a larger organisation with the consequential effects on senior staff, which filters down to all staff.

At the time of Mr E's care there were a significant number of consultant posts that did not have a substantive Consultant Psychiatrist in that position. It was acknowledged that the community mental health services were in need of redevelopment and modernisation to address aspects that could be considered to have a potentially adverse effect on service delivery. Locum Consultant Psychiatrists were not part of a peer group and so were working, to a degree, in isolation. This has now been addressed by the Trust and any locum now appointed is assisted to join a peer group by their colleagues.

An appraisal process is currently in operation and monitored by the Trust's Medical Director but was not available in 2003/4. In addition the distribution of consultant workload has been changed to be directly proportional to the amount of time that each is contracted for, thus ensuring equity of workload.

8.9 Clarity regarding Roles and Responsibilities

It is the responsibility of the care co-ordinator to coordinate the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree them. This includes the crisis and contingency plans. Regular contact with the service user should be maintained and their progress monitored whether they are in hospital or at home. If a service user who remains vulnerable refuses to take part in the CPA process then all steps should be taken to find out why and to continue to try and engage them.

There was confusion as to which member of the community staff was responsible for the co-ordination of Mr E's care. The inquiry panel did not have access to all of the ways in which the team worked (such as the meetings notes), but is not confident that there were the systems in place to review individual care such as changes to care plans, either multi-disciplinary review meetings or one to one supervision.

It was reported that the population within the team's catchment area was described as one which had individuals with complex needs and it did not appear that the staff (especially agency staff without mental health experience) had the most appropriate skills or training to meet those needs. These complex needs included mental illness together with substance misuse and social care needs.

8.10 Dual Diagnosis

It is well known that people with mental illness are significantly more at risk of substance misuse than those in the general population. We saw no evidence that this factor was considered when arrangements for Mr E's discharge were being considered, although expert help was available locally.

It is also recognised that individuals do self medicate using illicit drugs or alcohol. It is our impression that staff, particularly on the inpatient unit, struggled to recognise the impact of illicit substances on individuals suffering from mental illnesses.

A substance misuse service operated within the area but the onus for treatment was on the individual. It was evident that there was a lack of training and supervision for staff in working with individuals who had a dual diagnosis.

A zero tolerance policy was in operation on the inpatient unit but the inquiry panel felt that the nursing staff saw Mr E's use of illicit drugs and alcohol as justification for him being discharged from hospital. It considered that some members of staff were preoccupied with the issue of whether Mr E's drug use was the primary problem, rather than whether his drug use might have been an attempt to self medicate. While this issue is of importance in terms of relapse prevention, the priority was to treat his psychosis. The inquiry panel felt that some staff believed that a history of substance misuse somehow made a patient less deserving of appropriate care and treatment and saw Mr E in a negative way because of this.

8.11 Housing

The inquiry panel heard evidence of arrangements made by the District Council for providing housing and supported accommodation to vulnerable people. It is acknowledged that arranging housing can take time and needs careful planning.

It was evident from the date of Mr E's admission to the inpatient unit that he could not be discharged to his mother's home. The inquiry panel was informed that there was a lack of supported housing in the area and that some bed and breakfast accommodation was available in Slough, just over the Buckinghamshire border. However, this was not considered suitable for Mr E.

The impression given was that frontline staff responsible for arranging Mr E's discharge (particularly those on the inpatient unit) had only a

limited grasp of how this system operated and what might be available for patients with Mr E's needs on discharge.

With the benefit of hindsight, the accommodation provided for Mr E was not the most appropriate as it became clear that he was not able to adequately care for himself. Although this was recognised early after his discharge there was no consideration of possible day care options.

The resources allocated, both human and physical, did not meet his evident needs. For whatever reason, the discharge plan made on behalf of Mr E was not adequate.

8.12 Joint Commissioning

In recent times the Local Authority and health bodies have worked hard with their partners to put in place robust arrangements for the joint commissioning and delivery of integrated services. However, at the time of this incident their development was in its infancy so, at best, working arrangements were operating in parallel rather than joint. For example

- although based in the same building, staff from different professional groups (particularly social workers and nurses) were located in separate rooms rather than the multi-disciplinary teams being based within the same team

- integrated case records had not been introduced

In addition the lack of a range of housing with different levels of support suggests a failure of joint commissioning to develop a housing strategy with the relevant agencies.

8.13 Carers

Mr E's mother played a major role in supporting her son. She took responsibility for his medication and reporting his mental state to the relevant professionals. It was at her instigation that he first visited the GP and his subsequent initial contact with the mental health services made.

Despite this involvement and her son's permission for his mother to be kept informed regarding his illness, she was marginalized. The inquiry panel heard that both the inpatient unit and community staff considered that Mr E should become more independent thus minimising any information provided to his mother.

There was no discussion in regard to updating Mr E's care plan even though his mother should have been considered as his primary carer. However she did attend the CPA reviews.

A carers' needs assessment was not undertaken. Mr E's mother had joined the Buckinghamshire Carers Association after seeing an advertisement at the Haleacre Unit and this was subsequently seen as adequate to meet her needs by the professionals involved in Mr E's care. However, it was explained to the inquiry panel that this group's purpose was to create a better understanding of mental illness, not to provide practical support to a carer and therefore did not address her needs as a carer. Additionally there was no mechanism in place for the establishment of links between the Carers Association and the statutory services.

The inquiry panel could find no evidence that Mr E's mother and half brother were ever considered to be at risk even though just prior to his hospital admission Mr E had been experiencing strong paranoid ideas in relation to his half brother and had thought that his thoughts were "destroying him".

8.14 Support provided to families after the homicide

The Trust had contacted both the families of Mr D and Mr E and asked them to participate in the internal review. However, although Mr D's family had seen a copy of the internal review report, this had not been fully explained to them. They considered that without the initiatives that they had taken to keep themselves informed of the situation. Information would not have been forthcoming.

When the inquiry panel met with Mr D's family it became clear that they needed formal support and this was arranged via the Trust.

Likewise Mr E's mother was in need of formal support and this was also arranged via the Trust.

Mr E's mother had not seen the internal review report and no contact had been made with her after she had given evidence.

8.15 Internal Review

From the documents made available, the inquiry panel were unable to form a view as to the Trust's progress against the recommendations of the internal review. Many staff we interviewed had not seen the report

and therefore were unaware of the findings of the internal review and it appears that these were not made widely available within the Trust.

The inquiry panel has considered the recommendations made by the internal review and comment on these in Section Ten.

9. Findings and Recommendations

Mr E's pattern of engagement with the services, with the exception of his GP, was that he was unlikely to attend for appointments and comply with specific interventions. Throughout his contact with the services it is clear that he was seen as someone who had a substance misuse problem and not regarded as someone with a severe mental illness with the exception of the locum Consultant Psychiatrist and CPN. The primary concern related to his substance misuse and the short term effect that it had on his mental health although no formal attempt was made to treat his substance misuse.

The discharge summary from the hospital stated that he could pose a risk to others if he became paranoid about them but there is no reason to interpret this as sufficient to predict that Mr E would have killed that person. It is the consideration of the inquiry panel that the killing of Mr D was neither, preventable or predictable.

However the inquiry panel did find that there were system failures that need addressing and would improve the service provision, these are outlined below.

9.1 Childhood and Adolescence

The inquiry panel found no evidence that Mr E's contact with the Child and adolescent mental health service during his early years was taken into consideration during his contact with the adult mental health services.

Recommendation one

It is recommended that previous contacts with other services are included in assessments undertaken by the adult services, taking into account full background information about the person's previous psychiatric history and social circumstances.

9.2 General Practitioner Service

The inquiry panel were impressed with the treatment and continuous support provided by Mr E's family GP and the practice as a whole. Their knowledge of mental illness and how they dealt with it should be commended and made a positive contribution to Mr E's care.

9.3 Initial Referral to Mental Health Services

The initial referral from the GP to mental health services in February 2003 appeared to have been 'mislaid'. The referral letter had clearly been written as a copy was found in both Mr E's GP and mental health records, however we were unable to substantiate when it arrived, who saw it and what action was taken. A gap of five months occurred between the original referral, re-referral and eventual outpatient appointment for assessment.

Recommendation two

In line with good practice a timescale of response to referrals should be agreed between primary and secondary care and the referring agency should develop a system for tracking when referrals are made and the response received.

9.3.1 Evidence was available at the time of Mr E's first assessment by the mental health service that he was capable of "going berserk" and following his hospital admission the SHO there identified the risk to others. It was found that there was not a systematic review of his risk assessment nor management. At no time was any consideration given regarding a risk he might have posed to others.

Recommendation three

It is recommended that risk assessment and management becomes an integral part of care planning and management and is regularly audited by the Trust.

9.3.2 Mr E did not appear to have attended his second outpatient appointment and the inquiry panel could find no evidence that an attempt was made to contact him. In the event he had to be re-referred by his GP for a further assessment as his mental state had deteriorated.

Recommendation four

It is recommended that the Trust develop a Policy on Managing DNA or Cancelled Appointments as detailed on the internal review's recommendation to ensure that there is an effective follow up of people who do not attend for appointments. It is further recommended that once the Policy is implemented that its operation and effectiveness is audited.

9.4 Admission to hospital

The panel considers that the admission to hospital in November 2003 was the right course of action. It acknowledged the pressure that the Trust inpatient staff were under in managing a busy acute admission unit whilst short staffed and relying heavily on agency staff. This may account in some degree for the fact that there is little evidence of any therapeutic activities or investigation to understand this young man's mental health problems. This was reflected in the manner of his treatment and discharge by:

- Insufficient consideration in regard to his substance misuse and the reasons why he was continuing to use it
- The fact that he was seen as an intimidating and disruptive young man, not the vulnerable person that he was seen to be by the Locum Consultant Psychiatrist
- Staff were not mindful of the contribution that Mr E's mother could have made so that she might have been more fully engaged in his care plan and also provide a fuller history of his mental problems
- A failure to engage in discharge planning early in his admission to ensure that the most appropriate housing and support was available

Recommendation five

The inquiry panel recommends that the inpatient unit review their processes to ensure that:

- Where a person continues to misuse substances then a more active management of these problems should be undertaken either by a referral to specialist services or through the adult service with support from the specialist service
- The contribution of carers is recognised and encouraged
- Preparation for discharge is commenced on admission including the identification of appropriate housing needs where relevant
- Meaningful therapeutic activities are available within the unit

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9.5 Discharge from Hospital

The inquiry panel could not identify from the evidence received the actual date that Mr E was discharged from hospital. It is known that a CPA review took place on the 9th January 2004 (a Friday) with a view to discharge him on the 12th January, and that Mr E was insistent that

he was discharged, despite the only available accommodation being an unfurnished bedsit. However discharge documentation records show that he was discharged on the 12th January 2004.

No attempt was made by the services to obtain an adequate range of furniture and domestic equipment for Mr E and up until the incident it is understood that his room remained sparsely furnished and equipped.

A care plan was agreed but this did not include an adequate contingency or crisis plan.

Recommendation six

It is recommended that where patients are discharged to unfurnished accommodation staff support clients to obtain adequate furniture and domestic equipment.

Recommendation seven

It is recommended that Care Plans contain full information on contingency and crisis plans and that the Trust audits this on a regular basis.

9.6 Contact with the Community Mental Health Services

Mr E is not an untypical patient in terms of his use of illicit substances. People like Mr E will tend to dis-engage from services if they feel under pressure or unwell.

It is the inquiry panel's view that none of the professionals involved in his care (with the exception of his GP), had an opportunity to develop a therapeutic relationship with him thus making it much harder to identify when his mental state was deteriorating.

The inquiry panel has concerns that a care coordinator was never clearly nominated with both the CPN and care manager considering that the other had this role. This led to a lack of case accountability.

Referrals to the Crisis and Assertive Outreach Teams were unsuccessful and the inquiry panel were concerned that the CPN was unable to obtain the help and support necessary for this complex case.

Conflicting evidence was provided in relation to the eligibility criteria for the service provided by the Assertive Outreach Team. A senior manager assured the inquiry panel that this had been reviewed and the six month rule no longer existed. However we received both written and oral evidence which stated that an individual must have been

disengaging with the mental health services for at least six months before considered for eligibility for the Assertive Outreach Team.

Recommendation eight

It is recommended that the allocation of a care coordinator is carefully recorded and that the professional and their role is clearly understood by his/her colleagues, the patient, carer and other relevant agencies.

Recommendation nine

It is recommended that the eligibility criteria for access to the Assertive Outreach Team is reviewed and that if the six month guidance remains then professionals seeking support for their patients/clients who are not accepted should be able to have an opportunity to discuss the case with the team and mechanism for dealing with unresolved referrals between the teams should be developed.

9.7 Communication between and within Teams

Systems for sharing and using information were inconsistent in this case. The inquiry panel had detailed information relating to Mr E that was not shared with other members of the team. For example:

- Inadequate case recording systems and processes in place
- Notes being kept separately by each member of the team with no integration of records
- Allocated team members working different duty rotas and therefore not being able to liaise with each other on a face to face basis

Recommendation ten

The inquiry panel understands that the Trust, together with its partner agencies, is reviewing and developing an electronic data system, which can be used by the multi-disciplinary team.

It is further recommended that the Trust:

- Reviews the implementation of integrated records to ensure that the transition to this new system is in place as soon as possible.
- Take into consideration duty rotas when allocating a team of professionals to one individual patient/client.

9.8 Leadership and Clinical Accountability

The situation within the local services during the period of Mr E's care indicates that there was inadequate leadership and accountability for both clinical and management arrangements.

The reorganisation and future of the BMHT must have impacted on both senior management and the operational teams. More specifically it is considered that there was a lack of nursing leadership; that a significant number of medical posts did not have a substantive Consultant Psychiatrists in those positions; that regular supervision and appraisal were not available to the medical team and locums were working to a degree in isolation.

Recommendation eleven

It is recommended that the Trust ensures appropriate professional support and supervision structures are in place for all clinical staff and that this is monitored.

9.9 Dual Diagnosis

The inquiry panel found that training for all staff on dual diagnosis work was insufficient and led in some cases to a belief that a person with a history of substance misuse was less deserving of treatment.

Recommendation twelve

It is recommended that staff are provided with training on the impact that substance misuse can have on a person with a mental illness and that local Dual Diagnosis Strategies are developed and implemented.

9.10 Carers

It is the responsibility of secondary care services to ensure that carers' needs are met and that a Carers' Assessment is offered and undertaken if accepted.

Mr E's mother, although actively involved with her son, was found to be marginalized; she was not informed or involved with compiling a care package for her son and felt that her views were not taken into consideration.

Recommendation thirteen

It is recommended that the following is taken into account and audited by the Trust: -

- The assessment process must include information gained from carers without compromising the individual's right to confidentiality.
- That carers are offered a Carers Assessment and that their support needs are recognised.
- That the services should establish better links with the Carers organisations in Buckinghamshire.

9.11 Support provided to families after the homicide

The inquiry panel found that both families had been contacted after the homicide and invited to participate in the Trust's internal review. However the Trust did not offer informal or formal support or keep them informed of the actions being taken following their investigation

Recommendation fourteen

It is recommended that the Trust should identify a senior manager to coordinate both informal and formal support to families after a homicide as set out in the "Building Bridges" and the National Patient Safety Agency guidance for "Supporting Families".

9.12 Concluding Comments

The value of an independent inquiry is in identifying issues that can be resolved by achievable recommendations. We therefore submit this report to NHS South Central and its Board and trust that the findings and recommendations are considered fully and put together into an action plan, the progress of which will be reviewed regularly.

10. Internal Report Action Plan

The following action plan was presented to the Trust's Executive Board during 2006.

Summary of Recommendations and Actions taken within the Trust since the internal publication of the Internal Inquiry Report

Recommendations	Action taken by the Agencies	Timescale	Progress
1) The Trust should review links with primary care, to raise awareness of its services, referral criteria and referral protocols.	• Operational policies for community mental health teams and primary care mental health teams will be written to complement each other and to demonstrate smooth transitions between services. • Primary care mental health services will have an established project steering group that will include the Buckinghamshire Mental Health Trust in its membership. • Referral pathways into the Primary Care Mental Health Services and Buckinghamshire Mental Health Trust Services will be clearly defined. • Joint assessment protocols between Primary Care and the Mental Health Trust will be in place. • Multi-agency assessment and liaison function (MAALF) to be implemented	June 06	

	• Monitoring of referral pathways and communication between services to be reviewed annually • Community Mental Health Teams will ensure there are visible links to GP surgeries		

Inquiry Panel Comment

The inquiry panel endorses this recommendation and refers the Trust to Recommendation two of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
2) The Trust should review internal communications to ensure that referrals are picked up whether made to CMHT or inpatient services.	• A single referral point for all emergency and urgent referrals will be in place via duty systems that will operate in the same way across the county • These duty systems will be the gatekeeper to admissions to inpatient services	February 06	

Inquiry Panel Comment

The inquiry panel endorses this recommendation and refers the Trust to Recommendation two of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
3) The Trust should introduce a DNA protocol for outpatient appointments	• A single DNA protocol will be in place across all community mental health services • Audit of DNA protocol to be completed annually	March 06 March 07	

Inquiry Panel Comment
The inquiry panel endorses this recommendation and refers the Trust to Recommendation four of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
4) Training in risk assessment and management should be developed and delivered. Risk assessment mechanisms and measures should be incorporated into operating practices and evidence of compliance demonstrated	• The Trust will have an ongoing risk assessment and management training place in place • Reconfigured CMHTs will have specific team training on risk assessment and management • A standard approach to risk assessment will be in place across all CMHTs • CPA documentation will support risk assessment being incorporated into operating practices • Annual audit of CPA will be in place	Dec 06 Sept 06	

Inquiry Panel comment
The inquiry panel endorses this recommendation and refers the Trust to Recommendation three of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
5) Complete full implementation of CPA within the Trust, including the development and delivery of appropriate training.	• CPA action plan implementation		

Inquiry Panel comment
The inquiry panel endorses this recommendation.

Recommendations	Action taken by the Agencies	Timescale	Progress
6) Develop an inpatient substance misuse protocol that is signed up to all disciplines.	• Agree an inpatient substance misuse protocol. • Develop training programme to support the implementation of the protocol. • Provide annual audit on compliance with substance misuse protocol.	Sept 06	

Inquiry Panel comment
The inquiry panel endorses this recommendation and refers the Trust to Recommendation twelve of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
7) Ensure that carers receive appropriate support through promoting to staff the range of support on offer, reviewing the resources and skills required and ensuring that carers' assessments are carried out.	• Ensure that Carer's Assessments are undertaken within CMHTs • Ensure documentation of Carer's Assessments and relevant information are filed appropriately. • Ensure steady increase of carers assessments are undertaken	April 06	

Inquiry Panel comment

The inquiry panel endorses this recommendation and refers the Trust to Recommendation thirteen of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
8) Provide training for professional in working with carers.	• Ongoing training programme to be in place for professionals across the Trust. • Specific training for the newly configured CMHTs to be provided by Carers' Development Workers.	March 07	

Inquiry Panel comment
The inquiry panel endorses this recommendation.

Recommendations	Action taken by the Agencies	Timescale	Progress
9) Continue and complete review of CMHT resources, training, clinical and management supervision	• CMHT Reconfiguration Project Plan to be fully implemented.	April 06	

Inquiry Panel comment
The inquiry panel endorses the recommendation and commends the Trust for the progress made to date.

Recommendations	Action taken by the Agencies	Timescale	Progress
10) Provide training for CMHT in dual diagnosis.	• Training programme to be developed for reconfigured CMHTs. • A worker within each CMHT to be identified and trained in dual diagnosis. • Operational working links with Community Drug and Alcohol Services to be formalised.	March 07	

Inquiry Panel comment
The inquiry panel endorses the recommendation and refers the Trust to Recommendation twelve of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
11) Review the development of the CMHT, AOT and CRT and their linkages.	• Linkages between CMHT, Assertive Outreach Teams and Crisis and Community Acute Services to be clearly defined within Operational Policies. • Referral Pathways and criteria to be clearly defined.	Achieved	

Inquiry Panel comment
The inquiry panel endorses the recommendation and refers the Trust to Recommendation eight of this report.

Recommendations	Action taken by the Agencies	Timescale	Progress
12) Continue the review of the provision of supported and rehabilitation accommodation.	• Participate in the review. • Buckinghamshire Mental Health Trust to be on Project Steering Group. • Information to be provided as required as part of the project.	Achieved	

Inquiry Panel comment
The inquiry panel endorses the recommendation.

Recommendations	Action taken by the Agencies	Timescale	Progress
13) Review discharge planning and preparation processes, including the type of accommodation and support provided.	• Discharge planning procedure for inpatient wards to be clearly defined. • The role of the Care Co-ordinator and Named Nurse from the ward and responsibilities in respect of discharge planning to be clearly defined. • Arrangements for 7 days follow up and in particular the booking of appointments prior to discharge will be in place. • Community Mental Health Team members and as far as possible the Care Co-ordinator to attend pre-discharge planning meetings on the ward. • Audit of discharge planning arrangements to be undertaken annually.	March 07	

Inquiry Panel comment

The inquiry panel endorses the recommendation and refers the Trust to Recommendations five, six and eight of this report.

Appendix One

Documents seen

Oxfordshire Mental Healthcare NHS Trust

Internal Review
Trust Structure
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Mr E's Buckinghamshire Mental Health NHS Trust Case Notes
Haleacre Unit inpatient notes
Rehabilitation File Notes
Assertive Outreach and Crisis Resolution Team Records
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Operational Policy of the Community Mental Health Teams
General Information provided to the Internal Review
Questions for the Panel, Mr D's family
Scilly Isles' (St Mary's Hospital) Records
Operational Policy for the Crisis Resolution and Home Treatment Team
Chief Nursing Officer, Review of Mental Health Nursing
Risk Assessment and Guidance Policy
Key Targets for the Trust
Care Programme Approach Policy
Serious Untoward Incident Procedure
Serious Adverse Event and Near Miss Policy
Trust Structure Charts
Press Statements
Directorate of Nursing and Clinical Governance Structure
CHI Report
Draft Operational Policy for the Early Intervention in Psychosis Service
Operational Policy for the Assertive Outreach Team
Service model for Buckinghamshire Mental Health Trust's community mental health services
Procedure and Standards for the Buckinghamshire Mental Health NHS Trust's Adult Community Mental Health Team's Duty System
Briefing paper regarding community mental health teams
Draft Community Mental Health Team operational policy
Primary Care Mental Health Teams Operational Policy
Information sheet for Primary Care Mental Health Teams
Trust Action Plan following Internal Review

Chiltern Primary Care Trust

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Social Services

County Council Social Services File

Thames Valley Strategic Health Authority

Strategic Health Authority Board Paper

Appendix Two

Glossary

Cannabinoids

Active chemicals contained within all forms of cannabis.

Care Programme Approach (CPA)

Introduced in April 1991 through the Department of Health Circular (HC(90)23/LASSL(90) 11 to offer guidance on a systematic and collaborative response in the assessment, planning and review of service users' health and social care needs.

Discharge Summary

Prepared by the responsible clinical team and sent to the patient's GP on their discharge from hospital, indicating future treatment requirements.

Dual Diagnosis

A person with a diagnosis of a psychiatric illness and in addition a secondary psychiatric disorder relating to for example drug misuse.

IC10

International Classification of Diseases 1992 (10th Edition). The ICD –10 classification of mental health and behavioural disorders: clinical descriptions and diagnostic guidelines. Ref: Genena :WHO

Mental Health Act 1983

Legislation relating to powers of compulsion for people suffering from a mental illness as defined by the Act.

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