An independent investigation into the care and treatment of RP

A report for NHS London

February 2010

NHS London

Contents

Appendices

1. Introduction

Overview

1.1 On 16 July 2004 RP shot and killed TS while robbing him. RP was receiving community care from East London and the City Mental Health NHS Trust (now East London NHS Foundation Trust). For more details about the trust see paragraphs 1.15 to 1.17.

1.2 The robbery was committed with three accomplices one of whom was TS's friend. On 13 October 2005, RP was found guilty of manslaughter and sentenced to 18 years' imprisonment. He is currently serving his sentence at HMP Gartree.

1.3 Police records indicate TS and RP lived in the same area of east London but did not know each other.

1.4 RP received care from his GP, Huntercombe manor (a private mental health hospital), the child and family consultation service (CFCS) (part of the child and adolescent mental health service [CAMHS] of East London and the City Mental Health NHS Trust), the Newham youth offending team (YOT) and the Newham East adult community mental health team (CMHT). During the period covered by this report, RP also spent time in Orchard lodge (social services secure accommodation) and HM Young Offender Institution and Remand Centre Feltham.

1.5 *HSG(94)27 Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36 issued in June 2005 state that in serious cases there must be an immediate internal investigation using structured investigation processes such as root cause analysis. It also states that an independent investigation must be held in the case of a homicide committed by a person who has recently been in receipt of mental health services.

Internal (trust) investigation

1.6 East London and the City Mental Health NHS Trust commissioned an internal investigation into the care and treatment of RP. It was carried out by a director of nursing, who was external to the trust; a consultant forensic psychiatrist; and a consultant psychiatrist both of whom worked for the trust. The internal report was undated but completed before RP's conviction in October 2005. It was presented to the trust board in December 2005. The internal report is examined in more detail in section 7.

Independent investigation

1.7 Verita, a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations, was commissioned by NHS London to undertake the independent investigation.

1.8 Our team consisted of David Knight, investigation manager, and Ed Marsden, managing director. Dr Douglas Gee, consultant psychiatrist and medical director for Humber Mental Health Teaching NHS Trust acted as a professional adviser.

1.9 We used the internal trust investigation as a starting point for our investigation.

1.10 This report sets out RP's care and treatment from September 1999 to July 2004. It provides a chronological overview of events and evaluates the care and treatment he received, including the communication between the numerous organisations involved.

1.11 This report quotes from contemporaneous documentation as well as from those who gave evidence to the investigation.

1.12 We agreed with the conclusions of the internal investigation but have also made a number of additional comments and recommendations.

Acknowledgements

1.13 TS's death profoundly affected the lives of his family. We offer them our condolences. We invited TS's parents to meet us but they did not feel able to do so. We understand this.

1.14 We would like to thank everyone who gave their time to give evidence to the investigation and who spoke so freely to us.

East London NHS Foundation Trust

1.15 East London and the City Mental Health NHS Trust was formed in April 2000 from mental health services previously provided by community trusts in Tower Hamlets, Newham and City and Hackney. The trust was awarded foundation trust status on 1 November 2007 and is now known as East London NHS Foundation Trust.

1.16 The trust serves a culturally diverse population of 710,000. Levels of social deprivation and service need are high. For example, Newham has the fourth highest demand for primary care in the country (measured by the Jarman index) and the tenth highest mental health need (measured by the mental health needs index).

1.17 The trust provides community and inpatient services to children, young people, adults of working age and older adults and forensic services to a wider population of 1.5 million in north east London.

2. Terms of reference

The main objectives of the independent investigation were to analyse the care and treatment RP received and to make recommendations to minimise the recurrence of a similar event.

The terms of reference state that:

The investigation team will:

- Investigate and review the mental health care and treatment provided by the trust to RP from his first contact to the time of the offence.

- Assess the adequacy of the risk assessment(s) of RP and actions consequent upon the assessment(s).

- Examine the nursing and medical leadership and management associated with RP's care and treatment.

- Review the extent to which trust services adhered to statutory obligations, relevant national guidance and local operational policies.

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

- Examine the extent and adequacy of interagency collaboration between the trust (including forensic services for young people), local authority, Huntercombe group, Metropolitan Police and RP's general practitioner.

- Review the trust internal investigation and assess the adequacy of its findings and recommendations and the progress made in their implementation.

- Provide a written report including recommendations specific to the care and treatment of RP to NHS London, the trust and its commissioning primary care trust (Newham PCT).

- Ensure that themes and recommendations are cross-referenced with investigations currently conducted by Verita covering East London NHS Foundation Trust.

The full terms of reference for the investigation are provided at appendix A.

3. Approach and structure

Approach to the review

3.1 The investigation was undertaken in private. In the course of the investigation we examined all available relevant documentation (see appendix C) and conducted ten interviews. We also conducted two telephone interviews and had email correspondence with one member of staff.

3.2 Those interviewed included various professionals involved in RP's care as well as RP and his nominated next of kin. Despite our best efforts we were unable to contact consultant 4 as he has returned to his country of origin. TS's family chose not to meet us. The absence of their direct testimony should be borne in mind when reading this report. A list of interviewees is provided at appendix D.

3.3 All interviewees were given the opportunity of being accompanied at their interview. They were also provided with the opportunity to comment both on the factual accuracy of their interview transcripts, and where appropriate, on relevant extracts of this report while it was in draft.

Structure of this report

3.4 We have made comments and recommendations based on our interviews with those referred to at appendix D and the information available to us to the best of our knowledge and belief.

3.5 Our comments are provided in ***bold italics***.

3.6 A list of abbreviations used in this report is provided at appendix E.

3.7 Section 4 provides an executive summary including conclusions and recommendations from this independent investigation.

3.8 Section 5 provides a biography of RP.

3.9 Section 6 provides a chronological summary recording the background and context to his care. It includes our comments and recommendations for each period in RP's care. We have used a timeline of the main services RP received (see paragraph 6.1) as the basis for describing and analysing his care.

3.10 Section 7 provides our review of the internal investigation undertaken by East London and the City Mental Health NHS Trust.

3.11 In section 8 we have cross-referenced the themes and recommendations from this investigation with those from another investigation conducted by Verita relating to East London and the City Mental Health NHS Trust.

3.12 Section 9 contains our recommendations.

4. Executive summary and recommendations

Synopsis of case

1984 -2000

4.1 RP was born in October 1984. He had a troubled childhood. His father took and sold drugs and physically abused his mother. His mother and father separated when he was eight years old but the domestic abuse continued despite the separation.

4.2 He was bullied at school and struggled with education. He began to take drugs when he was about 12 years old. He began to commit robberies to buy drugs and other items. He robbed for gain. As a result he came into contact with the criminal justice system and mental health services.

4.3 In 1999 following his conviction for robbery RP, then aged 14, received a 21 month custodial sentence. He was sent to Orchard lodge local authority secure accommodation. While there he became mentally unwell and in December 1999 he was transferred to Huntercombe manor (a private mental health hospital). The multi-disciplinary team had concerns about his emerging paranoid personality traits and his persistent problems with poor impulse control. He was assessed as being a moderate to high risk to others. He assaulted two fellow patients and was threatening to staff. (Appendix B provides an overview of documented examples of RP's physical and verbal aggression). RP was diagnosed as suffering from drug-induced psychosis with paranoia and treated with antipsychotic medication.

4.4 On 18 August 2000 RP was discharged from Huntercombe manor to his mother's home. He was still subject to a detention and training order[1] (DTO). His discharge plan

[1] "The detention and training order (DTO) sentences a young person to custody. It can be given to 12 to 17 year-olds. The length of the sentence can be between four months and two years. The first half of the sentence is spent in custody while the second half is spent in the community under the supervision of the youth offending team (YOT). A DTO is only given by the courts to young people who represent a high level of risk, have a significant offending history or are persistent offenders and where no other sentence will manage their risks effectively.

indicated that local services would offer support in the community and the care plan was focused upon relapse prevention, supportive social work intervention and anger management. His care moved to Newham youth offending team (YOT) and the child and family consultation service (CFCS) (part of the child and adolescent mental health service provided by East London and the City Mental Health NHS Trust).

4.5 While RP attended the majority of appointments with YOT his attendance at CFCS was poor. As the compulsory element of his DTO was drawing to a close RP made it clear that he would not co-operate with another service and YOT therefore made no onward referrals. In December 2000, YOT closed RP's case and his DTO expired. Contact with CFCS was left open.

2001

4.6 On 15 January 2001, 20 days after the completion of this DTO, RP was arrested for his involvement in the armed robbery of a taxi driver. He was remanded in custody to Feltham where he complained that he was hearing voices. While he was at Feltham, CFCS provided a report indicating that RP was unlikely to benefit from community interventions and would benefit from long-term therapy in a secure setting. He was referred to the national medium secure adolescent forensic services and was subsequently assessed as suitable for admission but the Gardener unit[2] had no beds available. Consultant psychiatrist 1, who had previously cared for RP during his first admission to Huntercombe manor, subsequently assessed RP at Feltham.

4.7 On 11 June 2001, four days after his conviction for robbery, RP was admitted to Huntercombe manor under section 37 of the Mental Health Act 1983.

The seriousness of the offence is always taken into account when a young person is sentenced to a DTO."
Source - The Youth Justice Board for England and Wales' website.

[2] The Gardener unit provides an in-patient resource for young people between the ages of 11 and 18 years, within medium security and who are detained under the Mental Health Act (1983). These young people present with serious mental illness or concern of significant psychiatric disorder; combined with violence or serious risk of violence to others. Source: The Greater Manchester West Mental Health NHS Foundation Trust website.

4.8 In August 2001, the notes of a care programme approach (CPA) meeting record that RP appeared settled and was no longer considered to require placement at the Gardener unit although there were concerns that he should not return home. A social worker based at the Gardener unit, attended the meeting.

4.9 In early October 2001 the clinical team at Huntercombe manor considered that RP was settled with no evidence that he was psychotic. While on escorted leave, RP climbed out the bathroom window of his aunt and uncle's house and absconded. The police were contacted but were unable to locate RP and he remained out of contact with services until he went to the YOT offices in March 2002.

2002

4.10 In March 2002 YOT and CFCS re-established contact with RP. However his attendance at meetings with CFCS remained sporadic. After an incident at York house (the CFCS base) in June 2002 in which RP became angry and hostile, it was decided that joint meetings with YOT (which was working with him on an informal basis as he was not subject to any particular order such as a DTO) should be arranged at the YOT offices.

4.11 During August 2002 RP went to the accident and emergency (A&E) department of Newham General Hospital complaining of feeling agitated and experiencing auditory hallucinations. Later that month he was seen jointly by CFCS and YOT. RP complained of feeling increasingly agitated. He had split up with his girlfriend, was fed up with his housing situation and complained of hearing a male voice in the background. He had been using marijuana. He was treated with antipsychotic medication.

4.12 In October 2002 as RP approached his 18th birthday he was seen by CFCS. He was accompanied by his aunt who was concerned about his welfare. CFCS wrote an open letter of support to help RP with his housing needs and contacted the manager of the Newham adult community mental health team (CMHT) to advise them that RP was ready to graduate from child and adolescent services into adult care but due to his ambivalence to services it was not possible to transfer his care.

4.13 After some confusion about which community mental health team would pick up his care, RP was allocated to the Newham East adult CMHT.

2003

4.14 RP's attendance at meetings with the CMHT was sporadic and followed a similar pattern to that with CFCS. When assessed RP spoke about his interest in martial arts and shooting guns. He was treated with antipsychotic medication. He did not attend his appointments in late February, March, April, May or June 2003. However RP and his girlfriend did have telephone conversations with the CMHT. In May 2003 RP told the CMHT that his relationship with his girlfriend had ended in violence.

4.15 In July 2003 RP was seen at home by his care coordinator, a social worker, and the CMHT psychologist. He told them that he was feeling threatened by a man in Stratford and the only way to deal with this was to kill the man first.

4.16 He did not attend a CPA meeting arranged later that month nor did he attend a psychology appointment. Following discussion within the CMHT it was decided to refer RP to the public protection panel. No one completed this referral.

4.17 On 25 September 2003 RP attended a meeting with the CMHT when he told them about the violent end to his relationship with his girlfriend and the thoughts he was having about revenge. The senior clinical medical officer recorded that he had asked RP's care coordinator to complete a referral to forensic services to assess RP's risk to others. However the care coordinator has advised that the expectation was that consultant psychiatrists or the associate specialist made the initial referrals to forensic services on a doctor to doctor basis. Notwithstanding, there is no record of a referral being completed.

4.18 During October 2003 the care coordinator visited RP at home; RP attended a meeting and they also spoke on the telephone. RP told us that he found it difficult to go to the team base as he felt increasingly paranoid.

4.19 In November 2003 the care coordinator completed a risk assessment. He recorded that RP owned a spear-gun but had not threatened anyone with it. He recorded warning signs for deterioration in RP's mental health such as "*disengagement from services …and stressful situations".* Later that month RP was attacked by a gang of youths and sustained an injury to his ear. The care coordinator visited him at home and RP told him that his spear-gun was broken but he had bought a crossbow. At a CPA meeting in December 2003 RP told the senior clinical medical officer that the spear-gun was for protection. The senior clinical medical officer recorded that RP was willing to take medication and re-referred him for psychology.

2004

4.20 During January 2004 RP failed to attend his psychology appointments and the CMHT psychologist closed his case. He attended a CPA meeting in March 2004. RP was accompanied by his aunt. The care coordinator recorded that RP arrived late for the meeting but this is disputed by RP and his aunt. No room was available to conduct the meeting and the senior clinical medical officer was not available as he was on leave. RP became angry, abusive and threatening and the police were called and he was escorted from the premises.

4.21 RP did not attend the meetings arranged in April, May or June 2004. His care coordinator telephoned him on a number of occasions and wrote to him about the need to attend appointments. They met on 17 June 2004 when they bumped into one another on the high street. The care coordinator recorded that RP appeared to be his usual self.

4.22 A CPA meeting was held on 6 July 2004. RP did not attend. As RP's home address was in the catchment area of another consultant it was agreed to transfer his care. It was considered that it would be "*helpful*" to make a forensic referral and that RP would remain on enhanced CPA.

4.23 On 16 July 2004 RP killed TS in the course of a robbery. He told us he intended robbing TS but regretted killing him. RP was convicted of manslaughter in October

2005. He was sentenced to 18 years and is currently serving his sentence at HMP Gartree. RP was 19 years old at the time of the offence.

4.24 After his arrest for killing TS (but prior to his conviction) an internal investigation was undertaken by the East London and the City Mental Health NHS Trust.

Internal Investigation

4.25 The internal investigation team came to a number of conclusions about the care and treatment RP had received which in the main we endorse. These are as follows:

- There was no failure in RP's care that contributed to the offence
- RP's compliance with services was erratic and services had sought to maintain contact and to provide support to him
- RP was deemed to be at high risk and there were concerns about his safety and the safety of others with whom he had contact. An agreement to refer his case to the public protection panel was not completed.
- The CMHT should have ensured that all appropriate services were involved in his care
- There is a gap in forensic services for young people who are no longer adolescents but not old enough for adult services
- CMHT record keeping failed to comply with the trust standards.

4.26 While we agree with the majority of these conclusions we do consider the trust did not carry out actions that could have safeguarded RP and others. If these had been carried out the risk he represented could have been reduced.

4.27 The trust made six recommendations which were developed into an action plan. The following is a summary of the areas of progress of which we have been advised by the trust:

- Care pathways for use within CAMHS and YOT have been developed. The trust provided us with copies of the pathways.
- A meeting with clinical directors has been convened to improve the communication with forensic services.
- Revised multi-agency public protection arrangements have been developed and are awaiting sign off by the trust medical director.
- A system of mandatory audits of record keeping has been established and the audit results then taken to the local clinical effectiveness meeting for any further action to be implemented.
- Improved supervision arrangements have been developed with the aim of ensuring clarity of role and expectations for staff especially when joint working (between services) is in place.
- There has been an independent audit of supervision arrangements.
- A revised incident policy has been developed.

4.28 We have identified through our independent investigation two areas relating to the internal investigation which we consider need to be addressed by the trust and are reflected in our recommendations. The two areas are summarised below:

Consultation with families

- When we spoke with the trust there was no evidence that either TS's or RP's family had been consulted as part of the internal investigation process. Current guidance issued by the National Patient Safety Agency advises that families should be consulted as part of the investigation.

Feedback to staff

- Some staff had not received any feedback from the trust's internal investigation. It is reasonable to expect that staff involved in an internal investigation of this nature receive feedback about the findings.

4.29 The findings and conclusions of our independent investigation are set out in paragraph 4.32. A number of our findings echo and further develop the conclusions of the internal investigation.

Findings from an investigation into the care and treatment of another patient of East London and the City Mental Health NHS Trust

4.30 In accordance with our terms of reference we have cross-referenced our investigation concerning RP with another investigation conducted by Verita into a homicide committed by a patient of the trust in 2006 (and relating to that patient's care which was provided from 2005 onwards).

4.31 The following themes are identified within both reports:

- risk assessment and use of CPA
- maintaining a broad view of the historical basis of risk
- post-incident feedback and reflective learning
- engagement with families.

4.32 The following extracts taken from the other Verita investigation report demonstrate the similarity of the findings:

Risk assessment and use of CPA

- *Particular attention should be given to ensuring care planning and risk assessments are at the heart of all CPA reviews.*

- *The trust should ensure that the importance of planning for and managing transitions … between services or within the trust… is reiterated as a key part of CPA.*

Maintaining a broad view of the historical basis of risk

- *Although there was occasional noting of risk there was never any real assessment or management of it.*

- *[This] led to views being taken about him which were based on immediate observation rather than on any longitudinal study. As the internal reports says there was "…an over reliance on passive observation as opposed to active inquiry as regards [his] mental state and risk management".*

Post incident feedback and reflective learning

- *The trust developed a detailed action plan following the internal investigation which has already led to a significant number of improvements but some of the staff we interviewed did not have much if any knowledge of it.*

Engagement with families

- *In our interview with [his] parents they told us that no one from the trust spoke to them about what had happened. This is unfortunate as families of perpetrators are as much victims as families of the victims.*

4.33 These are themes which are clearly reflected in our findings and conclusions arising from the independent investigation of the care and treatment of RP.

Findings and conclusions

4.34 The following section is a summary of the findings and conclusions from our independent investigation.

October 1984 –2000

Given RP's clinical presentation during his care at Huntercombe manor, the package of treatment offered to him was appropriate. The aspects of emergent personality disorder with which RP presented (poor impulse control for example) were given secondary importance.

We recognise that the willingness to make a diagnosis of emergent personality disorder in adolescents was only beginning to develop by 2004.

A coordinated handover between the inpatient services provided by Huntercombe manor and the community services provided by YOT and CFCS was put in place.

By December 2000 when RP's DTO finished YOT and CFCS had a clear understanding of the risks RP posed.

2001

In January 2001 whilst RP was in Feltham he was referred to the Gardener unit. Following RP's conviction for robbery in June 2001, a placement at the Gardener unit was not available.

He was transferred from Feltham to Huntercombe manor on 11 June 2001 from where he absconded in October 2001 and agencies lost contact with him.

2002 – YOT and CFCS

RP made contact with YOT in March 2002 and although outside their remit at that time they continued to help him.

RP's contact with YCFCS was problematic. There was a clear mismatch between RP's expectation of the service he believed they should *provide and that which they were able to provide. RP's resulting frustration combined with his impulsivity, led to aggressive outbursts and violent behaviour.*

CMHT October 2002 – July 2004

Absence of consultant intervention

RP, despite being on enhanced CPA (September 2003), was not seen by a consultant psychiatrist until after he had killed TS in July 2004. High risk and complex cases (like RP) should have consultant input.

Medical supervision within the team should have been better. We would have expected consultant psychiatrist 4 to be more involved in RP's case. As a minimum, we would have expected to see documentary evidence to support a detailed discussion of RP's case between the senior clinical medical officer and consultant psychiatrist 4.

Team support processes and supervision

RP's care coordinator had only recently qualified as an approved social worker (ASW) and had not received an induction programme when he became RP's care coordinator. Previously the major part of RP's care coordinator's career had been with people with learning difficulties.

Given the complexity of RP's needs and his well documented ambivalence to intervention, care coordinator responsibility should have been allocated to a more experienced member of the CMHT.

RP was a challenging and difficult case to manage. As he had a well documented history of risk (including his inconsistent attendance and non compliance with treatment) his case should have been discussed in supervision. Support and supervision for all grades of staff regardless of profession should have been in place.

Application of CPA

CPA meetings were arranged and care plans completed. However a CPA level was not recorded until September 2003.

A contingency plan to manage the risks RP presented should have been put in place by the multi-disciplinary team when RP's care coordinator correctly identified RP's risks and warning signs in July 2003. RP had not complied with appointments and was under stress due to the violent break up of his relationship. Although RP did not completely disengage from the CMHT, in keeping with the trust CPA policy, more active and earlier consideration of onward referral to the assertive outreach team should have been given.

Risk assessment and risk management

The team appear to have focused on his immediate presentation rather than giving sufficient weight to the well documented history of violence, aggression and impulsivity evident from RP's clinical records (see appendix B). If this information had been analysed, an emerging personality disorder may have been identified behind what may have been drug-induced psychotic episodes. This may have led to an alternative management approach.

The risk assessments that were undertaken by the team understated RP's potential for violence towards others.

Referral to specialist teams

Although decisions were made by the team to refer RP to the forensic service and to MAPPA[3] (multi-agency public protection arrangements), neither referral was made. There was a lack of clarity about referral processes and the function of specialist team. The senior clinical medical officer's perception (that the forensic

[3] MAPPA arrangements operate across England and Wales and allow agencies to review the risk posed by offenders and the actions taken to manage them.

referral was undertaken by the care coordinator) directly conflicted with the care coordinator's view (that it was undertaken by medical staff).

RP was not referred to the assertive outreach team despite his sporadic compliance with medication, intermittent attendance at CPA meetings and the need to closely monitor his mental state. The prevailing culture was that the team could cope with any referral it received and this may have contributed to the failure to engage relevant services in meeting RP's needs and managing the risks he represented.

Documentation

It is reasonable to expect that key decisions agreed at meetings would be recorded and followed up. The CMHT clinical records failed to record updates on agreed decisions. There were no medical entries other than letters sent to RP's GP recording meetings with RP.

Overall conclusion

The CMHT never gained a full understanding of RP's condition and his dangerousness. As a consequence it failed to carry out some important actions that could have safeguarded him and others. RP was not referred to the MAPPA panel or the forensic service despite agreements to do so. Nor was RP referred to the assertive outreach team despite the guidance given in the trust CPA policy.

The plans of care developed focused on risk assessment and monitoring rather than intervention and risk management.

Recommendations

4.35 Our recommendations for East London NHS Foundation Trust arising from our independent investigation (some of which may already have been acted upon by the trust) are given below.

R1 The trust must ensure professional or managerial supervision arrangements are in place for all clinical staff. Responsibilities of supervisors and supervisees should be clearly documented and understood. The risk assessment and follow up of patients considered to pose a threat to themselves or others should form part of the supervision meeting.

R2 The medical director of the trust in conjunction with the director of nursing should commission, for completion within six months, audits of:

- compliance with the supervision policy currently in place
- risk management to examine:
  - Comprehensive collation of risk indicators – past and present
  - Quality of analysis of information regarding the conclusions about the degree of risk(s)
  - Quality and appropriateness of subsequent action plan

R3 The trust should explain to the Metropolitan Police immediately following an incident what contact they want to have with the perpetrator and victim (if appropriate) and their families so as to discharge the trust's responsibilities and obligations. They should challenge any unnecessary restrictions imposed by the police under the terms of the national agreement signed in 2006 "*Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive".*

R4 The trust should ensure that there are systems in place to enable staff involved in a serious untoward incident to receive feedback from the subsequent investigation.

R5 The trust should review as a priority its CPA guidance in the light of the Department of Health guidance on CPA[4], the findings of the internal investigation report and this investigation. Particular attention should be given to ensuring care planning (including onward referral to specialist teams) and risk assessments are integral to all CPA reviews. An audit against progress should be undertaken after six months and annually thereafter.

R6 The trust should review processes for the allocation of care coordinators to ensure that the skills, competencies and experience of the coordinator are appropriate to the needs of the service user.

R7 The trust should ensure that where there are indicators of previous violence or aggression a history identifying the incidence of behaviours (such as violence and aggression) and potential contributory factors (for example the absence of support systems) are collated from all services involved in an individual's care. This information should form an integral aspect of an individual's risk assessment and care planning. This information must be passed on when care is transferred between services and/or between organisations and must be regularly updated to incorporate any new risk behaviours.

R8 The trust should ensure within six months of completion of this report that clinical staff have either received or have built into their personal development plans and appraisal processes the necessary changes to ensure that they have the required skills and competences to undertake a risk assessment. Six months thereafter an audit of all personal development plans and appraisal processes should be undertaken to ensure that the skills and competences have been acquired or are in the process of being acquired by clinical staff.

[4] *Refocusing the care programme approach: policy and positive practice guidance*, *Department of Health, March 2008*

5. Biography

Early life

5.1 RP was born in Newham General Hospital on 26 October 1984. He has always lived in east London.

5.2 He is the middle of three brothers. His father is currently in prison and his mother died in December 2007. RP told us he has maintained contact with his younger brother and maternal grandparents but has no contact with other family members. He said that he did not want us to speak to other members of his family.

Comment

We believe that complying with RP's request did not undermine our investigation.

5.3 RP described a troubled and dysfunctional childhood. He told us that his father took and sold drugs. His mother drank heavily and was regularly physically abused by his father. When he was around eight years old his parents separated and his father moved out of the family home but continued to visit.

Comment

When we interviewed RP he told us about his relationship with his father. He described a troubled, disturbed and difficult childhood which was characterised by criminal behaviour, drug taking and violence. He lacked positive role models to influence his behaviour and to curb his criminal activities.

Education

5.4 RP attended Keir Hardie primary school (a mainstream community primary school) until he was 11. He moved on to Cumberland secondary school but his attendance was poor and he was excluded due to his behavioural problems. Following

a period of home schooling he attended Walton Road school, a social services facility for young people who are 'looked after' or who are at risk because of their offending behaviour, where his attendance improved significantly.

5.5 At interview RP told us that he found learning difficult. He told us he did not attribute his difficulty to his disturbed family circumstances. He described being bullied at school but then taking revenge when the opportunity became available. While in prison he has improved his reading skills and now enjoys reading books.

Illegal drug use and offending history

5.6 RP described using cannabis at around 12 years of age. He told us that he had also used lysergic acid diethylamide (LSD). He said cannabis made him feel good but when he was around 13 or 14 this began to change and he experienced bad thoughts. He said he started feeling paranoid all the time. He told us that his father gave him drugs.

5.7 By September 1999 RP had been convicted of a number of offences.

Table 1:

Year	Conviction	Sentence
1997	Possession of an offensive weapon	Conditional discharge 12 months
1998	Intimidating a witness and juror	24-hour attendance centre order
1999	Aggravated taking and driving away	Detention centre 21 months
1999	Robbery	Detention centre 21 months

Comment

By the age of 14, RP already had a significant career in crime. His criminal activities included threat, violence and the use of weapons. Sanctions placed on him did not prevent his reoffending.

6. Chronology and analysis

6.1 From 1999 onwards RP received care from a number of agencies. This section analyses the care and treatment he received from each agency. An overview of the service providers and indicating the period/s when RP received care is provided below.

- *Orchard lodge social services secure accommodation (September to December 1999).*

  Orchard lodge is a local authority secure children's home in Southwark, London providing accommodation for children who have been through the criminal justice system or who are placed there for welfare reasons.

- *Huntercombe manor (first admission December 1999 to August 2000, second admission June 2001 to October 2001).*

  Huntercombe manor, in Maidenhead, provides psychiatric intensive care for young people in a locked secure facility. The unit (now called the Huntercombe Hospital) is run by the Huntercombe Group.

- *Child and family consultation service (CFCS) (first period of care August 2000 to January 2001, second period of care October 2001 to October 2002).*

  The child and family consultation service, part of East London and the City Mental Health NHS Trust, comprises a specialist child and adolescent mental health team working with children and families experiencing multiple, severe and persistent problems. They are based at York house, Plaistow in east London.

- *The Newham youth offending team (YOT) (first period of care August 2000 to January 2001, second period of care October 2001 to October 2002).*

  Newham YOT, which is based in east London, includes police and probation officers, social workers and has links with the NHS. They focus on managing young offenders in the community.

- *Feltham young offender institution (January 2001 to June 2001).*

  HM Young Offender Institution and Remand Centre Feltham in Middlesex accommodates young people from the age of 15 to 21.

- *Newham East community mental health team (CMHT) (October 2002 to July 2004)*

  This multi-disciplinary team is part of East London and the City Mental Health NHS Trust, is based in east Ham and provides a single point of entry and emergency referral service. It focuses on the assessment and care of adults who have serious and enduring mental health problems.

Orchard lodge, 3 September 1999 to 22 December 1999

6.2 Following his conviction for robbery RP, then aged 14, received a 21 month custodial sentence under section 53 (2) of Children and Young Persons Act 1933 Act and on 3 September 1999 was sent to Orchard lodge local authority secure accommodation.

Analysis

His sentence demonstrates how seriously the court considered RP's crime. Section 53 (2) is reserved solely for serious offences by young people. Hansard records that in 1999 only 132 children or young people in England and Wales were in local authority accommodation under this section.

6.3 On 27 October 1999 his supervision plan was completed by social worker 1 at Newham YOT who identified that RP presented "*a considerable risk to the public or of self harm through drugs use".*

6.4 RP appeared to become mentally unwell at Orchard lodge. His symptoms appeared to be psychotic in nature and he was referred to Huntercombe manor.

Huntercombe manor (first admission), 22 December 1999 to 18 August 2000

6.5 On 22 December 1999 RP was admitted to Huntercombe manor under section 47/49 of the Mental Health Act 1983[5].

6.6 The records from Huntercombe manor show that RP had a diagnosis of drug-induced psychosis with paranoia and that he was treated with risperidone, an atypical antipsychotic medication.

Analysis

By the age of 15 RP had been identified as a young man with mental health problems, a history of illicit drug use and criminal convictions for robbery and violence. His drug-taking led him into crime and contact with a peer-group which indulged in crime. His crime and drug taking resulted in his admissions to Orchard lodge and Huntercombe manor.

Poor impulse control

6.7 The associate specialist at Huntercombe manor prepared a medical report covering the period 14 March 2000 to 10 April 2000. She recorded that RP had rarely complained of 'voices' during this period and that there was no evidence of an affective (mood) disorder. However, amongst the multi-disciplinary team there were

[5] Section 47/49 Mental Health Act 1983 is a transfer direction (from custody to a mental health facility) under section 47 together with a restriction direction (requiring ministry of justice [at the time of RP's detention this would have been the home office] sanction for discharge) under section 49.

concerns about his emerging paranoid personality traits and his persistent problems with poor impulse control. He was assessed as being a moderate to high risk to others and his sensitivity and impulsivity were noted. She also recorded that RP had been visited three times by his father but that all of the visits had been supervised "*to reduce the risk of drugs being brought in to RP".*

6.8 In May 2000 social worker 1 contacted CFCS to inform them that RP was due for release (subject to license) from Huntercombe manor on 18 July 2000 and that it would need to provide RP's care in the community.

6.9 A Huntercombe manor nursing report prepared for the CPA meeting on 18 May 2000 noted that RP had poor impulse control and that he had been verbally and physically aggressive. He had punched a fellow male patient and was verbally abusive and intimidating towards staff. This had included him jumping through a serving hatch towards staff when told there was not enough milk for him.

6.10 RP had also punched a female patient in the mouth which resulted in her needing seven stitches. The female patient had 'tutted' at him in the school room. RP was noted to have been remorseful following this incident. He was charged with common assault and sentenced to an additional month in custody.

Analysis

RP displayed disturbed, aggressive and violent behaviour. He acted upon impulse when he felt he was insulted even in the most minor of ways.

His father could not be trusted to visit unsupervised as staff were concerned that he would give RP illicit drugs. Rather than assisting with his son's care his father colluded with RP who, despite his criminal history was still only 15 years old, to try to bring him illicit drugs.

Hostility while at Huntercombe manor

6.11 In May 2000 consultant psychiatrist 1, RP's consultant at Huntercombe manor, told the Home Office that RP's mental state had settled and his psychotic symptoms were in remission. He recommended that he should be transferred back to Orchard lodge to complete his custodial sentence. This also meant that he would have no further contact with the female patient he had assaulted. However, following correspondence between consultant psychiatrist 1, Orchard lodge and the Home Office, it was agreed that he should remain at Huntercombe manor; RP was moved to another ward and remained there until the end of his custodial sentence.

6.12 Consultant psychiatrist 1 told us there were times during the early part of his admission when RP was hostile and threatened to kill the staff. However, he recollected that after the incident in which he assaulted the female patient, RP had settled down with no serious incidents thereafter. He went on to say that he thought RP's psychotic symptoms were probably drug-induced, and that this seemed to be borne out in the course of the admission. He said RP's psychotic symptoms carried on for the first few months and were exacerbated when RP had managed to smoke some cannabis he had hidden on admission.

Analysis

RP's behaviour shows an emerging pattern of violence and aggression. He acted impulsively to situations with violence and hostility. His presentation moved away from his psychotic symptoms (close attention to limiting possible access to illicit drugs would have helped with this) to his problems with impulse control, sensitivity to others and subsequently violence and aggression.

Discharge planning

6.13 Consultant psychiatrist 1 told us about RP's drug treatment. When admitted RP was prescribed olanzapine (an antipsychotic) on a gradually increasing dose, but he gained weight (a side effect of olanzapine) which he disliked and his medication was changed back to risperidone for the rest of his admission. Consultant psychiatrist 1

recalled that for the last two or three months of that admission, he seemed to be free of any psychotic symptoms.

6.14 CPN1, the CFCS community psychiatric nurse, and social worker 1 met on 4 July 2000 to discuss discharge plans for RP.

6.15 On 17 July 2000 a section 117[6]/CPA meeting was held at Huntercombe manor at which discharge arrangements for RP were discussed and agreed. Support from CPN1 was put in place as well as arrangements for him to attend college. A Huntercombe family therapy report, indicated the *"dominant theme throughout has been concern re RP's discharge, specifically how he can keep himself safe enough in the environment outside home"*.

6.16 While at Huntercombe manor RP's records show that he received a wide range of care including psychology, family therapy, nursing and education. There are records of care programme approach meetings including regular updates provided by members of the mult-disciplinary team involved in his care and evidence that RP had been involved in the discussion regarding his care. When funding for travel was made available, RP's mother attended a meeting at Huntercombe manor.

6.17 A follow up care package, in keeping with CPA, was organised with CFCS and YOT prior to RP's discharge from hospital.

6.18 On 14 August 2000 the Home Office wrote to RP to tell him that the provisions of section 49 Mental Health Act 1983 finished on 18 August 2000 but that he was still subject to probation. On 18 August 2000 RP was discharged from Huntercombe manor to his mother's home. The discharge plan indicated that local services (CFCS and YOT) would offer support in the community. His care plan focused on relapse prevention, supportive social work intervention and anger management.

[6] In England and Wales, if someone has been detained in hospital for assessment and treatment under sections 3, 37, 45A or 47 of the Mental Health Act 1983, aftercare services should be provided under section 117 of the Act.

Analysis

The clinical records from Huntercombe manor provide a clear and comprehensive record of RP's care. A coordinated handover between the inpatient services provided by Huntercombe manor and the community services provided by YOT and CFCS was put in place.

Given RP's clinical presentation and his use of cannabis (which appears to have exacerbated his psychotic symptoms) both prior to and during his admission the package of treatment offered to him was appropriate. The aspects of emergent personality disorder which RP presented (poor impulse control for example) were given secondary importance. We recognise that the willingness to make a diagnosis of emergent personality disorder (EPD) in adolescents was only beginning to develop by 2004.

Child and family consultation service/youth offending team

6.19 In September 2000 social worker 1 at the YOT contacted consultant psychiatrist 2 at CFCS to inform her that the custodial element of RP's sentence had been completed but that he was still subject to license in the community. A post-transfer planning meeting was held on 14 September 2000 which was attended by social worker 1, consultant psychiatrist 1, CPN1, RP and his mother.

6.20 RP was still subject to a detention and training order (DTO) that required him to meet with YOT and CFCS.

Intermittent attendance at meetings

6.21 In September 2000 RP attended meetings with social worker 1. Although RP met with CPN1 in September he missed some of the meetings arranged for later that month.

6.22 At that initial meeting on 8 September 2000 it was agreed that RP's treatment would concentrate on impulse control with sessions to last 30-40 minutes to

accommodate his limited attention span. CPN1 noted RP's intermittent compliance with medication. RP also told CPN1 that he would not continue with therapy after his license period had been completed.

Violence toward others

6.23 During September and October 2000 RP was involved in two violent incidents while at Walton Road school. In the first incident RP hit a worker during a school visit to the Millennium Dome and in the second he hit a fellow student which resulted in his suspension from school. In October 2000 RP's Walton Road school half-term report shows that he had an 80 per cent attendance record (compared with five per cent in mainstream schooling) and that he was popular with staff and other pupils. However, by the end of the school term his December report indicates that his attendance after half term had deteriorated to 50 per cent.

Assessing risk

6.24 As a consequence of these violent incidents social worker 1 at YOT considered recalling RP to complete his sentence in custody. However, following discussion within the team, she issued a 'final manager's warning'. RP and his mother were told that any more incidents would result in his recall to custody.

6.25 A professional risk strategy meeting attended by social worker 1 and RP was held on 20 October 2000. CPN1 was unable to attend the meeting but sent apologies. At the meeting a number of risks were identified which included:

- the deterioration of RP's mental health if he discontinued attendance at mental health sessions post expiry of his license
- further psychotic episodes if he discontinued medication or took illicit drugs.

6.26 It was also noted that RP's mother had difficulties in setting boundaries for him. RP was considered to be at a high risk of reoffending but it was thought that this could be reduced within a long-term consistent therapeutic relationship which included anger management strategies.

Analysis

By 2000, YOT and CFCS had a clear understanding of the risks RP posed. A history of his violent behaviour had been established, his difficulty in complying with boundaries, his mother's difficulty in setting and policing boundaries, his use of illicit drugs and subsequent deterioration into paranoia and aggression were all documented.

6.27 During November and December 2000, RP did not attend appointments with CFCS. Records indicate that RP called to say that he was not attending and that travel costs as a family were a problem.

Non compliance with treatment once the compulsory element of DTO was completed

6.28 As the compulsory element of his DTO was drawing to a close, social worker 1 recorded that RP *"has made it quite clear that he does not want, and will not co-operate with, another agency or team".* YOT therefore made no onward referrals although contact with CFCS was left open. YOT subsequently closed RP's case on 20 December 2000 and on 25 December 2000 RP's DTO license expired.

6.29 Social worker 1 had maintained a close rein on RP's attendance. RP described her intervention as:

> *"…she was all right…It was just like I couldn't put a foot wrong, I weren't allowed to do this, weren't allowed to do that…but I just think maybe all that stuff she was doing was just another tactic for dealing with young people, like trying to keep them straight."*

6.30 Consultant psychiatrist 2 noted that RP had developed a better relationship with social worker 1 at YOT than with CPN1 at CFCS. She told us:

> *"…he disengaged immediately after Christmas and CPN1 did quite a lot of work with the youth offending team. I think it's unfortunate that he did actually have quite a good relationship with his youth offending worker, who I think*

left, but the youth offending team made it very clear, and I think it is their remit, that they can't work with people once the orders are ended. That is a real shame because I think they actually built up quite a good relationship with him and then that goes…"

Analysis

Leaving the contact open with CFCS (i.e. that CFCS would re-engage with him if he requested help) was a reasonable action to take given that RP had made it clear that he was not willing to accept any other onward referral. If, as we have been advised is the case now, YOT had been in a position to continue to offer a service to RP the relationship may have continued to develop and RP may have become more amenable to contact from other agencies such as CFCS.

Completion of the DTO

6.31 While the DTO was in place YOT acted as the lead (coordinating) agency for RP. Risk assessment information was circulated between the agencies involved. This enabled a clear understanding of the risks presented by RP. YOT and CFCS sought to engage with RP's family and a number of meetings were arranged with RP's mother.

6.32 In early January 2001 CPN1 contacted RP offering to see him. While recognising his attendance was not compulsory, she suggested that he should consider attending the youth awareness project (YAP)[7]. RP did not want to attend – he said his father had been and had not found it useful. She told RP that he still needed support to avoid getting back into trouble and recommended his continuing medication and seeing her to monitor this. She urged him to avoid illicit substances which might worsen his condition.

[7] Newham youth awareness project aims to provide a range of services to reduce drug-related harm and raise opportunities of employment through the provision of treatment and education. Source: YAP website.

Analysis

RP appears to have had difficulty in accepting his mental illness symptoms and he had an uneasy relationship with CFCS staff and mental health services generally. His relationship with staff at YOT was much more acceptable to him as the focus of the service was tackling the risk of reoffending rather than his mental health problems.

Once his DTO had finished, responsibility for RP's care fell to CFCS which had no powers to compel him to attend. CFCS staff found it difficult to develop a rapport or an enduring relationship with RP who felt that he was not benefitting from the input from CFCS and therefore did not regularly engage with the service.

YOT worked well to ensure that a full picture of RP was gained through liaison with health (CFCS) and also education services (Walton Road school). YOT also maintained an effective relationship with RP but following the completion of the DTO it had no option other than to withdraw from providing a service to RP. YOT worked within the remit of the service in place at the time.

Our discussions with representatives of the youth offending services indicate that services have now been developed for children and young people who are at risk of offending (rather than requiring that an order be in place for YOT to be involved) and that pathways of care and risk assessment have now been developed. The senior nurse manager for Newham child and adolescent mental health service provided us with evidence of 'care pathways' which are now in place. These pathways provide mental health services staff with clear steps to help assess and manage patients who enter the service from the criminal justice system.

HM Young Offender Institution and Remand Centre Feltham

6.33 Twenty days after the completion of his DTO, on 15 January 2001, RP was arrested for his involvement in the armed robbery of a taxi driver. He was considered

to be fit to plead and was remanded in custody to HM Young Offender Institution and Remand Centre Feltham.

Concerns about the need for RP to receive long-term care in a secure setting

6.34 A psychiatric report prepared by consultant psychiatrist 2 and CPN1 on 19 January 2001 states:

> *"…it is clear that community based interventions which require co-operation from RP and his family to address his offending behaviours, conduct disorder and level of risk cannot be effective. We therefore recommend that RP be involved in a rehabilitation programme, which may need to be provided in a secure facility. This needs to be long term in order to allow for change."*

6.35 The report and an addendum psychiatric report completed after RP had been seen by CPN1 on 5 February 2001 at Feltham YOI were sent to the registrar at Feltham YOI on 21 February 2001.

Analysis

RP's arrest for armed robbery of a taxi driver and the use of a weapon (a knife) represents an escalation in his violence. The concerns raised in the risk management meeting held in October 2000 that he would reoffend if he discontinued attendance at mental health sessions after the expiry of his license came about within three months of the meeting.

The report provided by consultant psychiatrist 2 and CPN1 from CFCS showed a clear recognition that community intervention with RP would not be successful, and that in order for effective treatment to work he would need long-term care.

National medium secure adolescent forensic services assessment

6.36 At Feltham YOI, RP complained that he was hearing voices. The registrar at Feltham YOI referred him to consultant psychiatrist 3, service director and consultant

adolescent forensic psychiatrist, at the Gardener unit (national medium secure adolescent forensic services). RP was subsequently assessed by consultant psychiatrist 3 as suitable for admission but as the Gardener unit had no beds available, she considered the alternatives.

6.37 Consultant psychiatrist 3 informed us that at the time there was a shortage of suitable adolescent forensic inpatient beds across the country but "*Huntercombe manor…* [was] *able to treat serious mental illness in conditions of adequate security for some young people*".

6.38 Consultant psychiatrist 3 also told us that when she assessed RP in 2001 there were 28 forensic beds available for the placement of young people nationally but that the number has since increased to 88.

6.39 We have been told by the national specialised commissioning group that eligibility criteria for placement in a national secure adolescent forensic services bed are 'diagnosis blind'. That is, that a person's diagnosed mental health problem is not considered as a reason for the provision of a placement within the service. The decision is based on expert opinion of the patient's needs.

Fascination with weapons

6.40 As part of her assessment consultant psychiatrist 3 noted:

> *"RP told me that he has had an interest in knives and guns for some years. He finds them fascinating and he likes them. He told me that he used to have loads of lock knives and flick knives and has had two guns at one time or another, one that wouldn't fire and an automatic weapon for which he had no bullets. He told me that he had carried them around and would threaten people with them. He told me that much of his time before coming into custody would involve him hanging around with other boys and robbing people. The boys involved are mostly his co-accused in the current offence."*

6.41 Consultant psychiatrist 3 recorded that:

> *"RP does not attribute his alleged offence to voices or illness, but is quite straightforward in saying that it reflects his desire to get hold of money for illicit drugs".*

6.42 Consultant psychiatrist 3's assessment did not indicate that she had seen the psychiatric report and addendum report provided to Feltham medical staff detailing the concerns raised by consultant psychiatrist 2 and CPN1.

6.43 On 19 February 2001 while at Feltham, RP assaulted a fellow inmate with a weapon made by placing batteries in a sock. On 20 February 2001 he smashed a telephone. He told us that this was because he thought that the staff were planning to kill him. On 11 March 2001 he assaulted another fellow inmate.

Analysis

RP's fascination with and increasing use of weapons is significant. His violence towards the taxi driver (although RP still disputes the level of violence used) and his preparation of a weapon (batteries in a sock) demonstrates a movement towards premeditated rather than impulsive violence.

6.44 Consultant psychiatrist 1, who had previously cared for RP during his first admission to Huntercombe manor, assessed RP at Feltham and arranged a place for him at Huntercombe manor. RP told him that he had committed a number of other robberies and that he was intermittently hearing voices that were telling him to eat people and lick their blood. Consultant psychiatrist 1 also recorded that RP had a "*serious conduct disorder with a clear propensity for armed street robbery with dangerous potential*". He did not note any other psychotic symptoms.

Analysis

Despite not directly referring to consultant psychiatrist 2 and CPN1's letter, consultant psychiatrist 3 arrived at similar conclusions about RP's offending history and risk (i.e. he required hospital admission to manage his problems).

By now four senior professionals (consultant psychiatrist 2, CPN1, consultant psychiatrist 3 and consultant psychiatrist 1) had reached the conclusion that RP needed treatment within a secure facility. There was a clear recognition that he posed a significant risk to others.

As a bed was not available at the Gardener unit RP was placed at Huntercombe manor. The information provided by consultant psychiatrist 2 and CPN1 should have been shared with consultant psychiatrist 3.

It is likely that if RP presented now and was assessed for forensic placement he would get a bed. The national medium secure adolescent forensic service treats mental illness but then also manages developing personality disorder issues which can often present once the mental illness element has been successfully treated.

RP's contact with local services was disrupted by the consequences of his offending behaviour. He then spent periods in custody at Orchard lodge and Feltham YOI followed on each occasion by Huntercombe manor. This may have significantly adversely affected any possibility that he would have developed a trusting relationship with those providing local services such as CPN1 and consultant psychiatrist 2 at CFCS.

Huntercombe manor (second admission)

6.45 On 11 June 2001, four days after his conviction for robbery, RP was admitted to Huntercombe manor under section 37 of the Mental Health Act 1983 from Feltham.[8]

6.46 On 21 June 2001 the secretary at intensive care 1, RP's ward at Huntercombe manor, contacted consultant psychiatrist 2 at CFCS inviting her to attend CPA meetings.

6.47 At Huntercombe manor, RP was treated with antipsychotic medication.

6.48 In August 2001 a CPA review meeting was attended by social worker 2 from the Gardener unit. Social worker 2 told us this was the first time she had met RP. She told us:

> *"I did attend a CPA meeting as I had attended a meeting in London the day before (not connected) therefore it was appropriate that I attended as a representative from the Gardener unit. My recollection is that RP was doing well and that plans were being made for discharge, therefore it was not deemed necessary to move from low to medium secure at this time".*

6.49 It was agreed at the meeting that RP no longer required medium secure care and that RP should not return home on discharge as "[he] *will require a high level of support*". A referral to Stratford Office child and family team social services was made by Huntercombe social worker 3 which states:

> "*…in my opinion RP will continue to follow previous patterns of behaviour unless he has an intense package of aftercare from social services or he is*

[8] Section 37 is a treatment order and is applied to people who are convicted of a serious crime punishable by imprisonment. After a period of six months patients detained under section 37 have a right of appeal to a Mental Health Review Tribunal and if no longer suffering from symptoms of mental disorder can be discharged by the tribunal. The responsible medical officer (RMO) [now responsible consultant (RC)] can discharge the patient without recourse to any discussion with the Home Office.

accommodated under section 20 of the Children Act 1989 as he is a child in need."

6.50 The next CPA meeting was arranged for 10 October 2001.

Analysis

In retrospect a longer term placement at a specialist adolescent forensic unit would have been beneficial for RP.

6.51 In September 2001 RP was referred to CFCS. On 2 October 2001 social worker 4 from Newham YOT attended a CPA meeting following a referral to Newham social services by social worker 3. He noted that RP was still aggressive and was worrying about his mother.

Absconded while on leave

6.52 In early October 2001, the clinical team at Huntercombe manor considered that RP was settled with no evidence that he was psychotic. They arranged escorted leave to his aunt and uncle's house. While there RP climbed out the bathroom window and absconded. The Huntercombe manor notes indicate that his absconding was considered to be impromptu. However, RP told us that he had planned to abscond and that his decision was confirmed when he arrived at his aunt and uncle's house and none of his family was there to meet him.

6.53 Social worker 3 contacted the police and RP's family to inform them he was missing. The police were told that RP had a history of offending and could be violent. A place at Huntercombe manor was kept available as a contingency in case RP was found. However on 6 November 2001 RP was discharged in his absence from both Huntercombe manor and section 37 of the Mental Health Act 1983.

Analysis

RP absconded on leave while he was escorted by staff from Huntercombe manor. Searches for him proved fruitless and his discharge arrangements, as required under section 117 of the Mental Health Act 1983, were disrupted and a smooth transition of his care into community services was not possible.

A comprehensive risk assessment was undertaken at Huntercombe manor but focused on how RP was presenting at the time and how to manage the risks while he was on the unit.

Child and family consultation service (CFCS) and youth offending team (YOT)

6.54 After RP absconded while on escorted leave from Huntercombe manor RP's 'aunt' re-established contact with him and tried to support him in his engagement with services. RP's aunt told us she has known RP since he was six or seven years old and that she considers herself to be his 'aunty'. RP described their relationship similarly. RP's aunt acted as an informal 'advocate' for RP - she sought to help him by contacting services (for example the benefits agency) on his behalf, providing financial assistance and trying to move him away from committing crime.

6.55 In February 2002 CPN1, seeking to re-engage with RP even though he had not been found by services, contacted RP's mother in the hope that an appointment with him could be arranged for early April 2002.

6.56 RP remained out of contact with services until March 2002 when he went to the YOT office and saw the duty officer. When we interviewed RP, he described himself as unrecognisable to others during this period. He told us that he was wandering the streets and was behaving in a bizarre manner and that he had grown a beard and that he had periods when he was unable to recognise people who he knew.

Contacted services asking for help

6.57 YOT notes indicate that during March 2002 RP saw the duty officer who made him an appointment. RP did not attend this appointment but attended the day after. Another appointment was made for early April 2002. RP missed this appointment too and his case was closed.

6.58 On 11 April 2002 RP attended his appointment with CFCS that CPN1 had arranged. He denied having any psychotic symptoms *"but did allude to incidents of violence and aggression".* After the appointment RP returned to speak to consultant psychiatrist 2 and asked for sleeping tablets. However he was told that this would require further discussion at another appointment. RP became angry and hostile and the police were called.

6.59 Recalling this incident RP told us:

> *"I went to walk out of the door, she went into reception and I went 'Excuse me' and I said 'Can you sort out some sleeping tablets?' and she asked me why and I told her, and she went 'No, ask me in five weeks when you come back for your appointment'. I said to her 'That is no good, I am having these problems now, I need to get to sleep', because sometimes I am not sleeping for two days and that, and she went 'No, come back in five weeks' and walked off, and that is when I punched the window and the window flew in and they started going mad at me, shouting and that. I just thought 'That's supposed to be my doctor' and then they forbade me from coming."*

Paranoid when smoking skunk

6.60 During April and May 2002 YOT provided support to RP. Social worker 5 with YOT was already working with RP's brother and was aware of his circumstances. RP told social worker 5 that he felt that CFCS "*professed to help him but do not"*. Social worker 5 suggested to RP that he attend the youth awareness programme (YAP) but RP was not keen to do this. He tried to help RP obtain benefits (for example disability living allowance) and also told him to contact social services although RP was not

willing to do this. He also noted that RP "*admitted that he becomes very paranoid when smoking dope, particularly skunk which he has been smoking recently*".

6.61 During this period RP's home circumstances deteriorated and he left home after an argument with his mother and a fight with his mother's partner. He sought guidance about his housing needs from social worker 5 who told him to re-engage with CFCS. Social worker 5 recorded "*He talked through his difficult relationship with [CFCS]. I suggested that he discuss this with them and explore alternatives without resorting to conflict.*" He also told RP to contact the homeless persons unit.

Aggressive outbursts

6.62 On 10 June 2002 RP attended his appointment with CPN1 at York house. He asked for help with housing and was told that he should contact social services. He became frustrated and angry stating that he was being '*passed around*'. As RP left his appointment he stated "*You're not laughing at me*" and kicked over chairs and a stool and smashed the front door. The police were contacted and RP left.

6.63 On 12 June 2002 CPN1 contacted social worker 5 and both acknowledged the need for CFCS and YOT to ensure closer lines of communication. They agreed to undertake joint appointments with RP at the YOT offices as following the incident on 10 June 2002 York house was not thought to be appropriate for further appointments. Social worker 5 wrote to RP advising him that the information from their discussion about his housing needs had not been relayed to CFCS prior to his meeting with CFCS and that this "*may have added to the confusion*".

Analysis

After he absconded from Huntercombe manor, CFCS sought to maintain contact with RP via his mother. Given that his whereabouts was unknown and direct contact could not be made, attempting to make contact via his mother was a reasonable course of action.

Given RP's violent behaviour at York house the decision to provide services from the YOT base in Stratford was appropriate.

There was a clear mismatch between RP's expectation of the service he believed CFCS should *provide and the service they* could *provide. This led to RP feeling frustrated. This combined with his impulsivity led to his aggressive outbursts and violent behaviour. The relationship between RP and CFCS was problematic, and the CFCS was unable to build a rapport with him.*

YOT helped RP even though he fell outside of its remit. Our discussions with YOT have identified that its focus has since changed and that teams now work from a proactive, preventive standpoint in addition to working with young people following an offence.

Ambivalence to services

6.64 RP did not attend the joint appointment arranged by YOT and CFCS for July 2002. In August 2002 RP spoke with the YOT duty officer. He said his home circumstances had deteriorated and he was feeling stressed. He was told to attend the accident and emergency (A&E) department at Newham General Hospital if he needed urgent assessment. On 26 August 2002 he attended A&E complaining of agitation and auditory hallucinations. He was prescribed risperidone.

6.65 RP raised his concerns with social worker 5 about his lack of rapport with both consultant psychiatrist 2 and CPN1. Social worker 5 told him to seek to develop the relationship. CPN1 and social worker 5 convened a number of joint meetings with RP. RP's relationship with CFCS remained fragile and RP did not feel that the service was helping him. He told us "*All she* [consultant psychiatrist 2] *wanted to do was get me off my medication, to sign me off and stop me from coming to the place, and that is how I felt".*

6.66 RP was seen by social worker 5 and CPN1 together on 29 August 2002. He complained of increasing agitation over the previous three weeks and said that he had broken up with his girlfriend, he was fed up with his housing situation (he was staying

with his paternal aunt and uncle), and was hearing a male voice in the background. He had also become increasingly aware of people looking *'funny'*. He claimed not to be acting on impulses. He was using marijuana.

6.67 In September 2002 Newham youth information and advice service identified RP as a vulnerable young person under section 17 of the Children's Act 1989 and contacted the duty social worker at Beckton local service centre. YOT social workers responded that they were currently working with RP.

6.68 RP's final appointment with consultant psychiatrist 2 at CFCS was on 18 October 2002 when he was seen with his aunt. He was still seeking assistance with housing and, following discussion with RP's aunt, consultant psychiatrist 2 wrote an open letter supporting this. RP was described as "*ambivalent about services"* but his aunt believed that he required assistance.

6.69 While RP felt that he still required assistance he did not feel that he was gaining any benefit from meeting with CFCS and consequently his attendance was intermittent. CFCS sought to maintain contact with RP. CPN1 told us:

> *"At that stage he was very ambivalent about a need for any continued service, or why would he need to be followed up by services. The only times we did get some level of compliance was if he did want to use medication, which at times I think he probably used for frustration and anger management for himself."*

6.70 At the same meeting RP's aunt also suggested that RP should be referred to adult mental health services as he needed ongoing support. RP was approaching his 18th birthday and consultant psychiatrist 2 contacted adult services *"I wrote to them saying I'm not transferring him as such but I'm referring him because I think it's important to know about him".* Consultant psychiatrist 2's letter dated 23 October 2002 to the manager of Newham CMHT East provided an overview of RP's history and his non compliance with therapy or medication once his DTO had been completed. She concluded that she was not sure if RP would attend but felt it important that the CMHT was aware of him.

6.71 RP's aunt also sent a letter to RP's care coordinator at Newham CMHT East, to say that *"RP is in need of help and child and family consultation services can no longer provide support for RP".*

Analysis

RP appears to have been more receptive to some adults, for example RP's aunt and social worker 1 at YOT, this demonstrates that he might have been influenced and helped to some extent. Services might have considered greater contact with RP's aunt as a moderating and positive influence upon RP.

6.72 Consultant psychiatrist 2 told us:

> *"I think my feeling was that he had quite significant behaviour difficulties, conduct-type disorder, from a young age. He had a very complex, difficult childhood and he was very poorly supported really, and I think his aunt was the most stable and helpful person."*

6.73 Consultant psychiatrist 2 also told us that she saw no evidence of a psychotic disorder and that RP was compliant with medication.

Analysis

Despite the difficulties experienced in building a relationship with RP we believe that consultant psychiatrist 2 and CPN1 developed an accurate understanding of his needs and the risk he presented. They recognised the need for him to be treated on a medium to long-term basis and had indicated that the likelihood of successful treatment within a community setting was limited. Given the avenues available at the time for the treatment of young people suffering from psychotic symptoms with emergent personality disorder their input with RP was appropriate.

The availability of services for people suffering from a dual diagnosis of psychosis and emergent personality disorder has developed since CFCS was involved with RP in 2002.

Youth offending services have been developed for young people at risk of offending (rather than for young people post offending and under a formal order).

We have concurred with the trust investigation which found there was a lack of specialist forensic support for people receiving care within the child and family adolescent service.

Newham East CMHT (adult services)

6.74 During October 2002 and November 2002 there was some uncertainty within the trust as to which CMHT had responsibility for RP because he had moved home on a number of occasions. This was eventually resolved when Newham East CMHT took responsibility for his care.

Analysis

Much like RP's refusal to accept any onward referrals from YOT, his transition to the CMHT and adult services was similarly difficult as he was not willing to cooperate with the transition. At the request of RP's aunt, consultant psychiatrist 2 provided information to the CMHT. RP was ambivalent and consultant psychiatrist 2 explained that without his cooperation the CMHT would have difficulty in becoming involved. Consultant psychiatrist 2 spoke directly with RP's care coordinator although in the circumstances she was unable to formally transfer RP's care.

6.75 RP was one of the first patients allocated to the care coordinator in October 2002. RP's care coordinator told us that he did not receive an induction on appointment to the CMHT:

"….the major part of my career has been with [people with] *learning difficulties. I joined Newham in 1979 as an assistant house parent in a residential home for people with learning difficulties, but I went away and did my ASW* [approved social worker] *training and came into my present post in October 2002."*

6.76 The trust operational policy indicates that in the allocation of patients to key workers (more correctly care coordinators) account should be given to matching the worker's skills to a client's needs as well as gender/ethnicity considerations and the apparent primacy of health or social care needs. This does not appear to have been the case in the allocation of RP's care coordinator. RP was not known to other members of the CMHT unlike the other patients on the care coordinator's caseload who were well established within the service. RP's care coordinator told us that he received supervision approximately six weekly but this did not include routinely consideration of all cases on his caseload.

6.77 On 18 December 2002 following his mother's eviction from her home, RP had become homeless.

6.78 RP and his girlfriend were also asked to leave their allocated bed and breakfast placement after they had argued with each other.

6.79 On 2 January 2003 an 'assessment information' form was partially completed - initial action identified as *"to be reviewed by senior clinical medical officer and passed to care coordinator for* [illegible – but possibly comprehensive] *assess".* Risk communication does not indicate any risk of violence or risk behaviours. The form is unsigned.

Continued fascination with weapons

6.80 On 14 January 2003 RP was seen by the senior clinical medical officer Newham East CMHT. He was now living in bed and breakfast accommodation in which he appeared settled. He stated that he had been taking risperidone intermittently for the preceding five to six months. He complained that he was hearing mumbling noises and

was feeling paranoid that people were talking about him. The senior clinical medical officer recorded that RP was also experiencing *"weird nightmares at times when he sees himself in difficult situations like people shooting him with guns and bullets going into his 'stomach'". The* senior clinical medical officer noted that RP was interested in learning martial arts and shooting guns *"he explained that he does not intend or think of harming anyone but always fancied these games as a game or hobby".* The senior clinical medical officer suggested continuing the antipsychotic medication. He agreed to review RP two weeks later. No CPA level is recorded.

Analysis

By 2003 RP had a well documented history of premeditated and impulsive violence. His fascination with weapons and shooting should have been considered a significant risk.

Help with benefits

6.81 On 20 January 2003 the care coordinator telephoned RP to let him know that the senior clinical medical officer was on sick leave and that he had rearranged RP's appointment with him.

6.82 On 7 February 2003 Newham Borough received a letter from Hereward and Foster solicitors, who were acting on RP's behalf, requesting a community care assessment. The letter indicated that RP required a social worker, assistance with suitable accommodation, and help in obtaining training and education.

6.83 An undated letter (but the context indicates the letter was written during early February 2003 and was in response to the letter received from RP's solicitors) was written by the care coordinator to support RP's claim for benefits. RP's CPA level is not described within the letter. The letter provides an overview of RP's condition and vulnerability and states:

> *"In my opinion RP fulfils the criteria to receive appropriate benefits and it would be detrimental to withdraw them. I believe that this may well result in*

him returning to his offending behaviour and also negatively affect his self-esteem and sense of worth."

6.84 On 10 February 2003 RP, accompanied by his girlfriend, was reviewed by the senior clinical medical officer and the care coordinator. The senior clinical medical officer recorded that RP *"seems to be suffering from paranoid schizophrenia".* He noted that RP was low in mood and angry but did not have any thoughts of self harm or of harming others. He agreed to change RP's medication to quetiapine (an antipsychotic), to discuss RP at the team allocation meeting (although by then RP was already allocated to his care coordinator) and to discuss options for care with the team psychologist.

Non attendance at meetings

6.85 RP did not attend his appointment with his care coordinator on 20 February 2003.

6.86 The care coordinator telephoned RP on 10 March 2003 and left a message on his answer machine.

6.87 On 11 March 2003 the care coordinator spoke with RP's girlfriend. He recorded that she told him that RP had been involved in an *"altercation with some people he knows. They have apparently threatened him and he is very worried about coming to the east Ham area."* He noted that RP's girlfriend would discuss attendance with RP.

6.88 Appointments were arranged for 12 March 2003 and 7 April 2003 but RP did not attend. On 14 April 2003 the care coordinator attempted to telephone RP but his mobile phone was switched off.

6.89 On 25 April 2003 RP's girlfriend contacted the care coordinator who recorded that she told him that they had been *"busy but will explain everything when they see me*". An appointment was arranged for 1 May 2003 but RP did not attend. On 7 May the care coordinator had a telephone conversation with RP who apologised for his non attendance at appointments. He said he had moved house to Beckton.

6.90 On 26 May 2003 RP telephoned his care coordinator. He said that he had been in hospital having been stabbed in the leg by his girlfriend following the break up of their relationship.

6.91 On 2 June 2003 the care coordinator completed a risk assessment of RP that identified a risk of violence to others and threats to harm, cannabis usage, poor budgeting skills, non compliance with medication and a tendency to miss appointments. A summary action plan indicated *"close liaison with RP and his partner, monitor mental health regularly via CPA, liaison with multi-disciplinary practitioners".* No CPA level is documented.

6.92 RP did not attend appointments on 3 June 2003 (CPA meeting) and 5 June 2003 (joint meeting with the care coordinator and the CMHT psychologist).

Analysis

Between February 2003 and July 2003 RP failed to attend at least six appointments with members of the CMHT. In keeping with the trust CPA policy more active consideration should have been given to referring his care on to the assertive outreach team.

Threat to kill

6.93 On 3 July 2003 the care coordinator and the CMHT psychologist visited RP at home. RP told them that he was feeling threatened due to a conflict with a man in Stratford who he believed wanted to kill him. The CMHT psychologist recorded that RP *"felt that the only way of dealing with this situation is to kill him first".* The CMHT psychologist arranged to meet with RP again on 16 July 2003.

6.94 RP did not attend his appointment on 16 July 2003. The CMHT psychologist, RP's care coordinator and the CMHT team manager agreed to refer RP to the public protection unit (MAPPA) although there is no record that they did so.

Analysis

RP had a well documented history of violent offending, drug misuse and impulsivity (see appendix B). The trust CPA policy states "an assessment of the service user's risk to themselves or others should be undertaken and action plans put into place"*. A referral to the public protection unit should have been completed. There was a lack of clarity within the team as to how and by whom this should be done. Based upon the assessment of RP's behaviour during the visit on 3 July 2003 and his non attendance on 16 July 2003, the multi-disciplinary team and RP's care coordinator should have ensured that a referral to MAPPA was completed and progress on this followed up at CPA reviews.*

Need for forensic assessment

6.95 The CMHT psychologist arranged to meet with RP on 23 July 2003 but again RP did not attend. Following discussion with the CMHT team manager, the CMHT psychologist closed RP's case within psychology although RP's care coordinator continued under CPA.

6.96 On 11 August 2003 RP kept his appointment with his care coordinator. He apologised for missing appointments. The care coordinator stated RP *"seems fairly well at the moment".* He noted RP was riding a moped and that he told him that he was wearing a crash helmet to make sure he was not recognised.

6.97 On 10 September 2003 a full needs assessment form completed by the care coordinator and signed by RP shows that he was assessed at standard CPA.

6.98 On 25 September 2003 RP attended a CPA meeting with the senior clinical medical officer and his care coordinator. RP had stopped taking risperidone as he claimed it was making him drowsy. He had also stopped taking olanzapine as it had caused him to gain weight. He stated he was feeling paranoid and thought people would attack him. He was experiencing persecutory ideas that were interfering with

his sleep. He had fallen out with his girlfriend. He described the end of their relationship, saying that she had stabbed him in the leg, that he hit her with a hammer as revenge and that he was still looking for more chances to take revenge. RP described feeling let down by old friends who 'cheated' him for money. He expressed no thoughts of self harm but was thinking about harming his girlfriend's family. RP's CPA level is recorded as enhanced.

6.99 The senior clinical medical officer suggested RP start taking quetiapine and recorded *"I have also requested his care coordinator to liaise with forensic services and make a request for forensic assessment in terms of his danger to others"*. The care coordinator has subsequently advised he understood (information he has checked with consultant psychiatrists) that the expectation was, consultant psychiatrists or the associate specialist made the initial referrals to forensic services on a doctor to doctor basis. The senior clinical medical officer told us:

> *"Forensic services had a nominated CPN, liaison CPN, who would visit different teams' offices on contact with them, or all the care coordinators would have his contact number, to contact if there is any need to discuss any referral."*

Notwithstanding the possibility of a referral being made, there is no record of a referral to forensic services being completed.

Analysis

A referral to forensic services should have been completed following this meeting. The violent end to his relationship with his girlfriend was further evidence of RP's deterioration and increasing violence.

The first record of RP's CPA level appears on 10 September 2003, when he is described as standard CPA and then revised to enhanced CPA on 25 September 2003. We could find no explanation for this change in level.

6.100 We noted that the senior clinical medical officer wrote to RP's GP detailing his meeting with RP in September 2003. However the letter is dated February 2003. When we met with RP's aunt she was concerned that this demonstrated an inconsistency in RP's care. However, the senior clinical medical officer told us that he dictated all letters which were then typed by support staff. He thought that the incorrect dating on the letter was as a result of a 'cut and paste' onto a previous letter (RP had also been seen on the February date).

6.101 On 7 October 2003 the care coordinator visited RP at his home which he was sharing with another service user. The care coordinator gave RP a prescription for more medication and reminded him to register with a GP closer to where he was living. He noted that RP was "*not eager to attend college or day opportunities*" and that RP denied any drug use.

6.102 On 22 October 2003 RP attended his appointment with the care coordinator. RP had misplaced his prescription. Later the same day the care coordinator spoke with the senior clinical medical officer and obtained a replacement prescription. He tried to contact RP by telephone but was unsuccessful.

Not attending appointments due to paranoid thoughts

6.103 On 30 October 2003 the care coordinator telephoned RP. RP appeared angry with him and stated nobody was *"genuine with him and that he could not trust anyone".* The care coordinator suggested that RP visit the CMHT office to talk but he declined. RP told us that he was feeling increasingly paranoid and did not feel able to attend. He described 'patrolling' the outside of his house and feeling scared to leave home to attend his appointments.

Risk assessment

6.104 On 11 November 2003 the care coordinator completed another risk assessment. He recorded RP's history of assault on individuals including the police, and that he owned a speargun but was not known to have threatened anyone with it. He also recorded warning signs or triggers (for deterioration in RP's mental health) as

"disengagement from services and practitioners [and] *stressful situations".* No reference was in the risk management plan to the decisions to refer to MAPPA and forensic services. The next risk assessment review was due to be completed on 10 May 2004.

6.105 The care coordinator contacted RP on 13 November 2003. RP said he had been assaulted by a group of youths who tried to cut off his ear.

Analysis

RP expressed lack of trust in everyone, his ownership of weapons and disengagement from services were all warning signs that his mental health was deteriorating. Given that it had by this time been agreed (but not acted upon) that his condition was of sufficient concern to merit referrals to both MAPPA and to forensic services, more assertive action to provide a comprehensive assessment should have been taken. As a minimum it would have been reasonable to refer him to the assertive outreach team for assessment which may have resulted in a more intensive package of care.

Weapons at home

6.106 On 14 November 2003 the care coordinator visited RP at home. He noted the injury to RP's ear. He also noted that RP was not taking his medication. RP was worried about his personal safety and was concerned that people were out to get him. The care coordinator told RP to take his medication and to contact him if he required any help. As he was leaving RP told him that he had broken the speargun (harpoon) but had bought a crossbow. The care coordinator recorded that RP refused to show it to him but said that he hadn't bought it to hurt anyone. RP told us that he had a number of weapons in his house and that the care coordinator had seen some of the weapons.

6.107 RP told us:

> *"He was sitting there asking questions about how I was feeling, I told him I can't fall asleep, I think people are trying to get me, and he says 'What are*

you doing about that? Are you taking any precautions?' He basically was hinting about getting weapons against them, getting weapons, and I said 'Yes' and I showed him my harpoon gun and my crossbow."

Analysis

We believe that the care coordinator and the senior clinical medical officer underestimated the risk RP represented to others. RP was disturbed, suspicious and possibly paranoid, had weapons and did not engage consistently with professionals.

In mitigation, we are aware that RP had not been seen by a consultant psychiatrist and had been discussed with other senior members of the CMHT. Furthermore the care coordinator was comparatively new in post having recently retrained. We are aware that RP presented significant challenges to all of the professionals with whom he had contact.

Risk assessments were completed by all agencies involved in RP's care and a considerable body of information relating to his offending behaviour and risk was well documented and generally shared between agencies.

Despite an awareness of the risks RP presented, services tended to focus upon his care in the 'here and now' and the perception of risk was influenced by current events. An easily accessible narrative chronology detailing risky behaviour and actions could potentially have changed this perception. A risk assessment based on his whole history may have led to a different conclusion and subsequently the development of a different plan of action.

6.108 RP told us about his fascination with weapons and the army and that he had a considerable number of weapons distributed around his house. The police inventory of home-made and acquired weapons (including firearms and coshes for example) removed from RP's property after his arrest is consistent with this description.

6.109 A CPA review was convened on 16 December 2003. RP, his care coordinator, RP's aunt, and the senior clinical medical officer attended. RP was recorded as being forgetful at times, he strongly believed that people were against him, did not trust the police, and had a harpoon and crossbow at home "*which he said was for his own protection*".

6.110 At the same meeting RP's aunt reported that RP was anxious and had a low threshold for anger. The senior clinical medical officer noted in a letter that RP appeared relaxed and *"does not seem to have any plans or intentions to attack others".* He also recorded that RP was willing to comply with medication. A plan was discussed and agreed with RP. He would remain on enhanced CPA and continue with medication (quetiapine). The senior clinical medical officer would refer RP to the team psychologist (the CMHT psychologist offered two more sessions) and RP was to be reviewed in three to four weeks time.

Analysis

In November 2003 the care coordinator identified the warning signs in RP's condition as disengagement from services and stressful situations. In December 2003 at the CPA review it was known by the wider CMHT that; RP had partially, disengaged from services; had been under stress in that he had been subject to violence from others; his relationship with his girlfriend had ended in a violent manner and that he had access to weapons. RP's history of violent offending using weapons should have prompted more, rather than less, intensive intervention.

CPA meetings

6.111 Although there was a delay in documenting his CPA level there were regular CPA meetings throughout the time RP was receiving care from the adult mental health team. He was subject to section 117 aftercare and was assessed as requiring care at the enhanced level of CPA. The trust CPA policy provided guidance on the management of patients on enhanced CPA. It states:

"There may be some service users on Enhanced CPA whose whereabouts and physical well-being is well known but have made it clear that they do not wish to have any contact with services or engage with the care coordinator.

The care coordinator should coordinate contact with all professionals and family/carers, where appropriate, involved with the service user to ascertain the full picture. Refusal of engagement should be discussed within the MDT and also communicated to the GP. An assessment of the service user's risk to themselves or others should be undertaken and action plans put into place.

The MDT should decide on the minimum type of contact with the service user, e.g. an attempt to visit, offering an out-patient appointment every 2-3 months or support via a third party such as a housing support worker. Consideration should be given to a referral to the Assertive Outreach Team."

6.112 The CMHT psychologist wrote to RP advising him that appointments had been arranged for 7 and 14 January 2004. RP did not attend the first appointment. When contacted by the CMHT psychologist on 14 January 2004 he agreed to attend but later called to advise her that his car had broken down and that he was unable to come. When he did not attend the second meeting the CMHT psychologist closed his case with psychology.

6.113 On 12 March 2004 the care coordinator wrote to RP inviting him to a CPA meeting on 16 March 2004. The care coordinator recorded that RP and RP's aunt arrived around 20 minutes late and, despite waiting a further 10 minutes, no meeting rooms were available. RP said he was *"OK"* but his aunt disagreed and said that RP was not sleeping well. RP said he had not taken medication since seeing the senior clinical medical officer in December. RP asked to see the senior clinical medical officer who was on leave. The care coordinator told RP that he was also due to go on leave. RP was very unhappy at the prospect of not being seen until April (his next appointment) and the care coordinator recorded that RP became *"verbally abusive and physically threatening. He accused us of abandoning him for months, not caring for him and wanting to pollute his body with chemicals".*

6.114 The care coordinator told us that:

> *"He was late and we'd taken the view with RP that it was better to see him than not see him at all, so we weren't about to say your appointment was at 11 and you've turned up at 11.30 so go away. We were very short of space, and I'd gone downstairs to see him in reception and asked if he would wait, and he said, 'No, I'm not about to wait'. I then offered to see him outside of the office, on the pavement, because the reception was full of people. Cutting a long story short, he didn't take that too kindly and felt that I was being disrespectful and all the rest of it.*"

6.115 The CMHT team manager, called the police and RP was escorted from the premises.

6.116 We have heard conflicting reports about this meeting. RP's aunt told us "*it was me that actually requested the meeting, and we were not late. The care coordinator had double-booked but we were not late at all".*

Continued non attendance at meetings

6.117 The care coordinator wrote to RP on 24 March 2004 inviting him to a CPA meeting on 6 April 2004. RP did not attend either the CPA meeting or the meeting with the care coordinator booked for 7 April 2004. On 8 April 2004 the care coordinator wrote to RP emphasising that he needed to engage with services to avoid a sense of being let down by professionals.

6.118 On 23 April 2004 the care coordinator received a telephone call from RP who apologised for not attending the CPA meeting. RP was worried about any possible reaction from staff towards him following the events of the meeting on 16 March 2004. RP told the care coordinator he was taking medication and finding it helpful.

6.119 The care coordinator wrote to RP on 27 April 2004 inviting him to a CPA review on the 18 May 2004. RP did not attend on 18 May 2004 but came on the 20 May 2004 having mixed up the date to attend. A full CPA meeting was not possible but he was

seen by the care coordinator. RP told his care coordinator that he felt like he was being watched. This was stopping him attending college. He also said he was having difficulty dealing with new people. He stated that his mobile phone and house keys had been stolen but he had not reported the theft to the police. He also stated that he had not taken medication during the previous three days. The care coordinator told RP that he should take it as it made him less paranoid. The care coordinator also recorded that RP told him that his telephone had been cut off due to non payment and that he owed rent and money to utilities.

Analysis

RP's limited attendance at meetings, engagement with psychology services, sporadic compliance with medication and difficulties with finances all confirmed the early warning signs that care coordinator had identified in November 2003. However, no action was taken to intensify intervention or to refer his care to a specialist team.

Final meetings

6.120 On 24 May 2004 the care coordinator wrote to RP inviting him to a CPA review on 8 June 2004. RP did not attend. The care coordinator wrote to RP on 8 June 2004 inviting him to a CPA review on 6 July 2004.

6.121 On 17 June 2004 the care coordinator saw RP on the high street. He recorded that RP seemed to be his usual self. RP promised to attend the next meeting, and said he had forgotten about 8 June 2004 meeting. The care coordinator agreed to visit RP at home.

6.122 On 25 June 2004 the care coordinator visited RP's home but was unable to get a reply. He left a note requesting that RP contact him.

6.123 A CPA meeting was held on 6 July 2004. RP did not attend and the meeting was held in his absence. Consultant psychiatrist 4 (consultant to whom the senior clinical medical officer was professionally accountable), the senior clinical medical

officer, the care coordinator and an unnamed senior house officer were at the meeting. The senior clinical medical officer and the care coordinator explained RP's history to consultant psychiatrist 4 who had not met RP. RP was described as a *"chronic non attender"* except when he needed help on specific issues. It was also noted that the team had continued to try to offer support rather than referring RP to the assertive outreach team but should his non attendance continue then referral to assertive outreach team would be considered. The care coordinator told us the assertive outreach team at that time was in an *"embryonic state"*. The criteria for referral to this service was not only poor attendance but also that a patient was deemed to be living in a chaotic state and that there was evidence of a degree of self neglect. RP's address fell within consultant psychiatrist 5's catchment area and the team agreed that arrangements to transfer his care to consultant psychiatrist 5 should be put in place. It appears other than to direct transfer to another consultant, consultant psychiatrist 4 did not appear to offer any other advice, support or guidance. It was also agreed that it would be helpful for a forensic assessment to be requested to look at previous incidents as well as assisting with RP's mental health diagnosis.

Analysis

RP's non attendance at meetings should have instigated a referral to the assertive outreach team and would have been in keeping with the trust's CPA policy. Notwithstanding the absence of evidence of the other criteria, the referral should have been made during the summer and autumn of 2003. A referral should have been made following RP's non attendance on 6 July and not postponed further.

Consultant contact

6.124 Like CFCS, adult mental health services struggled to build a rapport with RP. His attendance at arranged meetings was sporadic. When we met with the care coordinator we asked him how the team had sought to maintain contact with RP. He told us that he sought to keep in contact through letters and mobile phone contact.

6.125 The first record of consultant psychiatrist 4's involvement is on 6 July 2004 when he attended a CPA meeting held in RP's absence. He first saw RP after he had been arrested. Despite our efforts we have been unable to contact consultant psychiatrist 4 who no longer works in the UK.

Analysis

Given the complexity of RP's needs, his ambivalence (even hostility) to mental health services and his history of offending, consultant psychiatrist 4 should have been more involved in overseeing his care.

Supervision

6.126 The senior clinical medical officer received supervision from consultant psychiatrist 4. The senior clinical medical officer told us he was meant to have weekly supervision but because consultant psychiatrist 4 had other duties to attend to, supervision happened less frequently. The senior clinical medical officer recalled it occurred on a two weekly to monthly basis. He was not able to recall if RP's case had ever been discussed during supervision. The trust standards for supervision state that all staff *"as an absolute minimum will receive a* minimum *of one hour's supervision a month"* with the supervision offering clinical staff the opportunity to "*discuss individual cases in depth*".

Analysis

Some staff providing direct care to RP did not receive regular supervision. RP was a challenging and difficult case to manage. As he had a well documented history of posing a risk to others (including his inconsistent attendance and non compliance with treatment), his case should have been discussed in supervision. Support and supervision for all grades of staff regardless of profession should have been in place.

6.127 The senior clinical medical officer wrote to RP's GP on 9 July 2004 (providing details of the CPA meeting on 6 July at which consultant psychiatrist 4 was present). He documented:

- *"Transfer of care to consultant psychiatrist 5.*
- *RP to remain on enhanced CPA.*
- *It was also suggested that it would be very helpful if a referral to the forensic team was made for further assessment in the light of previous incidents and to also clear the doubts on diagnosis.*
- *Care coordinator to contact consultant psychiatrist 5 re future management".*

6.128 On 14 July 2004 the care coordinator wrote the notes of 6 July 2004 CPA meeting. He documented:

- *"Care coordinator was to arrange a transfer CPA meeting*
- *Care coordinator was to continue to engage with RP but consideration was to be given to his transfer to* [assertive outreach team] *if issues with non attendance continued*
- *RMO*[9] *responsibility* [sic] *to be transferred to consultant psychiatrist 5*
- *Consultant psychiatrist 4 and senior clinical medical officer to contact forensic services for an assessment as soon as possible."*

6.129 With respect to the referral to forensic services the senior clinical medical officer told us:

> *"I think there wasn't anything agreed during this meeting that myself and consultant psychiatrist 4 would do this piece of work. My understanding would be that the care coordinator would take the lead on that."*

[9] This, at the time, was a term only for detained in patients referring to the consultant in charge of their care

6.130 RP's care records were mainly completed by the care coordinator with a small number of entries made by the CMHT psychologist. There were no medical entries other than letters sent to RP's GP recording meetings with RP.

6.131 The care coordinator told us:

> *"I was quite amazed by what we'd done, not done and written in there, because we'd do it differently now…. the history we had and the aggression of whatever sort that was around, because we weren't necessarily seeing it, it was minimalised, and it was, 'We're going to do this for you', and it's all very nice and all very, 'Thank you very much'."*

6.132 The care coordinator told us about the culture within the CMHT:

> *"I think the general ethos of the time, although not written, would have been to keep stuff in-house: we can deal with people of whatever, we can cope. Rather than perhaps saying we're not quite sure what's happening with this person, and transferring it out to other people within the trust, other than keeping it fairly tight within the team."*

Analysis

The 'can do' ethos within the CMHT may have led to a culture within which there was a reticence to refer to specialist teams with a clear preference for dealing with any issues 'in house'. We have been unable to discuss this or the management of RP's care with consultant psychiatrist 4 as at the time of our investigation he was no longer in the UK.

Homicide

6.133 On 16 July 2004 RP killed TS during an attempted robbery.

6.134 RP was reviewed at Limehouse Police station by the forensic medical examiner who recorded *"no current presence of psychotic symptoms or any other symptoms of*

mental or behavioural disorder". RP was considered fit to be detained and interviewed.

7. Review of the East London and the City Mental Health NHS Trust internal investigation report concerning the care and treatment of RP

7.1 The internal investigation report is undated but was presented to the board on 1 December 2005 as a serious untoward incident (SUI) report. The board minutes record the recommendations made in the SUI report.

7.2 The report was presented to the board almost 18 months after the incident was reported to the trust by the police.

7.3 The investigation was chaired by a senior member of staff from outside the trust. The trust has told us that this was to provide additional scrutiny and rigour to the investigation. The other team members worked for the trust but not within the clinical areas in which RP had received care.

7.4 The report covered the correct period reviewing the services offered by CAMHS and the adult CMHT. The internal report provided an examination of the care RP received from 1999 onwards.

7.5 The terms of reference were appropriate and covered (in summary):

- the care RP received from the trust up to the time of the incident
- the suitability of his care given the assessment of his health and social care needs
- the extent to which his care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies
- the exercise of the care plan and its monitoring by the key worker and multi-disciplinary teams
- the support offered to staff following the incident.

7.6 The term 'key worker' relates to CPA processes which should no longer have been in place at the time of the incident.

7.7 The internal investigation team interviewed five members of staff. No staff from either Huntercombe manor or Newham YOT were interviewed as part of the process but copies of correspondence from Huntercombe manor (such as CPA documentation) and also YOT records were available to the internal investigation as they formed part of the clinical records held by the trust.

7.8 The report indicated that staff were offered support after the incident.

7.9 The internal report provided a narrative chronology including a brief personal history, contact with the criminal justice systems, mental health and reasonable detail of contact with RP in the months leading up to the incident.

7.10 The report does not mention interviewing RP, his family, the family of the victim and, where appropriate, offering support to them. As such, until this independent investigation was commissioned no contact was made by the NHS with either TS's or RP's family.

7.11 We found the internal report was inconsistent as the same person is referred to by the use of different anonymised titles. The same title is also used to indicate more than one person. This was confusing.

7.12 In some areas the report is factually inaccurate (for example RP is recorded as absconding from Huntercombe manor on the 26 October while on weekend leave whereas this happened on 2 October while he was on day leave).

7.13 The findings were based on evidence. The internal report identifies a number of conclusions (see section 4 of this report) but then makes recommendations that relate to those conclusions but also directly to issues documented in the findings. The report could have provided more clarity in differentiating findings and conclusions.

7.14 We have noted that the recommendations generated in the internal report do not have specific leads or timetables for completion although the subsequent action plan indicates a lead person with responsibility for carrying out the recommendations.

7.15 The internal investigation concluded that:

- There was no failure in RP's care that contributed to the offence.
- RP's compliance with services was erratic and services had sought to maintain contact and to provide support to him.
- RP was deemed to be at high risk and there were concerns about his safety and the safety of others with whom he had contact. An agreement to refer his case to the public protection panel was not completed.
- The CMHT should have ensured that all appropriate services were involved in his care.
- There is a gap in forensic services for young people who are no longer adolescents but not old enough for adult services.
- CMHT record keeping failed to comply with the trust standards.

7.16 The internal investigation team made the following six recommendations:

IR1 There is a need for a clearer pathway for forensic involvement to support adolescents within CAMHS services who pose a risk within children's services.

IR2 The criteria and procedures for referring to the police public protection team needs to be clarified and this should include clear guidelines indicating the criteria for referral and documentation. Decisions and outcomes should be clearly documented in clinical notes.

IR3 There must be a clear procedure for documenting any liaison and referral to forensic services by general and specialist mental health services.

IR4 Documentation should always be made and kept on file of all assessments including those carried out in extraordinary locations; as these act as an important source of information for future care and treatment.

IR5 The clinical teams need to adhere to standard practice of record keeping, particularly where joint assessments/contacts are made between two or more

professionals. There must be an agreement as to who will take responsibility for recording the outcome of the contact.

IR6 The trust should continue to provide debriefing training for staff.

7.17 The trust developed the recommendations into an action plan. The progress they told us they have made is shown at appendix F. We have summarised the areas of progress below:

- Care pathways for use within CAMHS and YOT have been developed. The trust provided us with copies of the pathways.
- A meeting with clinical directors has been convened to improve the communication with forensic services.
- Revised multi-agency public protection arrangements have been developed and are awaiting sign off by the trust medical director.
- A system of mandatory audits of record keeping has been established and the audit results then taken to the local clinical effectiveness meeting for any further action to be implemented.
- Improved supervision arrangements have been developed with the aim of ensuring clarity of role and expectations for staff especially when joint working (between services) is in place.
- There has been an independent audit of supervision arrangements.
- A revised incident policy has been developed.

7.18 We have identified through our independent investigation two areas relating to the internal investigation which we consider need to be addressed by the trust and are reflected in our recommendations. The two areas are summarised below:

Consultation with families

- We acknowledge that at the time the internal investigation was undertaken, RP's case had not progressed to court. However both families could have been consulted as part of the investigation.

- Current guidance issued by the National Patient Safety Agency advises that families should be consulted as part of the investigations. When we spoke with the trust there was no evidence that either TS's or RP's family had been consulted as part of the internal investigation process. The trust told us that systems are now in place to ensure that this consultation now occurs.

Feedback to staff

- Although the trust identified that feedback to staff following incidents (and incident investigations) is important some staff had not received any feedback from the internal investigation. It is reasonable to expect that staff involved in an internal investigation of this nature receive feedback about the findings of the investigation.

8. Themes and recommendations from another mental health investigation relating to the trust

8.1 In accordance with our terms of reference we have cross-referenced the themes and recommendations from this investigation with those from another investigation conducted by Verita relating to East London and the City Mental Health NHS Trust. The other Verita investigation concerned a homicide committed in 2006 (and relating to care which was provided from 2005 onwards).

8.2 The following themes are identified within both reports:

- risk assessment and use of CPA
- maintaining a broad view of the historical basis of risk
- post-incident feedback and reflective learning
- engagement with families.

8.3 The following extracts taken from the other Verita investigation report demonstrate the similarity of the findings:

Risk assessment and use of CPA

- *Particular attention should be given to ensuring care planning and risk assessments are at the heart of all CPA reviews.*

- *The trust should ensure that the importance of planning for and managing transitions … between services or within the trust… is reiterated as a key part of CPA.*

Maintaining a broad view of the historical basis of risk

- *Although there was occasional noting of risk there was never any real assessment or management of it.*

- *[This] led to views being taken about him which were based on immediate observation rather than on any longitudinal study. As the internal reports says there was "…an over reliance on passive observation as opposed to active inquiry as regards [his] mental state and risk management".*

Post incident feedback and reflective learning

- *The trust developed a detailed action plan following the internal investigation which has already led to a significant number of improvements but some of the staff we interviewed did not have much if any knowledge of it.*

Engagement with families

- *In our interview with [his] parents they told us that no one from the trust spoke to them about what had happened. This is unfortunate as families of perpetrators are as much victims as families of the victims.*

8.4 These are themes which are clearly reflected in our findings and conclusions drawn from the independent investigation into the care and treatment of RP.

9. Recommendations

9.1 We have made a number of recommendations as a result of our independent investigation into the care and treatment of RP and our review of the East London and City Mental Health NHS Trust internal investigation report. These are set out below.

R1 The trust must ensure professional or managerial supervision arrangements are in place for all clinical staff. Responsibilities of supervisors and supervisees should be clearly documented and understood. The risk assessment, the risk management plans and follow up of patients considered to pose a threat to themselves or others should form part of the supervision meeting.

R2 The medical director of the trust in conjunction with the director of nursing should commission, for completion within six months, audits of:

- compliance with the supervision policy currently in place.
- risk management to examine:
  - Comprehensive collation of risk indicators – past and present
  - Quality of analysis of information regarding the conclusions about the degree of risk(s)
  - Quality and appropriateness of subsequent action plan

R3 The trust should explain to the Metropolitan Police immediately following an incident what contact they want to have with the perpetrator and victim (if appropriate) and their families so as to discharge the trust's responsibilities and obligations. They should challenge any unnecessary restrictions imposed by the police under the terms of the national agreement signed in 2006, "*Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive".*

R4 The trust should ensure that there are systems in place to enable staff involved in a serious untoward incident to receive feedback from the subsequent investigation.

R5 The trust should review as a priority its CPA guidance in the light of the Department of Health guidance on CPA[10], the findings of the internal investigation report and this investigation. Particular attention should be given to ensuring care planning (including onward referral to specialist teams) and risk assessments are integral to all CPA reviews. An audit against progress should be undertaken after six months and annually thereafter.

R6 The trust should review processes for the allocation of care coordinators to ensure that the skills, competencies and experience of the coordinator are appropriate to the needs of the service user.

R7 The trust should ensure that where there are indicators of previous violence or aggression a history identifying the incidence of behaviours (such as violence and aggression) and potential contributory factors (for example the absence of support systems) are collated from all services involved in an individual's care. This information should form an integral aspect of an individual's risk assessment and care planning. This information must be passed on when care is transferred between services and/or between organisations and must be regularly updated to incorporate any new risk behaviours.

R8 The trust should ensure within six months of completion of this report that clinical staff have either received or have built into their personal development plans and appraisal processes the necessary changes to ensure that they have the required skills and competences to undertake a risk assessment. Six months thereafter an audit of all personal development plans and appraisal processes should be undertaken to ensure that the skills and competences have been acquired or are in the process of being acquired by clinical staff.

[10] *Refocusing the care programme approach: policy and positive practice guidance*, *Department of Health, March 2008*

Appendix A

Terms of reference

Independent investigation into the care and treatment of Russell Patterson

Commissioner

This independent investigation is commissioned by NHS London with the full cooperation of East London NHS Foundation Trust (the trust). The investigation is commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005.

Terms of reference

The aim of the independent investigation is to evaluate the mental health care and treatment given to RP from the time of his first contact with mental health services to the time of the offence. The investigation will review the trust internal investigation and assess the progress made on the implementation of its recommendations.

The investigation team will:

- Investigate and review the mental health care and treatment provided by the trust to RP from his first contact to the time of the offence.

- Assess the adequacy of the risk assessment(s) of RP and actions consequent upon the assessment(s).

- Examine the nursing and medical leadership and management associated with RP's care and treatment.

- Review the extent to which trust services adhered to statutory obligations, relevant national guidance and local operational policies.

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

- Examine the extent and adequacy of interagency collaboration between the trust (including forensic services for young people), local authority, Huntercombe group, Metropolitan Police and RP's general practitioner.

- Review the trust internal investigation and assess the adequacy of its findings and recommendations and the progress made in their implementation.

- Provide a written report including recommendations specific to the care and treatment of RP to NHS London, the trust and its commissioning primary care trust (Newham PCT).

- Ensure that themes and recommendations are cross-referenced with investigations currently conducted by Verita covering East London NHS Foundation Trust.

Approach

The investigation team will conduct its work in private and will take as its starting point the trust's internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team. The investigation team will also seek to engage with RP and his family and also the family of the victim, TS. This will assist in ensuring that the investigation and review achieve a thorough understanding of the incident from the perspective of those directly involved.

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

If the investigation team identify a serious cause for concern then this will immediately be notified to NHS London and the trust.

The written report will include recommendations to inform the appropriate commissioning of the service by Newham PCT.

The investigation team

The investigation team will comprise of two Verita investigators as well as expert advisor(s) with nursing, medical or other relevant experience.

Timetable

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

Anne Douse
Head of Clinical Governance
NHS London
8 May 2008

Appendix B

Overview of documented episodes of physical and verbal aggression

Table 2:

Year	Setting	Documented physical or verbal aggression
1997	Community	Conviction for possession of an offensive weapon.
1998	Community	Conviction for intimidating a witness and juror.
1999	Community	Conviction for aggravated taking and driving away.
1999	Community	Conviction for robbery of a newsagent.
1999	Huntercombe manor	Punched a fellow male patient and was verbally abusive and intimidating towards staff.
2000	Huntercombe manor	Punched a female patient in the mouth which resulted in her needing seven stitches.
2000	Walton Road school	Hit a worker during a school visit to the Millennium Dome.
2000	Walton Road school	Hit a fellow student which resulted in his suspension from school.
2001	Community	Conviction for armed robbery of a taxi driver.
2001	Feltham YOI	Assaulted a fellow inmate with batteries placed in a sock, smashed a telephone and assaulted a fellow inmate.
2002	CFCS	In a meeting with CFCS staff alluded to incidents of violence and aggression.
2002	CFCS	Became angry and hostile at the CFCS base and the police were called.
2002	Community	Left home after an argument with his mother and a fight with his mother's partner.
2002	CFCS	Kicked over chairs and a stool and smashed the front door at the CFCS team base.
2003	CMHT	Told staff he was interested in shooting guns.
2003	CMHT	Conflict with a man in Stratford who he believed wanted to kill him. RP *"felt that the only way of dealing with this situation is to kill him first."*
2003	CMHT	Stabbed in the leg by his girlfriend, RP hit her with a hammer as revenge and was looking for more chances to take revenge. Thinking about harming his girlfriend's family.
2003	CMHT	Assaulted by a group of youths who tried to cut off his ear.
2003	CMHT	Owned a speargun and crossbow.
2004	CMHT	Verbally abusive and physically threatening to staff at CMHT. Police called.

Appendix C

Documentation reviewed

Documentation 1

Policies and procedures against which we assessed RP's care:

National

Multi-Agency Public Protection Arrangements (MAPPA) guidance March 2003. Home Office.
(MAPPA supports the assessment and management of the most serious offenders. MAPPA's aim is to ensure that a risk management plan for the most serious offenders benefit from the information, skills and resources provided by the individual agencies being coordinated through MAPPA).

East London and the City Trust policies/procedures

Revised CPA policy draft version 2 November 2003
(The copy of the policy provided to the investigation team had been circulated within the trust for comment in November 2003 but provided track changes which also provided a copy of the predecessor policy).

MAPPA referrals -the trust told us that in 2004 the procedure for referral to forensics services and to MAPPA was via a letter written by a consultant. There was no formal policy in place.

Transition from child and adolescent services to adult mental health services, March 2004.

Mental health referral pathways for young people who offend – Newham, 2007.

Mental health referral pathways for young people who offend – Tower Hamlets, 2007.

Supervision policy, 2002.

Safe working for staff in the community policy, 2002.

Record keeping policy, 2002

Operational policy for Newham CMHTs, 2004 (draft)

Operational policy for Newham CMHTs, 2006

Documentation 2

Records of intervention with RP:

Huntercombe manor clinical records

CFCS and CMHT clinical records from East London NHS Trust

GP electronic record

YOT records

Police records

Appendix D

List of interviewees

Name	Title
[Name deleted]	Consultant forensic psychiatrist and internal report panel member
care coordinator	Social worker/care coordinator, CMHT
consultant psychiatrist 1	Consultant psychiatrist, Huntercombe manor
consultant psychiatrist 2	Consultant psychiatrist, CFCS
CPN1	CPN, CFCS
director of nursing	Chair of internal panel and internal report author
RP	Perpetrator
RP's aunt	Aunty and friend of RP
senior clinical medical officer	Senior clinical medical officer, CMHT
social worker 5	Social worker, YOT

Telephone discussions with:

consultant psychiatrist 3	Service director and consultant adolescent forensic psychiatrist, Gardener unit
[Name deleted]	National specialised commissioning group

Email contact with:

social worker 2	Social worker, Gardener unit

Appendix E

List of abbreviations used

A&E	Accident and emergency department
ASW	Approved social worker
CMHT	Community mental health team
CPA	Care programme approach
CPN	Community psychiatric nurse
CFCS	Child and family consultation service
DLA	Disability living allowance
LSD	Lysergic acid diethylamide
MAPPA	Multi-agency public protection arrangements
MDT	Multi-disciplinary team
MHA	Mental Health Act
MINI	Mental illness needs index
NPSA	National Patient Safety Agency
PCT	Primary care trust
RGN	Registered general nurse
RMN	Registered mental health nurse
RMO	Responsible medical officer
SHO	Senior house officer (a term now no longer in use subsequent to the implementation of modernising medical careers in 2006)
SUI	Serious untoward incident
YAP	Youth awareness programme
YOI	Young offenders institution
YOT	Youth offending team

Appendix F

Recommendations from the review of the East London and the City Mental Health NHS Trust internal investigation report concerning the care and treatment of RP updated May 2008

RECOMMENDATION	ACTION POINT	UPDATE ON PROGRESS	LEAD
1. There is a need for a clearer pathway for forensic involvement to support adolescents within CAMHS Services who pose a risk within Children's services.	Access to local specialist forensic advice has been established – essentially the service links to the arrangements in place for adult assessment which is available from borough designated forensic psychiatrists. Recommendations are made including the need to access national services.	A care pathway has been put in place incorporating the established arrangements for managing forensic referrals in CAMHS, as well as the forensic links between CAMHS and the Newham YOT (see attached). Update May 2008: New SLA with YOT in place which includes Youth Inclusion Support Panels. Work on-going	CAMHS/Forensic Directorate Team Borough/Clinical Director
2. The criteria and procedures for referring to the Police Public Protection Team needs to be clarified and this should include clear guidelines indicating the criteria for referral and documentation. Decisions and outcomes should be clearly documented in clinical notes.	The Forensic Directorate has enhanced the resources available for specialist advice to Newham adult services (includes regular surgeries, joint attendance at MAPPA and MDO meetings and ad hoc access). Now arrangements for referral are being formalised in documentation to be appended to the Community Team Operational Policies.	Forensic interface meeting arranged with Clinical Directors. Update May 2008: Deputy Borough Director has reviewed PPP arrangements and is awaiting the Medical Director's sign off.	Deputy Borough Director/Adult and Forensic Clinical Directors/Medical Director
3. There must be a clear procedure for documenting any liaison and referral to Forensic Services by general and specialist mental health services.	See above. These arrangements link to public safety mechanisms.	As above. Update May 2008: Deputy Borough Director has provided review of arrangements to the Medical Director for sign off.	Deputy Borough Director/Adult and Forensic Clinical Directors/Medical Director

4. Documentation should always be made and kept on file of all assessments including those carried out in extraordinary locations; as these act as an important source of information for future care and treatment.	ELFT has a Trust-wide record keeping policy that reflects these standards. Practice is audited annually as part of the core audit process. Learning from audits is discussed and action planning formulated at and monitored via the Newham Clinical Effectiveness meeting. These arrangements have been established since the incident and are on-going. The governance arrangements link to line management and performance arrangements so individual as well as team/service performance and standards can be supported.	Mandatory record keeping audits carried out and performance reported to Trust and locality governance/team meetings on a regular basis. Action plans formulated and monitored via Newham Clinical Effectiveness meetings. Update May 2008: Continues as above.	Borough & Clinical Directors/Locality/Team Managers
5. The Clinical Teams need to adhere to standard practice of record keeping, particularly where joint assessments/contacts are made between two or more professionals. There must be an agreement as to who will take responsibility for recording the outcome of the contact.	In line with Trust Record keeping policy and audits, as described above. Team supervision arrangements are in place and are audited as above. Specific performance issues are discussed and reviewed at the Newham Team Managers' meetings and at Ward Managers' meetings, and in the case of individual performance by the line manager with the individual.	As above. Additionally, two independent supervision audits have been undertaken with improvement noted in the second. The ensuing improvement plans were actioned. Update May 2008: Continues as above.	Borough & Clinical Directors/Locality/Team Managers
6. The Trust should continue to provide debriefing training for staff.	Access to debriefing is part of the ELFT Incident Policy. The availability of debriefers requires review and a plan to ensure capacity is maintained.	Assurance Department aware of Panel recommendation. Revised Trust incident policy ratified. Update May 2008: Head of Training requested to provide update.	Head of Training in liaison with Director of Operations and Director of Partnership.