Independent desktop review of the internal investigation into the care and treatment provided to Mr H

May 2012

A report for NHS London
Undertaken by Caring Solutions UK Ltd

NHS London

Investigation Title:	Independent Desktop Audit Review of the Internal Investigation Report on the Mental Health Care and Treatment Provided to Mr H
Incident Date:	31st December 2009
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Investigation Report Date:	April 2012

Acknowledgements

The Independent Review Team would like to extend their condolences to the children, family and friends of Mrs H who died on the 31st December 2009. It is our sincere wish that this desktop review audit report provides no further occasion for additional pain and distress. We hope that this Independent desktop review report will provide further assurance that all the issues identified in this case have been addressed and acted upon.

The Independent Review Team wish to also thank the Patient Experience Manager, and her colleagues at Barnet, Enfield and Haringey NHS Mental Health Trust for providing them with the Multidisciplinary Independently Chaired Board Level Internal Panel Inquiry Investigation report, patient records, and for providing the latest version of the updated action plan in November 2011 and information regarding its implementation.

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1 Executive Summary

1.1 Introduction

1.1.1 Mr H was an open case to Barnet, Enfield and Haringey NHS Mental Health Trust (the Trust) when, on the 31st December 2009, he strangled Mrs H (his wife) after an argument about the paternity of their youngest child. There is no further information about the circumstances leading up to the incident other than that Mr H was intoxicated at the time. On the 23rd August 2010 Mr H was found guilty of manslaughter on the grounds of provocation. Judge Jeffrey Peggden QC ordered that Mr H serve an indeterminate sentence for public protection with a minimum term of eight years which was reduced to six years on appeal. During the trial the Jury were told that Mr H had a personality disorder with alcohol dependence, had a history of domestic violence, and that he posed dangers to women that he had relationships with.

1.1.2 In accordance with the National Patient Safety Agency National Reporting and Learning Guidance (2005) the Trust carried out an immediate initial management review following the incident. The Trust then commissioned an independently chaired Board Level Internal Panel Investigation into the treatment and care Mr H received from the Trust prior to the incident. The Board Level Internal Investigation Team (Internal Investigation Team) was chaired by an experienced independent consultant who was supported by two senior health care professionals who had overall management responsibility for Mr H, and a Non-Executive Director from the Trust. On the 8th August 2010 the investigation team produced its final report entitled "Board Level Internal Panel Inquiry re: Mr H Root Cause Analysis Investigation Report" (hereafter this report is referred to as the Internal Report). The Internal Report identified a number of Care and Service Delivery Problems and some contributing factors. However, the Internal Report found no root cause for the incident. A detailed action plan was developed in response to the findings contained in the Internal Report and progress has been monitored by the Trust senior management team and the Trust Board.

1.2 Purpose

1.2.1 This independent desktop review was commissioned by NHS London in October 2011 and was produced in accordance with guidance published by the Department of Health circular HSG (94) 27: "The discharge of mentally disordered people and their continuing care in the community" and the updated paragraphs 33-6 issued in June 2005. The aim of the independent desktop review is set out in the Terms of Reference provided by NHS London in October 2011 (see Section 2 below for details) but, in brief, the aim of the desktop review was to audit the Internal Report to ensure the adequacy of its findings, recommendations, action plans and other matters set out in the Terms of Reference.

1.3 Methodology

1.3.1 The Independent Review Team audited the Internal Report using an audit tool that was originally developed by the Health and Social Care Advisory Service (HASCAS) in conjunction with a number of mental health trusts in the North West of England and subsequently developed by Caring Solutions UK Ltd. Members of the team individually audited the Internal Report and then met to reach a consensus using the latest version of the audit tool that was published in 2010. The findings from the audit tool were then brought together into a consolidated analysis of the Internal Report from which a number of conclusions were drawn and recommendations made.

1.3.2 The Independent Review Team then audited the action plan which was produced to address the recommendations made in the Internal Report to assess if the action plan had captured all its recommendations. For some actions evidence of outcomes were available through performance management reports to the Trust Board. These reports are publicly available through the internet. A member of the team evaluated relevant Trust Board reports published to identify evidence of this outcome.

1.3.3 To provide context this desktop report includes details of the findings published in the Internal Report, and its recommendations. It also includes details of the action plan that was produced in response to the recommendations that were made in the report. The Independent Review Team had an opportunity to further audit all the relevant documentation in this case and a full list of the documentation that was audited is included in Appendix One for information. Members of the Independent Review Team visited the Trust on the 29th November 2011 to meet members of the senior management team. The Independent Review Team was provided with a further update on progress made in implementing the action plan at that meeting.

1.3.4 It should be noted that the team commissioned to review the Internal Report is termed the “Independent Review Team” in this report. This should not be confused with the “Internal Investigation Team” that carried out the investigation that led to the production of the Internal Report.

1.3.5 The Internal Report identified that eight of its services had contact with Mr H following his renewed contact with mental health services in January 2008. (This was after a thirteen year gap in his contact with mental health services). They were:

1. Acute In-patient services, Haringey
2. Dual Diagnosis Services, Haringey
3. Crisis and Assertive Outreach Team (CAT)
4. Emergency Reception Centre (ERC) St Ann’s Hospital Tottenham

5. Short Term Assessment and Recovery Team (START) St Ann's Hospital, Tottenham

6. West Home Treatment Team (HTT)

7. North London Forensic Service (NLFS) – Pentonville Prison

8. Community Mental Health Teams (CMHTs)

1.3.6 Note: the truncated service titles are used in the main body of the report.

1.4 Summary of Findings Contained in the Internal Report and Main Conclusions of the Independent Review Team

1.4.1. In summary the Internal Report found the following Care and Delivery Problems (details in paragraph 4.3.1):

1. A major reconfiguration of services: This took place in 2007 and a number of difficulties were reported by staff working in START and ERC.
2. Admission in February 2008: Failure to access Mr H's historic notes meant that clinicians were unaware of possible risk factors and previous psychiatric diagnoses.
3. Referral to Home Treatment Team (HTT): On the 5th December 2009 a member of the START team assessed Mr H for referral to HTT: the referral pathway at that time was 'not sufficiently delineated' and clarification was needed.
4. Access to health records: A number of failings in record keeping were noted.
5. Liaison with Children & Family Services: There are references in both the written medical records to Mr H's acknowledged episodes of threatening and violent behaviour to his wife; staff also knew there were young children in the family. However there was no suggestion that Mr H had ever been discussed with Haringey's Children and Family Services and this is considered to be a serious omission.
6. Interface between the Trust's general mental health services and the forensic service: A consultant psychiatrist, employed by the Trust had seen Mr H in prison in 2009 prior to the incident, but his assessment and treatment were not recorded in such a way that they were available to the START and ERC teams.
7. Referral to the Haringey Multi-Agency Risk Assessment Conference (MARAC): There was no evidence that any of the mental health teams had discussed or considered the possibility of referring Mr H's case to MARAC. The panel considered that the mental health teams should have considered the option of referral to MARAC.
8. Referral to Haringey Advisory Group on Alcohol (HAGA): Two referrals were made by nursing staff to HAGA (a local voluntary sector organisation) in January 1995 and in 2008. The Director of HAGA reported that the referral process from the Trust to HAGA was unsatisfactory and that his attempts to make improvements had had not been approved.

9. Debriefing and Support for Staff: The Trust procedures had been followed in some but not all cases. There was no clarity of understanding as to what constituted support or how it should be offered. Policy was left to individual managers and team leaders to interpret and implement.

1.4.2 As a result of the desktop review audit the Independent Review Team came to the following conclusions regarding the Internal Report (full details in Section 5).

- Following the incident on the 31st December 2009 an initial management review was completed and the Trust commissioned an internal investigation in accordance with the current National Patient Safety Agency policy and procedure which NHS Trusts use in responding to Serious Untoward Incidents, including homicides.
- All the Trust services that had contact with Mr H were identified and reviewed.
- All the staff that had contact with, or responsibility for, Mr H were identified and interviewed; witness statements were also taken to inform the investigation.
- Having applied the audit tool to the Internal Report and considered the available records the Independent Review Team considered that the ten Service Delivery Problems, two Contributory factors and the nine recommendations that were made in Report were properly drawn from the evidence that was collected as part of the internal investigation.
- The need to improve liaison between agencies was covered by the Internal Report.
- The management reconfiguration and introduction of the new electronic patient record system (RiO) were identified as significant contributory factors.
- The Independent Review Team acknowledges that the Safeguarding Children aspects of this case have been thoroughly investigated as part of the London Borough of Haringey Serious Case Review process. The Independent Review Team note that the Internal Report had already identified and addressed many of the issues concerning safeguarding children and domestic violence that were identified in the Serious Case Review report.
- The Independent Review Team noted that at the time of the review senior managers from the Trust had still not had direct contact with the families of the victim or perpetrator even though this had been included as an objective in the Internal Report. The Trust is making further efforts to contact both families.
- The Independent Review Team noted that that the Internal Report had identified that Mr H and a member of staff who worked for the Emergency Reception Centre, St Ann's Hospital had raised concerns about mental health services in January 2009 but these concerns had not been made subject to investigation. The Trust is addressing this issue as a matter of urgency.
- The audit of the Internal Report found that the investigation had looked in detail at the extent to which Mr H's care had been provided in accordance with statutory obligations, and relevant national guidance. The audit found that the Report had properly found, given the information available to clinical staff, that Mr H did not meet the criteria for CPA or admission to hospital under the Mental Health Act (MHA) 1983. However, the Independent Review Team judge that the NLFS could have used the National Guidance on Borderline Personality Disorders (January 2009: NICE) after Mr H had been diagnosed with a Borderline Personality Disorder when he was in prison in mid – 2009.

- The Independent Review Team concur with Board Level Internal Investigation Team that although there were a number of Care and Service Delivery Problems and two significant contributory factors that no root cause for this incident was evident.
- The Report was open, transparent, and very detailed: it was also well written.

1.4.3 The Independent Review Team audited the action plan arising from the Internal Report and the progress made on its implementation. The following conclusions were made:

1. The action plan addressed all the recommendations made in the Internal Report and met the Terms of Reference that had been set for the Investigation.

2. The Trust provided the Independent Review Team with assurance that action plan implementation is being monitored through a variety of mechanisms including publicly available performance management reports to the Trust Board (balanced scorecard reports, using the established 'Red, Amber, Green' system). Where available, the Independent Review Team have reviewed published evidence (available on the internet) of monitoring and found that this is indeed taking place.

3. Members of the Independent Review Team met with senior managers from the Trust on the 29th November 2011 and received an updated extract on further progress that had been made in implementing the Action Plans. The Independent Review Team was assured by the plan that had been put in place to address the remaining four actions that had not met the review date on the 11th November 2011.

1.5 Additional Actions

1.5.1 The Independent Review Team has concluded that the Internal Report provided a comprehensive analysis of the care and treatment provided to Mr H but there are three additional actions arising from this desktop review. Namely:

1. The Trust should consider making further efforts to contact the victims and perpetrators families to ensure that they have had the opportunity to become involved in, or make comment upon the investigations that have been made into the care and treatment of Mr H.

2. The Internal Report identified that Mr H and a member of staff working in the ERC had concerns about mental health services in January 2009. To date these have not been investigated. It is recommended that the concerns raised are investigated and the outcome included for further action or consideration.

3. NHS London should share with other mental health and learning disability trusts the risk that Consultant Forensic Psychiatrists visiting prisons may not input and update electronic patient record systems, meaning that critical information is not shared with community mental health teams when patients are discharged from prison.

2 Terms of Reference

2.1 NHS London set the Terms of Reference for this review. These were:

1. A review of the Trust's internal investigation to assess the adequacy of its findings, recommendations and action plans.

2. Reviewing the progress made by the Trust in implementing the action plan from the internal investigation.

3. Involving the families of both Mr H and the victim as considered appropriate in liaison with the police.

4. Assess the adequacy of risk assessment and consideration to Safeguarding issues.

5. An examination of the mental health services provided to Mr H and a review of the relevant documents

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

7. Consider such matters as the public interest may require.

8. Complete an independent desktop review report for presentation to NHS London within 12 weeks of commencing the investigation and assist in the preparation of the report for publication.

3 Introduction

3.1 Background

3.1.1 Caring Solutions UK Ltd was commissioned by NHS London in October 2011 to undertake a desktop review to assess the adequacy, findings and action plans contained in the Internal Report in to the homicide committed by Mr H on the 31st December 2009 that was produced on the 8th August 2010. At the time of the incident Mr H was an open case to the Trust but no worker had been allocated to his case

3.1.2 The primary focus of the desktop review was to address the elements that had been set out in the Terms of Reference provided by NHS London. The Independent Review Team used a standardised audit tool developed by Caring Solutions UK Ltd from work originally carried out by the Health and Social Care Advisory Service (HASCAS) in conjunction with Cheshire and Wirral Partnership NHS Foundation Trust, 5 Boroughs Partnership NHS Foundation Trust and Mersey Care NHS Trust. The Independent Review Team was also given access to all the relevant medical records including the prison records and the "Integrated Homicide Action Plan". Members of the Independent Review team visited the Trust on the 29th November 2011 and met with senior managers who had participated in the production of the Internal Report and who also had responsibility for the oversight of the implementation of the action plan arising out of the recommendations made in the Internal Report. Due to the multi-agency Safeguarding issues in this case the Independent Review Team also considered the findings contained in the London Borough of Haringey Serious Case Review Report concerning this case that was published on the 20th November 2010. This report addressed the multi-agency Safeguarding issues that were identified during the Serious Case Review process. The Trust's Director for Nursing represented the Trust during the Serious Case Review process.

3.1.3 This report contains the outcome of the desktop review namely an evaluation of the Internal Report and the extent to which the action plan had been implemented. This report concludes with the Independent Review Team's observations on the quality of the Trust's own investigation of the case and on the implementation of the action plan, including recommendations for any further action

3.2 The Incident and its Context

3.2.1 On 31 December 2009 the Assistant Director of Children's Services, London Borough of Haringey informed the Acting Director for the Trust that a service user was being sought by police on suspicion of having killed his wife. Mr H was later arrested and charged with murder.

3.2.2 Mr H had had no contact with mental health services for eleven years prior to his contact with the ERC located at St Ann's Hospital, Tottenham at 17.45 on the 29th January 2008.

3.2.3 It would appear from the medical records that this presentation followed Mr H's release from prison. At this presentation, Mr H was intoxicated. He was breathalysed by staff (routine clinical practice). Mr H was told that he would be seen by a member of the Crisis and Assertive Outreach Team (CAT) when his alcohol levels had reduced. It is not clear from medical records, but it is assumed that Mr H remained in the ERC, for over four hours, until 22.04 pm when two members of East CAT arrived at ERC to assess him. It is recorded that Mr H then "walked out" of the ERC before the assessment was undertaken. Staff tried to make contact with Mr H on the mobile phone number he had provided but it was switched off. It was decided that two members of CAT would visit Mr H at his home address the next day (30th January 2008). The Police were also given his details owing to concerns about his mental health.

3.2.4 At 12.50pm on the 30th January 2008 two members of CAT visited Mr H's home address to undertake an assessment. Mr H was not at home. A message was left on his mobile phone by a member of the CAT. This was then followed up by a second home visit on the 31st January 2008. As on the previous day Mr H was not at home but his wife was at home and invited the CAT staff into the family home. During the home visit Mrs H provided CAT members with three important pieces of information. Firstly, that she was pregnant; secondly, that her husband had not lived in the family home for a while, and thirdly that she did not know where he was living currently.

3.2.5 Medical records indicate that the CAT staff that made the home visit focused their attention on Mr H and did not complete a family based assessment. Following the home visit on the 31st January 2008 the CAT advised the Short Term Assessment and Recovery Team (START) and ERC that no further home visits would be made by them and no further action was planned until Mr H was located. Mr H's details were circulated to the Police Missing Persons unit.

3.2.6 Medical records indicate that on the 18th February 2008 Mr H presented to ERC once again. On this occasion a full mental health assessment was completed by a duty doctor. The doctor identified that Mr H was a 44 year old male who was dependent on alcohol and living rough. The doctor noted that Mr H had a history of both self-harm and attempted suicide. The doctor identified symptoms of depression but with no active suicidal ideation. The doctor also recorded that Mr H presented with paranoid ideas. As a result of this, the duty doctor discussed the case with the on-call Specialist Psychiatric Registrar (SpR) and, given the risk factors that had been identified during his assessment; a decision was made to admit Mr H to Alexandra Ward, St Ann's Hospital as a voluntary patient. A risk assessment and risk management form was completed on Mr H. The form records: current aggression/violence to family/staff/others as "low"; suicide as "medium to high" and substance misuse as "high". Mr H had informed the clinical team that he

had four children aged 6, 4, 2 and two weeks of age and that he: “lives with his wife normally and she kicks him out frequently and then he returns home”. RiO contains information that Mr H had been in prison twice: once in 2003 for assault on the police and once aged 18 for GBH. Mr H’s wife was not informed about his voluntary admission to hospital and therefore it is not clear in the medical records how staff who completed the risk assessment concluded that “risk of violence to family is low”.

3.2.7 On the 20th February 2008 Mr H was reviewed by the ward doctor (who had been the duty doctor in ERC at the point of his voluntary admission to hospital). Mr H agreed to stay in hospital for a five-day period of detoxification. Given Mr H’s psychiatric presentation it was decided that Mr H would be referred to the START so his case could be allocated to a care co-ordinator. Medical records note that Income Support and Incapacity Benefit forms were collected by ward staff from the general office so they could be completed with Mr H. On the 21st February 2008 ward staff made a referral to the Haringey Advisory Group on Alcohol (HAGA) and Mr H was assessed for intervention by the Occupational Therapy service.

3.2.8 From the 21st February 2008 to the 24th February 2008 RiO indicates that Mr H was settled and compliant with his care plan. On the 24th February 2008 Mr H was reviewed again by the ward doctor and during the review he asked for a self-discharge from hospital. The review identified that Mr H had no psychotic symptomatology, no abnormal perception, no thoughts of harm to himself or others and the risks of alcohol withdrawal were discussed with him.

3.2.9 On the 25th February 2008 Mr H was again seen by the duty doctor. He signed a self-discharge form and left the hospital. Mr H did not receive a 7-day follow up from the Hospital Discharge Team and his case was not allocated to a care co-ordinator following his discharge from hospital in accordance with the care plan (this was because he did not meet the criteria for CPA at the time of his discharge)**.**

3.2.10 Medical records show that five weeks after Mr H was discharged from hospital a member of staff from HAGA rang the START team to inform them that Mr H had been sent an assessment appointment for the 20th February 2008. He had failed to attend this appointment or make any other contact. Following discussions with the START team manager a decision was made that no further action be taken. Mr H’s wife was not informed about the decision by the START team manager to take no further action on the case. HAGA then took five weeks to inform START that Mr H had failed to engage with services - this matter has been dealt with as part of the action plan.

3.2.11 In April 2008 Mr H was made subject to a second Non-Molestation order following a complaint made to police by his wife (this information is taken from Court records).

3.2.12 In November 2008 Mr H was convicted of the common assault of his wife and given a suspended prison sentence.

3.2.13 On the 29 January 2009 an advocate working for the Patient's Council made a written referral to START. Clinical records indicate that the advocate had been told by Mr H that he was: "not happy with the treatment he had received from mental health services and that he was homeless". Mr H told the advocate that he had gone to HAGA but did not like group work. The advocate responded by taking a referral to the START duty team. She informed START that she had spoken to a member of staff at St Ann's Hospital who had responsibility for housing matters. Allegedly this member of staff had told her that, "in her view Mr H had been badly let down by mental health services". There is nothing in the medical records to show that the concerns raised about mental health services by Mr H or by the St Ann's Hospital member of staff went through the Trust complaints or investigation procedures.

3.2.14 A decision was made to refer Mr H to the START West Team for assessment. Given that Mr H was homeless it was decided that the advocate would see him on a weekly basis until the assessment was completed.

3.2.15 On the 30th January 2009 Mr H was referred to the START West service by START Duty. On the 10th February 2009 Mr H self-presented to the ERC requesting assessment for depression and help in stopping his alcohol dependence. The clinical notes describe how Mr H said that he felt low and withdrawn and had been drinking a lot and was homeless. He did not present with current thoughts of self-harm. Following a discussion with a member of staff Mr H decided not to wait for an assessment and left the building. He told a member of staff that he would return to ERC if his sleep did not improve because this would affect his mental state. Medical records do not indicate if Mr H's advocate was informed about this episode or asked for an update on the weekly contacts she was undertaking to support Mr H.

3.2.16 On the 17th February 2009 a referral was made by the START team manager to the West START requesting that the case be discussed. An outpatient appointment was made for Mr H to see a doctor on the 10th March 2009. Mr H failed to attend the appointment. A letter was sent to the Patient's Council informing them that as Mr H failed to keep his appointment no further appointments would be made. The letter advised that Mr H should go the ERC if he required further help.

3.2.17 In the chronology produced by the Trust there is a four month gap in contact with Mr H from the 10th February 2009 until May 2009 (when he was seen by a Consultant Forensic Psychiatrist when he was in prison). The gap can be explained because Mr H breached his suspended prison sentence for common assault on his wife and was remanded into custody to await sentence. This remained unknown to Trust staff.

3.2.18 Mr H was remanded in custody to HM Prison – Pentonville. Whilst in prison he was referred for general psychiatric input because of self-harming behaviour. Mr H was seen by a Consultant Forensic Psychiatrist also employed by the Trust on the 13th May 2009. Prison medical records indicate that Mr H told the consultant that his index offence was domestic violence and that he had been recalled to prison for

breaching conditions of his release. He also told the consultant that whilst out of prison he had visited his wife and their four children.

3.2.19 The Consultant Forensic Psychiatrist identified that Mr H had been homeless prior to being sent to prison and had no G.P. Mr H had informed the Consultant that he had been married for 16 years but had been homeless for seven of those years. No mental illness was identified but the Consultant diagnosed borderline personality traits and assessed him as having difficulty coping with stress. He prescribed a low dose of antidepressants and some sedatives to help with distress and the borderline personality features.

3.2.20 The Consultant was aware that Mr H had been previously seen at St Ann's Hospital. He had reviewed Mr H's electronic patient record RiO notes and understood that his case had been closed by community mental health services. During the period Mr H was in Pentonville prison the Consultant Forensic Psychiatrist saw him on eight occasions. The last recorded contact with the Consultant was on the 15th July 2009.

3.2.21 Court records indicate that Mr H received a 12 month prison sentence on the 28th July 2009 for breaching his licence but was he was released from prison in error and was not returned until the 3rd August 2009. Following his return, Mr H spent a further three months in prison and was released in October 2009. A further appointment was made for Mr H to see the Consultant Forensic Psychiatrist on the 2nd September 2009. Mr H did not attend this appointment but the reasons for this are not clear. The last entry in the general prison health record is dated the 14th October 2009.

3.2.22 From the Court records it appears that Mr H received early release from prison in October 2009 (the date is note clear in the records). The Internal Report did not consider the involvement of the London Probation Trust because Mr H was not made subject to probation as he had served less than a twelve month sentence. It appears Mr H left prison homeless and there is no evidence that risks he posed to his wife were addressed at the point of his discharge from prison.

3.2.23 Shortly after his release from prison, at 18.35 hrs. on the 20th November 2009, Mr H went to the ERC. He was intoxicated and agreed to be breathalysed. Mr H was then recorded as becoming abusive and threatening to staff. Security services removed him from the ERC at 19.35 hrs.

3.2.24 Because the Consultant Forensic Psychiatrist had not updated electronic record RiO; ERC staff did not have the full detail of Mr H's recent index offence, psychiatric treatment, diagnosis, and risk history. This may explain why ERC staff made no attempt to contact Mr H's wife following this episode.

3.2.25 Mr H again presented to the ERC on the 5th December 2009. He informed a member of staff that he was having suicidal thoughts and felt that this was because of the number of people he had assaulted. During this contact Mr H informed the member of staff that he had been released from prison "last month" for domestic

violence to his wife. He informed the member of staff that he had returned to the family home. He said that when in prison he had received treatment for depression and he wanted to recommence the treatment. It is recorded that Mr H also informed the member of staff that his wife had told him that he did not have mental health problems but it was alcohol misuse.

3.2.26 Following the review on the 5th December 2009 the medical records show that Mr H's presentation was alcohol related with some psychotic features. The staff who assessed him decided that he had no suicidal thoughts, had good insight, and recorded that he denied any thoughts of harm towards others. Home Treatment was considered to be the most appropriate service. Mr H was informed that he had been referred to the West Home Treatment Team and asked to wait for another assessment. RiO confirms that Mr H left the ERC before his assessment could be completed. A member of the West Home Treatment Team rang Mr H's wife to discuss the situation. It is recorded that Mr H's wife said that he "did not have a mental illness and did not need mental health services". She confirmed he had been binge drinking and went on to say that he was not supporting her at that time.

3.2.27 This was the last contact Mr H's wife had with services before her murder. The contact was focused on Mr H and the medical record does not indicate that Mrs H was concerned about her safety.

3.2.28 RiO shows that after this contact ERC staff attempted to contact Mr H on his mobile phone to ascertain if he still wanted support from mental health services and Information gained from any contact would be passed to the Home Treatment Team for information.

3.2.29 On the 7th December 2009 electronic patient record RiO confirms that the referral to the Home Treatment Team was closed although that decision was not communicated to ERC. Twenty four days later on the 31st December 2009 RiO indicates that police were trying to make contact with Mr H about his wife's murder (a timeline is provided in Appendix 3 for information).

4 Desktop Review of the Internal Report

4.1. Establishing the Trust Investigation Process

4.1.1 The audit found that membership of the Internal Investigation Team is clearly set out in the Report: the Internal Investigation Team consisted of an Independent Consultant/Chair of the Panel, the Director of Nursing for the Trust, the Assistant Director Crisis and Emergency Services for the Trust and a Non-Executive Director from the Trust. The Independent Review Team audit confirmed that the Independent Consultant/Chair had no involvement in the care of Mr H or the locality responsible for his care and this fact is made explicit in the Internal Report. The Internal Investigation Team was supported by a dedicated facilitator.

4.1.2 The audit found that prior to commissioning the Internal Investigation the Trust had completed an initial review within 72 hours of the incident to identify any necessary urgent action. The date of the publication of the final Internal Report (8th August 2010) is clearly stated. The Independent Review Team noted that the completion date of the Internal Report exceeded the 90 days target date for the completion of Internal Investigations that is set out in the "Independent investigation of serious patient safety incidents in mental health services-Good Practice Guidance" that was published in February 2008 by the National Patient Safety Agency. However, the delay is explained, in part, by the fact that during the investigation Mr H was subject to criminal proceedings.

4.1.3 The audit identified that Internal Investigation Team applied the approach to their investigation that is set out in the Department of Health in circular HSG 94 (27) (LASSL (94)4) "*The discharge of mentally disordered people and their continuing care in the community"* and the updated paragraphs 33-6 issued in 2005.

4.1.4 The audit found that that the Internal Report had a clear structure and Terms of Reference covering: Care and Treatment, Risk Assessment/Risk Management, Liaison with other agencies, Alcohol dependency, Support to Staff and Victim's Family, and Recommendations. During the Investigation the Internal Investigation Team scrutinised all of Mr H's health records, including his prison medical records. All relevant policies including Safeguarding protocols, and the Reconfiguration of Service documentation were also scrutinised by the Internal Investigation Team. A tabular time line was produced as part of the investigation.

4.1.5 The audit found that the Internal Report identified all the services that had contact with Mr H from January 2008 to the date of the incident on 31st December 2009. At the start of the investigation the Internal Investigation Team identified that twenty two staff had contact with Mr H during this period. As part of the Investigation, the twenty two witnesses were interviewed and witness statements taken. Each witness was sent a transcript of their interview for them to review, sign and affirm that the evidence was true. This was done in accordance with the Trust's Salmon

procedure, witnesses were then informed about the findings and recommendations made in the final report. Two members of the Independent Review Team reviewed the witness statements as part of the desktop review process.

4.1.6 The audit found that the Internal Report acknowledged that the families of the victim and the perpetrator had not been contacted or involved in the investigation due to the on-going police investigation and proximity to the Court proceedings. This is a significant weakness in the which is recognised in the Internal Report namely: " The Trust will also contact both the victim's family and the family of the perpetrator, once permission to do so, is received from the Metropolitan Police".

4.2 Reporting the Incident

4.2.1 The audit found that the date and location of the incident (31st December 2009) is clearly documented in the Internal Report. The actual time of the incident is not recorded because it was not provided to the Trust by Haringey Children's service or the Police at the time the Trust was informed about the incident.

4.2.2 The immediate aftermath of the incident is clearly set out in the Internal Report namely that:

- A report was made to the Acting Director for Haringey Mental Health Services, by the Assistant Director London Borough of Haringey that Mr H, a service user, was being sought by the by the Police on suspicion of having killed his wife (Mrs H). Mr H was later arrested and charged with her murder
- At the time of the incident Mr H was homeless but he travelled to the family home to see his wife. When he arrived Mrs H was at home, and the four children of Mr H and Mrs H, all aged less than 10 years, were asleep in the house when the homicide was committed.
- Following Mr H's arrest the four children were taken into care by Haringey Children's Services and Mr H was remanded into HMP Pentonville awaiting trial.
- Mr H's prison record states that he informed his prison doctor that he killed his wife, because she had informed him that their youngest child was not his.
- At the time of the incident Mr H was intoxicated. The Independent Review Team have no further information about the circumstances prior to and surrounding the homicide.
- A 72 hour management review was commenced

4.3 Understanding the Trust's Internal Investigation Report

4.3.1 The audit demonstrated that the Internal Report had identified and examined, in detail, Mr H's early background, his family, psychiatric and forensic history and had considered his historic medical records. A detailed chronology leading up to the incident is provided with each contact with Trust services being set out beginning on the 29th January 2008 and concluding with a record on the 31st December 2009 when the Trust had been contacted by Haringey Children's Services and the Police following the homicide. The audit found that the nine Care and Service Delivery

Problems identified by the investigation had been appropriately identified by the Internal Report namely:

- **Admission to St Ann's Hospital** – 18th February 2008. Mr H presented to the ERC and was admitted to St Ann's Hospital, Tottenham for detoxification. This presentation followed a thirteen year gap in contact with mental health services. During this admission the clinical care team failed to access his historic medical records (pre 2008) and therefore had no understanding of his past risk history, and the possible risk to his wife and family. Because Mr H's historic written records were not used his past diagnosis of personality disorder was not considered and the clinical team did not believe that Mr H met the criteria for Care Programme Approach Services because they focused on his alcohol dependency rather than any potential mental illness. This intervention and focus on alcohol dependence set the scene for all future contact with mental health services.

- **Treatment of Personality Disorder** - The Internal Report contains details of the outcome of a review of Mr H's historic medical records - prior to 2008. The Internal Report found that Mr H's historic medical records contained detailed information about his personal history and difficulties which were consistent with a diagnosis of Emotionally Unstable Personality Disorder and Alcohol dependence. It also found that the electronic patient record (RiO) notes relating to Mr H's assessment in ERC in February 2008, which led to his admission to hospital, provide a personal history which could have alerted the in-patient clinical team to the possibility of an underlying personality disorder. The diagnosis of personality disorder does not appear to have been considered at the time of diagnosis, and was not included in the care plan following his self-discharge from hospital or on subsequent presentations.

- **Presentation at ERC/START –** The Internal Report found that following Mr H's in-patient admission to St Ann's Hospital on the 18th February 2008 he then self-presented to the ERC on the 10th February 2009, 20th November 2009 and the 5th December 2009. At the first presentation following discussions with a member of the ERC staff he decided that there was nothing to be gained from having an assessment as his 'problems/housing' had not changed. At the second presentation Mr H was escorted off the premises by security staff because he was displaying aggressive behaviour. At the final presentation Mr H was assessed and referred to the Home Treatment Team. The Internal Report found that in the absence of any Care Programme Approach staff at the ERC responded to Mr H on an ad-hoc basis with the focus being on alcohol dependence rather than an underlying mental illness.

- **Referral to Home Treatment Team -** Here, the Internal Report found that following Mr H's presentation to ERC on the 5th December 2009 he was assessed and then referred to the HTT. He left the premises before being re-assessed by the HTT. The Internal Report also found that the HTT assumed that Mr H remained the responsibility of ERC and ERC staff believed that he

was the responsibility of the HTT. Therefore the Internal Report found that the referral pathway between ERC and HTT needed to be clarified and that once ERC had assessed a patient as needing HTT, in future, there should be no need for the HTT to have to re-assess the patient again.

- **Access to Health Records -** the Trust had in place a "24 Hour Access Policy" to enable staff to access medical records. The Policy was issued in November 2002 and revised in November 2003 (next review date: January 2006). The Policy gives information on how staff can access health records both during and out of hours. For easy reference staff also had access to a flow chart which showed how to access health records out of hours. The Internal Report found that in this case, Mr H's historic written health records had not been accessed. The Internal Report found that the written health records contained valuable information about Mr H and the risk he presented that were not available on the electronic patient record (RiO) which only went back to 2008.

- **Liaison with Children and Family Services -** The Internal Report identified a lack of liaison between the Trust and Children and Family Services in Haringey. For example, it found that Mr H's health records showed that staff from the CAT had been active in contacting Mr H's wife and visiting the family home in 2008 following his admission to St Ann's Hospital for detox treatment for alcohol abuse. In 2009 a further contact was made with his wife following his presentation in ERC. At this contact staff were informed by his wife that Mr H did not have need of mental health services, but had been "binge drinking". Given the knowledge of the family situation the Internal Report found that contact should have been made with Haringey's Children and Family Services, to enable a joint care plan to be agreed. The Report found that this should have been done prior to Mr H's discharge from ERC in 2008 and after the contact in 2009. The Internal Report also found that despite the Trust, Haringey PCT, and Haringey Council having agreed joint Children's Safeguarding protocols in place insufficient attention was given to the needs of the children.

- **Referral to Haringey's Multi-Agency Risk Conference (MARAC) -** The Internal Report found that Mr H had not been referred or discussed by Haringey's Multi-Agency Risk Conference. The Internal Report identified that staff should have given consideration as to whether or not Mr H's case should have been referred to MARAC. It found that staff needed much better awareness amongst the involved agencies (including police, family and children's services, health visitors and schools) as to the risks of domestic violence that were present in the family. In this case information about domestic abuse had not been shared amongst the agencies.

- **Referral to Haringey Advisory Group on Alcohol (HAGA) –** The Internal Report found that Mr H's health records show his clinical care team made several referrals to HAGA so that alcohol services could be commenced. However, the Internal Report identified that Mr H's never attended despite two

appointments being made for him. The Trust had been advised about his non-attendance by HAGA but had taken no further action on each occasion. As a consequence the Internal Report identified that the referral pathway needed to be reviewed.

- **Debriefing/Support to Staff –** The Internal Report found that as part of the Trust's procedures for managing incidents there was no clear understanding or agreement by staff as to what constitutes support or how it should be offered. It also found that staff members felt they had not been supported, or that an inadequate level of support had been given.

4.3.2 The audit found that the Internal Report also appropriately identified two important contributory factors that had affected the ability of staff to deliver services namely:

1. **Reconfiguration of Services in 2007 -** A high number of closed cases had been passed to START by Community Mental Health Team's (CMHT's) that still required work. The new START service received a high volume of referrals on a daily basis that needed to be triaged. There were difficulties allocating cases to staff in START because some were still allocated CMHT cases. A loss of experienced staff, the inflexibility of the ERC due to ERC staff combining the assessment of patients under Section 136 of the Mental Health Act (1983), with managing admissions, bleep holding and bed management responsibilities. The continual change of managers resulted in inconsistencies regarding the implementation of work practices. The pressures of the reconfigured service combined with the rapid turnover of senior managers meant no single manager held a longer term perspective of Mr H's case.

2. **Trust roll out of the electronic patient record system (RiO) -** the Trust implemented its new RiO electronic patient record system in January 2007. At the time of the implementation risk chronologies were not routinely uploaded by staff onto RiO. This meant that they were not available on the electronic system. The Internal Report notes that the Director of Nursing had already instructed staff to input risk chronologies onto RiO.

4.3.3 The audit supports the finding contained in the Internal Report that there was no root cause for the incident and therefore it was impossible to identify anything which could have been done to prevent the homicide.

4.3.4 The audit found that Internal Report properly identified seven key lessons which captured the key clinical issues in this case namely:

1. When assessing service users staff should access past records to ensure that the person's risk history is fully up to date and make themselves aware of the person's family history and social situation.

2. Risk chronologies must be updated and recorded on RiO for all patients.

3. Prisoners who are seen by the North London Forensic Service and who are known to the Trust should have the outcome of the assessment recorded on RiO.

4. When staff are aware of domestic violence and there are children in the family contact must be made with Children and Families Services so that joint working can, if necessary, be considered.

5. Closer working relationships and liaison needs to be established with HAGA in order to manage and treat service users and duel diagnosis (alcohol dependency).

6. Staff must be fully debriefed following an incident and any subsequent needs discussed and considered.

7. When the ways in which services are delivered are changed the transitional period should be carefully managed to ensure that both staff and service users are supported.

4.3.5 The audit found that the nine main recommendations contained in the Internal Report addressed the Terms of Reference that had been set and identified all the main issues in this case namely:

1. **Review of the ERC/START** – It is recommended that the review should look at the way in which referrals are being made and managed by the Trust to ensure that all referrals are appropriately screened, assessed and sign posted on to the correct service. If a referral is to be held for short term intervention work by a member of START, team management arrangements must be in place to ensure that the reason why the referral has been allocated is understood; that the work is regularly reviewed and discussed in supervision and once the outcome achieved the patient should be referred back to primary care or on to another service. An audit process should be built into the pathway of care to ensure that any problems meeting these objectives can be monitored and dealt with.

2. **Care Pathway between START and HTT** – It is recommended that a protocol be developed to clarify the care pathway between START and the HTT. This protocol should make it clear what action is to be taken by whom when a person is referred on to the HTT. Secondly the protocol needs to spell out what happens when the HTT does not accept the referral from START.

3. **Access to Health Records** – The current 24 Hour Access Policy must be brought up to date to ensure that it reflects the new service line organisation. The procedure for accessing old records out of hours must be revised and simplified to bring it into line with the updated policy. Consideration should be given to including this topic in the appropriate training events for staff e.g. staff mandatory training. The normal practice of accessing notes should be audited at regular intervals to clarify any difficulties in the process.

4. **Risk Chronologies** –The Director of Nursing has already issued an instruction to all care co-ordinators that risk chronologies for their patients must be updated onto RiO to include past risk events. A special audit should now be conducted within all teams to find out the level of compliance with this instruction. Consideration should also be given to updating the Care Programme Approach (CPA) Policy and Procedures to reflect this need. The topic should be included in staff mandatory training. This is already subject to audit which should be repeated at Team level at regular intervals.

5. **Multi Agency Risk Assessment Conference (MARAC)** – Staff awareness of the existence of MARAC is low. It is recommended that a protocol should be established clarifying for staff which cases should be brought to MARAC and how to present a case. The existence of MARAC needs to be publicised and reinforced at all training opportunities. The utilisation of MARAC and its clinical usefulness need to be part of a regular audit process.

6. **Interface between NLFS and the Trust** – It is recommended that that the NLFS review the way in which information about known service users is recorded onto RiO when they are assessed and seen in prison. The outcome of all reviews and assessments must be recorded on RiO.

7. **Referral to Haringey Advisory Group on Alcohol (HAGA)** – It is recommended that a clear pathway between the Trust and HAGA should be agreed for those persons who have a dual diagnosis (mental disorder and alcohol problems. The pathway must address the issue as to what action will be taken by the service line and HAGA in the event the patient does not present to HAGA for treatment. The pathway must take account of the variety of services which may need to be involved with this client group, including specialist dual diagnosis and psychological services. The draft 'referral for HAGA' protocol should be agreed by the Directors of the Service Lines. The form should include a current risk assessment and risk history.

8. **Debriefing and Support to Staff** – The Trust is currently developing a policy regarding the support of staff following an incident. This policy will clearly outline for managers the procedure that must be implemented to ensure that all staff are properly debriefed and supported following an incident. In serious cases, a personal letter of support should be sent by a member of the Executive Management Team within 24 hours of the incident. Concordance with these recommendations should be regularly audited.

9. **Management of Frontline Services during periods of Change** – From January 2009 the Short Term Assessment and Recovery Team (START) (the gatekeeper to the whole of the local mental health services) underwent a number of major alterations and reconfigurations with significant changes in staff. During this period there were a succession of interim managers who were unable to provide consistent support and leadership throughout the whole of the change process. One consequence of this was difficulties experienced in providing adequate staff supervision during this time. It is

recommended that Senior Management within the Trust undertake a formal risk assessment of any planned major changes in services to ensure that sufficient and stable management support to front line services during periods of change is achieved.

4.4 Relationship between the Facts, Conclusions and Recommendations made in the Internal Report

4.4.1 The audit found that because clear Terms of Reference were provided at the outset of the investigation, the Internal Report provided a focused, systematic analysis of the evidence. The fact that the Internal Review Team reviewed all of Mr H's historic medical records covering the period 1988 to 1995 strengthened its conclusions. The audit found that the Safeguarding issues in this case had been clearly identified in the Internal Report particularly in relation to staff failing to liaise with, or share information with, Haringey Children's Services in accordance with agreed Safeguarding Policies and Procedures. The limitations of the liaison between the North London Forensic Service and Trust community mental health services are clearly identified. The audit found that the Internal Report properly identified that the reconfiguration of services was a significant contributory factor in this case. The audit found no gaps in the documentary sources of information that were scrutinised as part of the Internal Investigation.

4.4.2 The audit found that the Internal Report had correctly identified that the risk assessments used during the assessment of Mr H were of variable quality and the risk assessment process in the Trust had been hampered by the introduction of RiO because it did not include information contained in the historic written medical records, particularly risk chronologies (prior to 2008). In Mr H's case this meant that information about his risk history was not accessed by clinical staff during the assessment process. This issue is clearly dealt with in the Internal Report and was dealt with immediately by the Trust's Director of Nursing.

4.4.3 The audit found that the Internal Report had examined in detail the mental health services that were provided to Mr H. The Report correctly concluded that community mental health services responded to Mr H in an "Ad Hoc" manner with no single team taking or worker being responsible for his care. The imprecise care pathways between the ERC and START services and between START and the HTT are identified as issues requiring action. The audit confirms that the Internal Report also properly concluded that the care pathway between the Trust and the alcohol service HAGA needed to be reviewed. The audit confirmed that the Internal Report had correctly identified that the way information was recorded on RiO by the North London Forensic Service about patients in prison needed to be resolved.

4.4.4 In relation to the mental health services that were provided to Mr H the audit did identify some gaps. The Internal Report had identified from the medical records that an advocate working with the Patients Council had been informed by Mr H that he was "not happy with the treatment he had received from mental health services and that he was homeless". The advocate reports that Mr H had not continued with

HAGA because he did not like group work. The advocate is then reported to have told a member of the duty team that she had spoken to a member of staff from St Ann's Hospital Tottenham, who dealt with housing issues. The member of staff had informed her that it was her view that that she felt that "Mr H had been badly let down by mental health services". The Report having identified the issues then failed to explore them in any of the main sections of the report. This matter was discussed by the Independent Review Team and senior managers from the Trust on the 29 November 2011 and it is being addressed as a matter of urgency.

4.4.5 The audit found that the Internal Report had examined the extent to which Mr H's care was provided in accordance with statutory obligations and relevant national guidance from the Department of Health, including local operational policies. The Internal Report correctly concluded that after Mr H re-presented to services the focus of staff at the ERC was on his alcohol dependence because his previous diagnoses of personality disorder and risk history had not been inputted into RiO. This meant that he was not made subject to the Care Programme Approach because staff were unaware of the past psychiatric and forensic risk history. The Internal Report acknowledges that different clinical decisions may have been made if all the relevant information had been available. The Internal Report does not make reference to the Borderline Personality Disorder Treatment and Management guidance that was produced by the National Institute for Excellence in January 2009. The guidance sets out the approach that should be taken with people diagnosed with borderline personality disorders. Since Mr H was diagnosed with a borderline personality disorder in mid-January 2009, it is the opinion of the Independent Review Team that the Forensic Service could have considered the guidance as a way of managing his care.

4.4.6 The audit also identified that the Internal Report did not specifically address the issue of how the Trust and police liaise outside of the MARAC process.

4.4.7 Although Mr H had been subject to Section 136 of the Mental Health Act (1983) prior to 1995 there is no evidence in the Internal Report or from the audit that he should have been made subject to detention under the Mental Health Act (1983) from January 2008 when he re-established contact with the Trust's community mental health services.

4.4.8 The audit found that during the investigation that led up to the production of the Internal Report the families of the victim and perpetrator were not involved in or kept informed about the investigation. This is a significant weakness that was acknowledged in the Report. This issue was discussed between members of the Independent Review Team and the Trust on the 29th November 2011. The Trust is continuing to make renewed efforts to contact both families.

4.5 The Internal Report Action Plan and Implementation

4.5.1 The audit found that the nine point action plan that was developed following the production of the Internal Report clearly articulated the recommendations made in the Report; the action to be taken, by whom and by what review date are clearly

written. The Trust provided written and verbal assurance that action plan implementation is being monitored through a variety of mechanisms including publicly available performance management reports to the Trust Board (balanced scorecard reports, using the established 'Red, Amber, Green' system in which the items are marked as green when the action is fully met; amber when the action has been partially met; and red when the action has not been met).

4.5.2 Where available, the Independent Review Team have reviewed published evidence (available on the internet) of monitoring and found that this is taking place. The Trust has introduced an Integrated Action Plan that provides the Board with detailed information on all homicide cases and it identifies the main themes and actions. Following a meeting with the Trust's senior managers on the 29th November 2011 the Independent Review Team received an update from the Trust on progress made in achieving the milestones set in the action plan. The update indicated that:

1. **Review of ERC/START**. Review the Emergency Reception Centre and the Short Term Assessment and Recovery Teams located at St Ann's Hospital, Tottenham to look at the working arrangements of the service from a staff perspective – **achieved October 2010**.

2. **Care Pathway between the START and HTT**. It was recommended that a protocol be developed to clarify the care pathway between the START and HTT. This protocol should make it clear what action is to be taken by whom when a person is referred on to the Home Treatment Team - **achieved October 2010**.

3. **Access to Health Records (Pre patient electronic system - RiO)**. The current 24 Hour Access Policy must be urgently brought up to date to ensure that it reflects the new service line organisation. The procedure for accessing old records out of hours must be revisited and simplified to bring it into line with the updated policy – **achieved October 2010**.

4. **Risk Chronologies**. The Director of Nursing has already issued an instruction to all care co-ordinators that risk chronologies for their patients must be updated on to the electronic patient record system (RiO) to include past risk events - **achieved October 2010**. A special audit should now be conducted within all teams to find out the level of compliance with this instruction – **achieved October 2010**. Consideration should also be given to updating the Care Programme Approach policy to reflect this need - **achieved November 2011**. This topic should be included in staff mandatory training – **achieved October 2010**. This is already subject to audit which should be repeated at Team level.

5. **Liaison with Children and Family Services**. Child protection is already a prominent part of the mandatory training programme and the Internal Investigation Team therefore wished to focus on the issue of domestic abuse and its relation to the safeguarding of children. It was recommended that a specific communication is sent out to all front line staff on the significance of domestic abuse in relation to safeguarding of children and that a clinical audit

is conducted to assess the clinical assessment and management of domestic abuse – **achieved September 2010**.

6. **Multi Agency Risk Assessment Conference (MARAC)**. Staff awareness of the existence of MARAC was low. It was recommended that a protocol should be established clarifying for staff which cases should be brought to MARAC and how to present a case. The existence of MARAC needed to be publicised and reinforced at all training opportunities. The utilisation of MARAC and its clinical usefulness needed to be part of a regular audit process – **achieved October 2010**.

7. **Interface between North London Forensic Service and the Trust**. It was recommended that the North London Forensic Service review the way in which information about known service users is recorded on RiO when they are assessed and seen in prison. The outcome of all reviews and assessments must be recorded on RiO – **achieved October 2010**

8. **Referral to Haringey Advisory Group on Alcohol (HAGA)**. It was recommended that a clear pathway between the Trust and HAGA should be agreed for those persons who have a dual diagnosis (mental disorder and alcohol problems). The pathway must address the issue as to what action will be taken by the service line and HAGA in the event that the patient does not present at HAGA for treatment. The pathway must take account of the variety of services which may need to be involved with this client group, including specialist dual diagnosis and psychological services. The draft referral form for HAGA should be agreed by the by the Directors of Service lines. The form should include risk assessment and risk history – **achieved October 2010**.

9. **Debriefing and Support for Staff**. The Trust was developing a policy regarding the support of staff following an incident. The policy will clearly outline for managers the procedure that must be implemented to ensure that all staff are properly debriefed and supported following an incident. In a serious case, a personal letter of support from a member of the Executive Management Team should be sent within 24 hours of the incident. Compliance with these recommendations should be regularly audited – **achieved October 2010**.

4.5.3 As part of the audit exercise the Independent Review Team was provided with an action plan extract taken from the Trust's Inquiry Action Plan dated 28th November 2011. The extract identified that three actions had received a red rating because the review date set out in the action plan, the 11th November 2011, had not been met. Two of the actions that had not been achieved concern the need to develop clinical audit tools. The first relates to the need for the Trust to develop a clinical audit tool to provide assurance that risk chronologies were being completed according to procedure. The second concerns the need to develop another audit tool to provide assurance that the assessment and management of domestic abuse in Trust services is being carried out by team managers. Both of these matters have been addressed and a resolution is expected in early 2012. The third red rating relates to

funding for dual diagnosis workers in Enfield having been withdrawn by the PCT. A further business case is being produced to address this issue. A further amber rating had been given to the need to update the 24 Hour Access to Medical Records Policy. This policy has now been updated and is going through the Trust Policy and Procedure approval process.

4.5.4 The Independent Review Team found that the Trust had actively managed and monitored the action at Board and senior management level. All the actions had owners and clear review dates.

4.5.5 The audit found that the learning points included in the Internal Report had been incorporated into the main recommendations and into the action plan.

4.6 Clarity on Accountability and Responsibility.

4.6.1 The audit found that the Internal Report had properly identified that the failings in this case were systemic and not the responsibility of one individual or agency. The two contributory factors were significant and impacted on individual managers and teams to the extent that no one individual had an overview of Mr H's case.

4.6.2 The audit found that the nine Care and Service Delivery Problems identified by Internal Report were logical given the evidence. The seven lessons learned captured all of the main clinical practice and management issues. The ten main recommendations contained in the Internal Report accurately reflect the findings of the investigation. Each section provided clarity about accountability and responsibility for action.

4.6.3 The Independent Review Team found that the Trust Board is actively managing the implementation of the action plan and has developed an Integrated Homicide Action Plan that enables the Trust to monitor actions against cross cutting themes. The Trust has acknowledged that more work needs to be done to ensure that the learning from this and other investigations is embedded in the Trust at every level. A series of "team learning events" is being considered as one way to address this issue.

4.7 The Structure and Writing of the Report

4.7.1 The Report is well structured and written. It provides a very transparent analysis of the role the Trust played in supporting Mr H in the months leading up to the incident. The Report also provides a detailed account of Mr H's early background, his psychiatric and forensic history.

4.7.2 The Report is comprehensive, it identifies the key Care and Service Delivery Problems, draws appropriate conclusions from the evidence, and it identifies lessons to be learnt from the incident and makes recommendations which follow from the analysis and conclusions. An action plan was devised from the recommendations and its implementation is monitored, with most actions rated 'green' or 'amber' in November 2011.

4.8 Positive Practice which should be disseminated

4.8.1 The audit found that the Internal Report had properly identified two examples of positive practice:

- The comprehensive mental health assessment carried out on the 5th December 2009 by a staff member at the ERC led to the formulation of an appropriate care plan and referral to the HTT
- The contacts made with Mrs H to attempt to encourage Mr H to re-present to services to enable HTT to become involved were admirable given the circumstances.

4.9 Practice Issues – Areas for Improvement

4.9.1 The audit found that the Internal Report identified all the main areas for improvement that have already been reviewed in this report (Section 4.3.1). The implementation of the majority of the action plan objectives will ensure that the services provided by the Trust are improved.

4.10 Other Observations

4.10.1 The following additional comments are made:

- The Director of Nursing for the Trust identified that the Forensic Service at Pentonville Prison provided services to other Trusts in London. The issue of information sharing between Trusts that did not use the electronic patient record system RiO suggests that further work needs to be done improve the care pathway following prisoners discharge to other Trusts.
- The lack of involvement of the victim and perpetrator's families in the case remains the Report's main weakness.

5 Conclusions

5.1 Review of the Internal Investigation Report

5.1.1 The Independent Review Team came to the following conclusions regarding the Internal Investigation Report.

- Following the incident on the 31st December 2009 an initial management review was completed within 72 hours of the incident and the Trust commissioned an independently chaired Internal Investigation. These actions were in accordance with National Patient Safety Agency policy and procedure that NHS Trusts use in responding to Serious Untoward Incidents, including homicides.

- All the Trust services that had contact with Mr H were identified and reviewed as part of the Internal Review.

- All the staff who had contact with, or responsibility for Mr H were identified and interviewed by the by the Internal Investigation Team as part of the investigation process. Witness statements were taken and used to inform the investigation.

- Having applied the audit tool to the Internal Report and considered the available records the Independent Review Team considered that the nine Care and Service Delivery Problems, two Contributory factors and the nine recommendations that were made in Report were correctly drawn from the evidence that was collected as part of the Internal Investigation.

- During the desktop review Trust Senior Managers recognised that more work needed to be done to embed learning from Serious Untoward Incidents, including homicides throughout the organisation and a Trust Board Level Integrated Action Plan had been produced to support this objective.

- The role of other agencies was covered by the Internal Report.

- The Independent Review Team concur with Internal Investigation Team that although there were a number of care and service delivery problems and some other contributory factors no root cause for this incident was evident.

- The Independent Review Team acknowledges that the safeguarding children aspects of this case have been thoroughly investigated as part of the London Borough of Haringey Serious Case Review of this case. The Independent Review Team note that the Internal Report had already identified and addressed many of the issues concerning safeguarding children and domestic violence that were identified in the Serious Case Review report.

- The Independent Review Team noted that at the time of the review (October 2011 until January 2012) senior managers from the Trust had still not contacted the families of the victim or perpetrator even thought this had been included as an objective in the Internal Report. This was discussed and senior managers from the Trust provided assurance that these matters would be addressed.

- The Independent Review Team noted that that the Internal Report had identified that Mr H and a member of staff who worked for the Emergency Reception Centre, St Ann's Hospital had raised concerns about mental health services in January 2009 but these concerns had not been made subject to further investigation. The Trust has now addressed this matter.

- The Report was open, transparent, and well written.

5.1.2 The Independent Review Team came to the following conclusions regarding the action plan arising from the Internal Report and progress made on its implementation.

1. The action plan covered all the recommendations made in the Internal Report and addressed the Terms of Reference set for the Investigation.

2. The Trust provided assurance that action plan implementation is being monitored through a variety of mechanisms including publicly available performance management reports to the Trust Board (balanced scorecard reports, using the established 'Red, Amber, Green' system). Where readily available, the Independent Review Team have reviewed published evidence (available on the internet) of monitoring and found that this is indeed taking place.

3. The Independent Review Team met with senior managers from the Trust on the 29th November 2011 and received an updated extract on further progress that had been made in implementing the Action Plans.

6 Additional Actions

6.1.1 The Independent Review Team has concluded that the Internal Report provided a comprehensive analysis of the care and treatment provided to Mr H but there are three additional actions arising from this desktop review namely:

1. The Trust should consider making further efforts to contact the victim's and perpetrator's families to ensure that they have had the opportunity to become involved in, or make comment upon the investigations that have been made into the care and treatment of Mr H. The Chief Executive of the Trust has written to say that this is being actioned.

2. The Internal Report identified that Mr H and a member of staff working in the ERC had concerns about mental health services in January 2009. To date these have not been investigated. It is recommended that the concerns raised are investigated and the outcome included for further action or consideration. Again, the Chief Executive of the Trust has written to say that this is being actioned.

3. NHS London should share with other mental health and learning disability Trusts the risk that Consultant Forensic Psychiatrists visiting prisons may not input and update electronic patient record systems meaning that critical information is not shared with community mental health teams when patients are discharged from prison.

Appendix 1: Abbreviations

1 Anonymisation

Initials	Role
Mr H	Perpetrator
Mrs H	Victim - wife of Mr H.

2 Organisational

Abbreviations	Meaning
A&E1	Accident and Emergency Department, North Middlesex Hospital
A&E2	Accident and Emergency Department, Whittington General Hospital
CAT	Crisis and Assertive Outreach Team
CMHT	Community Mental Health Team
ERC	Emergency Reception Centre (St Ann's Hospital)
NFA	No Fixed Abode
GBH	Grievous Bodily Harm
HAGA	Haringey Advisory Group on Alcohol (voluntary organisation)
HTT	Home Treatment Team
MARAC	Multi-Agency Risk Assessment Team
MHA 1983	Mental Health Act (1983)
NFLS	North London Forensic Service
The Trust	Barnet, Enfield and Haringey Mental Health NHS Trust
RiO	Electronic Patient Record system
START	Short Term Assessment and Recovery Team

Appendix 2: Documentation audited by the Independent Review Team.

Patient's Health record, including written (historic) records and printed copies taken from RiO.

The Health Care Prison Record HMP – Pentonville, Barnet, Enfield and Haringey Mental Health NHS Trust

Barnet, Enfield and Haringey Mental Health NHS Trust Report for the Serious Case Review and the full Haringey Council Family Serious Case Review Report.

22 witness statements.

Reconfiguration of Haringey Community Mental Health Services: Intermediate Care Service Operational Policy: Issued 11th May 2007.

Consultation Paper (ERC/START) Reconfiguration of Staffing arrangements in Short Term Assessment and Recovery and Emergency Reception Centre at St Ann's Hospital.

Policies:

CPA Policy: date of issue March 2007. Review date March 2008

CPA Policy: current. Date of Issue :January 2009

Risk Assessment and Risk Management Policy 2010

Serious Untoward (SUI) Reporting Guidance Policy 2007

24 Hour Access to Records Policy (2003, to be reviewed June 2006)

Dual Diagnosis Strategy / Standard October 2008.

Home Treatment Team Operational Policy 2011

Barnet, Enfield and Haringey Mental Health NHS Trust Child Protection Policy

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HM Government (2006)

London Child Protection Procedures (2007)

Haringey Joint Protocol between Children and Young Peoples Services and Adult Mental Health Services (2008)

Appendix 3: Timeline

Contacts with the Criminal Justice System – most of this information was available in the written records only, which were not accessed by staff in relation to Mr H's presentations from January 2008 onwards and so were unknown to them. The clinical team were however aware of his imprisonment in 2003 and in 1983 from entries in RiO.

Time/Date	Event
1983	6 month prison sentence, Grievous Bodily Harm (GBH) against his wife
June 1988	Admitted to St Ann's Hospital after self-harm Diagnosed with paranoid personality and referred for psychotherapy
1990	Detained by police, subject to Section 136 of the MHA (1983): diagnosis of personality disorder with alcoholism
May 1990	Mr H attended St Ann's Hospital, informed doctor he had committed violent offences including 2 rapes. Referred to a consultant psychiatrist but did not attend appointment.
Jan 1993	Admitted under Section 136, after he tried to stab his wife and heavy drinking. Diagnosed with a depressive illness due to alcohol and possibly a borderline personality disorder. Referred for psychological therapy but discharged himself after 9 days before the therapy could begin. No evidence of follow-up after this episode.
	Custodial sentence following driving under the influence of alcohol (date unclear)
Jan 1995	Admitted to St Ann's Hospital but absconds (no information available on date of discharge)
	Not seen by mental health services for 13 years; Mr H and his family were known to Criminal Justice system and Children's Services during this time.
2003	12 month sentence of imprisonment (assault on a policeman)
29 Jan 2008 17.45 hrs. 22.04 hrs.	 Mr H presented to the ERC; under the influence of alcohol; advised he would be seen by the CAT when his alcohol levels were reduced. 2 staff from CAT arrived at the ERC to assess Mr H: he walked out; message left on his mobile voicemail; details circulated to police because there were concerns regarding his mental state.
30 Jan 2008	2 CAT staff attended his home address to carry out an assessment; he was not there. Message left on mobile voicemail.
31 Jan 2008	CAT team visit to Mr H's home address; spoke to wife, he had not lived there for some time and she did not know where he was. CAT team informed ERC and START team no further visits would be made. No further interventions planned until Mr H was located.
18 Feb 2008	Mr H presented at ERC; duty doctor carried out full mental state assessment. Noted: Alcohol dependence No Fixed Abode (NFA) History of self-harm and suicide attempts Some evidence of paranoid ideas Given vulnerability and risk factors, he was admitted to Alexander Ward (St Ann's Hospital). Risk assessment and management form completed, recording: Risk of violence to others - low Risk of suicide – medium to high

	Risk of substance misuse – high
20 Feb 2008	Mr H reviewed by ward doctor (also duty doctor of 18th assessment): he agreed to stay in hospital for 5-day detoxification. In addition the following were agreed as part of his care plan: Referral to START and 'Key Support' Benefit forms completed
21 Feb 2008	Mr H referred to HAGA; Mr H assessed for occupational therapy – a programme was implemented
21 – 24 Feb 2008	RiO records show Mr H complied with nursing care plan and appeared settled. No evidence of alcohol withdrawal symptoms.
24 Feb 2008	Ward review: Mr H asked to discharge himself; no psychotic phenomena; no thoughts of harm to self or others; no plans of self-harm.
25 Feb 2008	Mr H seen by duty doctor; Signed the 'self-discharge form' and left the ward.
1 April 2008	START informed by HAGA that Mr H had been sent appointment for 20 February but had failed to attend. Agreed no further action would be taken.
April 2008	Public Order (Guilty); Breach of conditional discharge
Sept 2008	Breach of non-molestation order
Oct 2008	Common Assault (Guilty); Breach of non-molestation order
Nov. 2008	Mr H was sent to prison (Common Assault/Breach of non-molestation order)
Jan 2009	Wounding with Intent to commit GBH against his wife
29 Jan 2009	Mr H referred to START Duty Team by advocate working with Patients' Council. Mr H had informed advocate he was not happy with the treatment received from mental health services, and was homeless. The advocate reported that: Mr H had been to HAGA but not continued as he did not like group work A member of staff at St Ann's Hospital had expressed the view Mr H had been badly let down by the mental health service. Mr H to be referred to START for assessment and for advocate to see him weekly until the assessment was made.
30 Jan 2009	Referral to START West team made by START duty team
10 Feb 2009	Mr H presented himself at ERC requesting assessment for depression with a view to stopping alcohol dependence. Informed staff he was low, had been drinking a lot, had been having thoughts of self-harm, but denied this was current. Mr H decided not to stay for assessment and left, saying he would return if unable to sleep.
17 Feb 2009	Referral made by START manager to START West Team requesting discussion of Mr H. Out-patient appointment sent to Mr H on 10 March 2009.
Feb 2009	Breach of suspended sentence; breach of non-molestation order x 2
10 Mar 2009	Mr H did not attend (in prison at this time). Advocate informed no further appointments to be made and advised that he should attend ERC if he needed help.
13 May 2009	Mr H seen by Forensic Psychiatrist from the NLFS (service provided by the Trust) for self-harming behaviour whilst he was in prison. Record states he was in prison for domestic violence and breach of conditions of his release.
	Six appointments with NLFS psychiatrist whilst Mr H was in prison (dates not given)
15 July 2009	Final prison appointment with NFLS psychiatrist
July 2009	Released from prison: the Internal Report notes initially that this was a mistake; but later that this was automatic release
July 2009	Breach of suspended sentence

August 2009	Recalled to prison, served remainder of sentence
Oct 2009	Released from prison
20 Nov 2009 18.35 19.35	 Mr H presented to ERC, intoxicated, then became abusive to staff Mr H escorted from building by security staff.
5 Dec 2009	Mr H presented at ERC, reporting thoughts of self-harm/suicide; that he had been released from prison (for domestic violence) the previous month; that he had been treated with anti-depressants; that he wanted to restart the medication; that he was back living with his wife. Assessment: Presentation due to alcohol with some psychotic features Denied thoughts of harm to self or others. Mr H referred to West HTT Mr H was asked to wait at ERC for assessment: he left ERC before assessment could be done. Staff from HTT arrived to assess him – telephone call to his wife who doubted he needed mental health services but he had been binge drinking and was not supporting her at the time. ERC staff to continue to try to contact him, check if he wanted support from mental health services and to provide feedback to HTT
7 Dec 2009	Referral to HTT had been closed
31 Dec 2009	Mr H killed his wife; START manager requested staff to inform police if Mr H presented at ERC; Police telephone inquiry to ERC asking if Mr H had presented; Later police arrived at ERC with picture of Mr H requesting possible identification.
Jan 2010	Mr H remanded to prison; his 4 children were taken into care
August 2010	Mr H convicted of manslaughter on grounds of provocation (trial data records that victim informed him the youngest child was not his); sentenced to an indeterminate sentence for public protection, with a minimum of 8 years before being considered for parole.