An independent investigation into the care and treatment of SP

A report for NHS London

July 2008

NHS London

VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

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Verita is an independent consultancy which specialises in conducting and managing inquiries, investigations and reviews for public sector and statutory organisations.

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1. Introduction

1.1 This independent investigation into the care and treatment of SP was commissioned by NHS London in accordance with the Department of Health (DH) circular HSG 94(27), *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36 issued in June 2005. The terms of reference for the investigation are given in chapter two of the report.

1.2 On the night of 18/19 February 2006 SP killed Matthew Carter, a stranger. On 28 July 2006 at the Old Bailey SP pleaded guilty to manslaughter on the grounds of diminished responsibility. He was sentenced to be detained in hospital under section 37 of the Mental Health Act 1983 (the MHA) coupled with a section 41 restriction order without a time limit.

1.3 At the time of the killing SP was a patient of South West London and St George's Mental Health NHS Trust (hereafter referred to as "the trust"). He was first referred to the trust by his general practitioner (GP) in April 2004. He had two episodes of inpatient care at Springfield Hospital. His care and treatment in the community was provided by a specialist community mental health team (CMHT) known as the early intervention service (EIS) which cares for patients experiencing the early stages of psychotic illness.

Background to the homicide

1.4 SP was born in 1976. He is a black British man. His family is of Caribbean origin. SP was raised by his mother. He was described to us as having a normal childhood. He did well at school and attended church regularly. He began to smoke cannabis at the age of 14.

1.5 After leaving school SP attended Northampton University where he studied for a degree in law, business and politics. He left university at the end of his second year to earn money. He lived briefly in a flat in north London but returned to live with his mother in early 2004.

1.6 In April 2004 SP's GP referred him to the East Mitcham CMHT and he attended an outpatient appointment in May 2004. He was seen briefly and a referral was made to the EIS. In June 2004, before his assessment by the EIS, he was sectioned under the MHA and

admitted to the trust's Springfield Hospital. He absconded a week later. After a disturbance at a local church he was readmitted under section in July 2004.

1.7 During this admission to hospital and during his subsequent admission SP was violent or aggressive on a number of occasions.

1.8 After responding well to treatment SP was discharged in September 2004 into the care of the EIS. He was cared for on the enhanced level of the care programme approach (CPA). His care coordinator was Neil Hickman who was also the EIS team manager.

1.9 He remained in contact with the EIS, but he was reluctant to address his mental health problems and refused psychiatric medication. In January 2005 SP moved from his mother's house into low support accommodation at Links Road in Tooting.

1.10 In April 2005 SP flew to Jamaica to visit relatives for two weeks. He became psychotic while he was there. On his return and in response to concerns about his mental state, Neil Hickman and a colleague, community psychiatric nurse (CPN) Sanjaya Warnatilake, visited him at his mother's house. During the visit, SP seriously assaulted Sanjaya Warnatilake. The police were called and SP was taken to hospital. SP was placed under section 3 of the MHA. In June 2005 he was again discharged into the care of the EIS.

1.11 From June 2005 until he killed Matthew Carter, SP's engagement with the EIS became increasingly limited and he continued to refuse psychiatric medication. In autumn 2005 he began a university course in London. Neil Hickman saw him face-to-face for the last time on 8 December 2005. Between then and the killing of Matthew Carter, the EIS had some telephone contact with SP and his mother.

1.12 On 8 February 2006 SP was arrested in Croydon and charged with a motoring offence. At the police station he was agitated and upset. He was seen by a forensic medical examiner (FME) who concluded that SP was not psychotic and later that evening he was released on bail.

1.13 In the week before the killing of Matthew Carter there was further telephone contact between the EIS and SP and his mother. Late on the night of 18 February 2006 SP's brother and uncle took him to his mother's house. They were concerned about his mental

health and believed he needed help. SP was disturbed and his mother found it impossible to control him. He left his mother's house and killed Matthew Carter shortly after.

Action following the homicide

1.14 The trust carried out an internal investigation to examine the circumstances surrounding the killing of Matthew Carter. The investigation reviewed the history of contact between SP and the trust. A report was completed which made recommendations for improvements to the trust's services. The report of the internal investigation team was submitted to the trust board on 6 June 2006.

1.15 In September 2006 Verita were commissioned to undertake the independent investigation.

1.16 Kate Lampard, a former barrister and strategic health authority chair, chaired the investigation.

1.17 Christine Brougham and David Watts were the supporting investigators. Both are Verita consultants with backgrounds in mental health.

1.18 Dr Jayanth Srinivas, a consultant forensic psychiatrist, acted as expert adviser to the panel.

1.19 The investigation began in January 2007 shortly after we obtained copies of SP's records and other relevant documentation. We studied the records and documents before we began interviewing. We interviewed 31 individuals, some of them more than once.

Acknowledgements

1.20 We are conscious that the death of Matthew Carter has deeply affected the lives of a number of people, in particular the members of his family and the family of SP. We wish to offer our deepest sympathy to Matthew Carter's family for their tragic loss.

1.21 We are grateful to Matthew Carter's mother and brother and to SP's mother for allowing us to interview them. We realise how difficult they must have found that process. Their evidence has greatly helped our work.

1.22 We have received full cooperation from the trust, the London Borough of Merton housing department and the Metropolitan police.

2. The independent investigation's terms of reference

2.1 The terms of reference for this investigation, agreed by NHS London, were:

"The aim of the investigation and review is to evaluate the care and treatment of [SP] *and understand the circumstances and root causes of events leading up to the death of Matthew Carter. The investigation and review will ascertain whether the recommendations of the South West London and St George's Mental Health NHS Trust internal investigation are being implemented. The investigation will provide further recommendations to the trust and NHS London to assist in helping to ensure future best practice in the provision of mental health care.*

The investigation panel will:

- *Investigate the mental health care and treatment offered and provided to* [SP]*.*
- *Investigate and identify the root causes of events leading up to the death of Matthew Carter:*
  - *Specifically this will include a comprehensive chronology of the incident identifying any care and service delivery problems as well as the factors that contributed to the incident thereby facilitating the identification of root causes.*
- *As appropriate, and in the interests of avoiding duplication of effort, draw upon the work and findings of the internal inquiry carried out by the trust into the circumstances surrounding the death of Matthew Carter.*
- *Consider the actions taken by the trust in response to the death of Matthew Carter and review any previously made recommendations and the progress made in their implementation.*
- *To make clear, sustainable and targeted recommendations, based upon and arising from its investigations and review. Such recommendations:*
  - *To be aimed at ensuring that the lessons arising from the investigations are learned, acted upon and shared,*
  - *To include, as appropriate, recommendations as to the future provision, operation and management of services and how such recommendations are implemented.*

- *Provide a written report including recommendations to NHS London, the trust and its commissioning primary care trusts (PCTs).*
- *Meet with key staff to outline the recommendations and assist them in developing an implementation plan as a means of ensuring full interpretation of the recommendations.*

Approach

The investigation and review will consist of two phases:

1. *An information and fact finding phase incorporating the gathering and review of relevant pieces of information to assist in establishing the scope of the second phase of the review,*
2. *Interviews with key staff and managers – either individually or in groups with fieldwork carried out as required.*

As well as interviewing key staff and managers the investigation panel will also aim to engage with [SP] *and his family as well as the family of Matthew Carter. This will assist in ensuring that the investigation and review achieve a thorough understanding of the incident from the perspective of those directly involved.*

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

The written report will include recommendations to inform the appropriate commissioning of the service by Sutton and Merton PCT and Richmond and Twickenham PCT as the lead commissioner of mental health services.

Publication

The outcome of the review will be made public. The SHA will determine the nature and form of publication. The decision on publication will take into account the views of the chair of the investigation panel, those directly involved in the incident and other interested parties.

The investigation panel

The investigation panel will consist of an appropriately knowledgeable Chair assisted by expert advisors with nursing, medical or other relevant experience.

Timescales

The process of the investigation and review is dependent on the panel having access to the necessary records relating to the care and treatment of [SP]. *The investigation and review will aim for completion within 6 months of the date that the investigation panel is given access to the records.*

The investigation panel will provide a monthly progress report to the SHA and the PCT."

3. Executive summary and recommendations

3.1 SP killed Matthew Carter on the night of 18/19 February 2006. He was charged and later convicted of manslaughter on the grounds of diminished responsibility and was ordered to be detained in hospital under section 37 of the MHA coupled with a section 41 restriction order without time limit.

3.2 The trust completed an internal investigation in June 2006. NHS London commissioned Verita to undertake the independent investigation in October 2006. The independent investigation started in January 2007 once we received copies of SP's medical records and other relevant documentation.

3.3 We found that SP's community care was largely provided by the EIS. The EIS provides specialist care to adults experiencing the early stages of a psychotic illness. The service is based on the site of the trust's Springfield Hospital and provides a service to the London boroughs of Wandsworth, Sutton and Merton. We found that the EIS does not comply with the DH's policy implementation guidance (PIG) in that its size makes it unable to meet the needs of the population of the three boroughs, it does not provide out-of-hours cover and it does not have dedicated inpatient beds. We were pleased to be told that a review of the EIS was taking place with a view to establishing how the EIS resources would be increased over the next two years.

3.4 Neil Hickman, the EIS team manager was SP's care coordinator. We heard praise for Neil Hickman as a manager and clinician. We were aware that he had a heavy workload but we found no evidence to suggest that this had adversely affected the care he offered to SP. We did however find that in caring for SP, Neil Hickman was unduly focused on the wishes and desires of SP and his family rather than on the risks he posed when unwell, and that Neil Hickman's failure to ensure that a face-to-face mental health assessment of SP was undertaken in February 2006 was a professional misjudgment.

3.5 We learnt that a significant number of the EIS patients are young black men but the EIS does not reflect this in its staff composition. Nevertheless, we do not believe that Neil Hickman's cultural background or that of the EIS as a whole was an issue that had any bearing upon the care and treatment of SP. We were told that the trust monitors the cultural makeup of the population that it serves and the cultural background of its staff. The trust has also employed community development workers to assist in making links with

the communities that it serves. We recommend that the trust should continue to expand its work on ensuring that its workforce in its makeup, its training and its development is able properly to respond to the cultural needs of the population that it serves.

3.6 We found that SP resisted psychiatric care and that the main approach taken to engage him in the community was to assist him in dealing with his social needs. This approach was only partially successful and SP consistently refused medication during the periods that he was cared for as a community patient. We recommend that patients who are as hard to engage as SP, should be considered for joint working by two care coordinators and that their care and treatment should be considered for external peer review.

3.7 SP's mother LP was actively involved with her son throughout the period that he was known to the trust. We found that there was regular communication between LP and the EIS however there was an over reliance on her as the means by which the EIS monitored SP's progress. She was not adequately equipped to fulfill that role or to act in her son's best interests. We recommend that carers should be offered dedicated education and training in respect of the mental health issues faced by the relative they care for and also an opportunity to voice their needs as a carer.

3.8 We are critical of the fact that there was no face-to-face mental health assessment of SP by the EIS in the 10 weeks before the critical incident on 18/19 February 2006. We believe that the need for such an assessment was made absolutely clear after SP's arrest for driving offences on 8 February 2006. However, we cannot say for certain that if an assessment had taken place it would have resulted in SP's detention and so prevented the events of 18/19 February 2006.

3.9 SP was known to be capable of great violence and to present a significant risk to others when acutely psychotic. Despite this, he was not referred for a forensic assessment because the EIS staff who cared for him believed there would have been limited value in such an assessment. We conclude that this was a lost opportunity to obtain a different, beneficial perspective on and approach to SP's care and treatment.

3.10 During both of SP's admissions to hospital he made a number of attempts to abscond. During his first admission he absconded from the psychiatric intensive care unit (PICU) at Springfield Hospital by climbing over the garden fence. During his second

admission he twice almost succeeded in climbing over the fence. We were particularly concerned to learn that SP was able to get hold of ward keys. However, we were assured that this was the result of lapses on the part of one particular member of staff who no longer works at the trust. We found that trust staff did not do enough to secure SP's return to the hospital after he absconded during his first admission to hospital. We reviewed the trust's missing person and absent without official leave (AWOL) policy and found that it is not explicit enough about the need to ensure the return of patients who pose a risk if left at large, and the powers available to trust staff for that purpose.

3.11 We considered SP's attack on Sanjaya Warnatilake on 20 April 2005. This was a particularly serious incident that caused acute injury and continuing distress. We were concerned to discover that witness statements were not taken until three months after the event. The Crown Prosecution Service (CPS) decided eventually not to prosecute SP for the attack. Although it was not for us to consider the merits of that decision, we found that a prosecution might have been beneficial for the treatment of SP for a number of reasons, including that it might have encouraged him to address his condition and engage with treatment. The issue of the attack on Sanjaya Warnatilake demonstrated the need for the trust to develop and maintain close working relations with the police and the CPS. It also demonstrated the need for the senior management of the trust to be aware of serious incidents involving trust staff so that they can offer staff appropriate support.

3.12 In February 2004 SP moved into accommodation managed under Merton Borough Council's supported housing scheme. We found that SP's carer under that scheme did not provide the level of care that she was contracted to provide. We also found that the EIS did not adequately inform the carer of SP's mental health issues and the potential risks that he posed. Nor did the EIS take the opportunity of using the carer as a means of engaging SP and monitoring his mental health.

Recommendations

3.13 Our recommendations are as follows:

R1 The trust should continue to work towards the expansion of the EIS in line with the DH policy implementation guidance and the creation of a borough-based early intervention service.

R2 The role of the EIS team manager should be kept under regular review. This will help ensure that the role is manageable and that the quality of any clinical work to be undertaken by the team manager is not put at risk in the future by the burdens of the team manager role.

R3 The hours of operation of the EIS and the provision of an out-of-hours service should be part of the current review of the EIS resources.

R4 The trust should continue and expand its work on ensuring that its workforce, in its make-up, training and development, is able to respond properly to the cultural needs of the population that it serves.

R5 The trust, in reviewing the service model of the EIS, should consider the best model for providing appropriate dedicated EIS beds.

R6 The EIS operational policy should be amended to provide that where a patient is proving hard to engage, the EIS should consider whether it would be appropriate for a patient to be joint-worked by two care coordinators while remaining the responsibility of a single named care coordinator for CPA purposes.

R7 The EIS should have an external peer review system, available in all cases thought likely to benefit from it, regardless of whether, or for how long, the service user in question has been in the "red zone" (the acute list).

R8 The EIS should ensure that all carers are offered dedicated time for education and training about the mental health issues faced by the patient they care for and also dedicated time to consider their own needs and any support they may require in acting as a link between the service user and the EIS.

R9 The trust should remind staff of the need to ensure that CPA documentation gives a comprehensive outline of a patient's care plan, and where necessary the plan should set out the role to be played by carers and any support they may require.

R10 The trust should ensure as part of its current review of forensic services that those services can offer the community teams the support and advice they need. Arrangements should be put in place for effective liaison between the forensic and community services.

R11 The trust should review its policies and procedures regarding the safeguarding of keys to its facilities.

R12 The missing person and AWOL policy should be reviewed by the trust and circulated to ensure that staff are clear about their responsibilities in the event that a patient absconds.

R13 The trust should enter into a local joint working protocol with the police as envisaged by the recent Memorandum of Understanding (MoU) between the Association of Chief Police Officers and the NHS Security Management Service (NHS SMS).

R14 The trust should keep under review the question of the resources needed to meet its changing and increasing responsibilities in progressing criminal prosecutions.

R15 The trust should review its processes and procedures for alerting senior managers to serious incidents which have significant potential for undermining staff morale and whether they offer adequate support for staff and adequately explain the trust's response to such incidents.

R16 Merton Borough Council should review its practice and procedure for ensuring that carers under the supported housing scheme provide the services expected of them.

R17 Merton Borough Council and the trust should consider how carers under the supported housing scheme can best be supported and managed to enable them to understand and make a reliable contribution to the care and treatment of service users in supported accommodation.

R18 The EIS should review its practice and procedure about informing local authority housing departments and carers under their supported housing schemes of the risk histories and risk assessments of service users and of significant revisions to the CPAs of service users.

R19 Merton Borough Council's housing support team should review its procedures for identifying and acting upon important information and documentation received by it and its arrangements for dealing with correspondence during staff absences.

3.14 We now list these recommendations by addressed organisation.

3.15 The EIS

- The trust should continue to work towards the expansion of the EIS in line with the DH policy implementation guidance and the creation of a borough-based early intervention service.
- The role of the EIS team manager should be kept under regular review. This will help ensure that the role is manageable and that the quality of any clinical work to be undertaken by the team manager is not put at risk in the future by the burdens of the team manager role.
- The hours of operation of the EIS and the provision of an out-of-hours service should be part of the current review of EIS resources.
- The EIS operational policy should be amended to provide that where a patient is proving hard to engage, the EIS should consider whether it would be appropriate for the patient to be joint-worked by two care coordinators while remaining the responsibility of a single named care coordinator for CPA purposes.
- The EIS should have an external peer review system, available in all cases thought likely to benefit from it, regardless of whether, or for how long, the service user in question has been in the "red zone" (the acute list).
- The EIS should ensure that all carers are offered dedicated time for education and training about the mental health issues faced by the patients they care for and also dedicated time to consider their own needs and any support they may require in acting as a link between the service user and the EIS.
- The EIS should review its practice and procedure about informing local authority housing departments and carers under their supported housing schemes of the risk histories and risk assessments of service users and of significant revisions to the CPAs of service users.

3.16 The trust

- The trust should continue and expand its work on ensuring that its workforce, in its make-up, training and development, is able to respond properly to the cultural needs of the population that it serves.
- The trust, in reviewing the service model of the EIS, should consider the best model for providing appropriate dedicated EIS beds.
- The trust should remind staff of the need to ensure that CPA documentation gives a comprehensive outline of a patient's care plan, and where necessary the plan should set out the role to be played by carers and any support they may require.

- The trust should ensure as part of its current review of forensic services that those services can offer the community teams the support and advice they need. Arrangements should be put in place for effective liaison between the forensic and community services.
- The trust should review its policies and procedures regarding the safeguarding of keys to its facilities.
- The missing person and AWOL policy should be reviewed by the trust and circulated to ensure that staff are clear about their responsibilities in the event that a patient absconds.
- The trust should keep under review the question of the resources needed to meet its changing and increasing responsibilities in progressing criminal prosecutions.
- The trust should review its processes and procedures for alerting senior managers to serious incidents which have significant potential for undermining staff morale and whether they offer adequate support for staff and adequately explain the trust's response to such incidents.

3.17 Inter-agency

- The trust should enter into a local joint working protocol with the police as envisaged by the recent Memorandum of Understanding (MoU) between the Association of Chief Police Officers and the NHS Security Management Service (NHS SMS).
- Merton Borough Council and the trust should consider how carers under the supported housing scheme can best be supported and managed to enable them to understand and make a reliable contribution to the care and treatment of service users in supported accommodation.

3.18 London Borough of Merton

- Merton Borough Council should review its practice and procedure for ensuring that carers under the supported housing scheme provide the services expected of them.
- Merton Borough Council's housing support team should review its procedures for identifying and acting upon important information and documentation received by it and its arrangements for dealing with correspondence during staff absences.

PART 1: BACKGROUND INFORMATION

4. The method the panel used

4.1 The guidance for internal investigations by mental health trusts was issued by the DH in HSG (94)27. It requires them to conduct formal internal reviews of critical incidents. The strategic health authority is required to commission an independent investigation in the case of homicides and other exceptional events. The guidance was amended in June 2005 and required trusts to conduct an investigation into the circumstances of any critical incident using a structured investigation process such as root cause analysis (RCA).

4.2 RCA is a structured and systematic approach to incident investigation and analysis for healthcare incidents. It is essentially composed of five main steps:

1. Getting started
2. Gathering and mapping evidence
3. Identifying the problems
4. Analysing the problems
5. Generating recommendations and solutions.

4.3 Our investigation began with a review of SP's records and the key policies and procedures. A full list of all the documents we reviewed is contained in appendix C.

4.4 We examined SP's case notes in detail and produced a timeline highlighting in chronological order the main events associated with his care and treatment, along with the names of staff delivering care. Our timeline extended the one developed by the trust to contain information in the following fields:

- Event date and time
- Event
- Supplementary information – other background and associated information of relevance at the time of the event
- Source of information
- Notable practice.

4.5 The timeline is available in appendix D.

4.6 Interviews were held between March and September 2007.

4.7 David Watts the investigation manager wrote to interviewees in advance, explaining:

- the nature of the investigation and the purpose of the interview
- who would interview them
- when and where the interview would take place
- that they could bring a friend or colleague for support

4.8 Each witness interview was chaired by Kate Lampard and attended by one or other panel members, David Watts and Christine Brougham. Dr Jayanth Srinivas, an expert adviser also joined the interviews with medical staff.

4.9 A stenographer transcribed each interview. Interviewees were given a copy of the transcript and encouraged to correct any errors or to add anything they felt had been omitted. This transcript was then returned with any corrections or amendments to David Watts. The transcripts were then sent to all panel members for review. The full list of formally recorded interviews is shown in appendix B.

5. The trust's EIS

5.1 In July 2001 the trust began operating a community-based service for the treatment of early-onset psychosis under the formal name of early treatment and home-based outreach service (ETHOS). The service was more usually called the EIS and that is how we refer to it.

5.2 The EIS was set up by Dr Swaran Singh, consultant psychiatrist. He had joined the trust in March 2001, at the invitation of Professor Tom Burns, at that time the clinical director of the trust's adult directorate, for the purpose of establishing and leading the new service.

5.3 The EIS treated SP from September 2004 until he killed Matthew Carter on the night of 18/19 February 2006.

5.4 The operational policy for the EIS dated July 2003, (hereafter referred to as "the operational policy") described the purpose of the EIS as follows:

> *"Research evidence suggests that the mean duration of psychosis before treatment is initiated is 1-2 years. The first three years of the illness is the time of maximum deterioration in functioning. This is the period of repeated relapses, with emergence of a) a 'revolving door' pattern of admissions, b) treatment resistant symptoms and c) major personal, social and occupation disabilities. Two thirds of suicides occur in the first five years. The onset of psychosis is mostly in the younger age groups, who are more likely to slip through the care net. This is therefore a crucial period for early intervention to therapeutically engage patients and improve long-term outcome.*
>
> *There is emerging evidence that early and assertive intervention in first-episode psychosis can improve the natural history of the disorder. With early intervention, patients experience better outcome with regard to overall quality of life and social functioning, have a lower average length of hospital stay and receive lower doses of neuroleptics."*

5.5 The aims of the EIS were described in the operational policy dated July 2003:

> "[the EIS] *is a developing service. The service currently aims to:*
> *Reduce the time between the onset of psychotic symptoms and initiation of effective treatment once the patient has been referred to us.*
> *Accelerate remission through effective biological and psychosocial interventions.*
> *Minimize individuals' adverse reactions to the experience of psychosis.*
> *Maximise social and work functioning.*
> *Promote recovery during the early phases of the illness.*
> *Prevent relapse and treatment resistance.*
> *Develop meaningful therapeutic engagement early in the course of the disorder based on assertive outreach principles.*
> *Provide comprehensive assessment, treatment and rehabilitation in the least restrictive setting.*
> *Focus on carer needs and involve the family in a therapeutic alliance."*

5.6 Dr Singh told us that, at the time that the EIS was set up, there were relatively few services in the UK dedicated to early intervention in psychosis. He described the style of working agreed by his new EIS team in the following terms:

> "[…] *we would have* […] *an assertive home-based approach, we would not let people go just because we were not sure of the diagnosis or just because they wanted to be discharged or just because we thought it was drug induced or just because we got into a battle over medication. We would work with people, and instead of saying: 'This is what we think you need' we would start by saying: 'What do you want us to do? We will start with that and around that build trust and engagement*."

Referral

5.7 The operational policy sets out the referral criteria for the EIS :

> *"The service will accept referrals from all Community Mental Health Teams within the Trust for individuals:*
> - *Aged over 17 and under 30 years*

- *Within a year of presentation to mental health services with a psychotic breakdown……*
- *With a primary diagnosis of psychotic disorders….*
- *Living within the boroughs of Merton, Sutton and Wandsworth*
- *With a level of risk manageable within the community"*

Staffing

5.8 Dr Singh told us that the EIS had three care coordinators and a team secretary when it started to accept patients on 16 July 2001. Dr Singh worked part-time for the EIS, splitting his week with an academic post at St George's Medical School. Dr Singh also procured the services of a research assistant at St George's Medical School who helped him by collecting and assessing data on the outcomes for the patients of the EIS.

5.9 The research undertaken into the outcomes for the patients of the EIS was reviewed after 18 months. Dr Singh said it revealed that the EIS had been notably successful in keeping in contact with patients, in keeping patients out of hospital, in reducing their risk behaviours, and in getting patients back into work and education. The findings of the research enabled the EIS to secure more money from the commissioning PCTs. Staffing was increased in October 2002 to a whole time equivalent of 7.4:

- 0.5 consultant psychiatrist
- 1.0 senior house officer (SHO)
- 2.0 CPNs
- 0.8 clinical psychologist
- 0.6 occupational therapist
- 1.0 community support worker
- 0.5 vocational worker
- 1.0 team secretary

5.10 The staffing of the EIS was expanded again in the autumn of 2003. In addition to further CPN, vocational work and occupational therapy posts, the post of team manager was created. This post was eventually filled by Neil Hickman, an approved social worker (ASW). When SP became a patient of the EIS in September 2004, the staffing of the EIS was a whole time equivalent of 10.1:

- 0.5 consultant psychiatrist
- 1.0 team manager/ASW
- 1.0 SHO
- 0.8 clinical psychologist
- 1.0 occupational therapist
- 3.8 CPNs
- 1.0 vocational worker
- 1.0 team secretary

5.11 While Dr Singh was the consultant psychiatrist for the EIS from July 2001 to February 2006 the EIS also had the services of a specialist registrar (SpR).

5.12 Neil Hickman told us the EIS now has 14 members of staff, some part-time, and there are four staff vacancies. He told us that when SP was a patient of the EIS there would have been 10-12 whole-time equivalent members of staff.

Facilities

5.13 The EIS has been based from the start at the Fir Tower at the trust's Springfield Hospital site in Tooting. Outpatients are seen at Clare House on the site of St George's Hospital, Tooting.

5.14 The EIS does not have its own inpatient facilities. Patients in need of inpatient care are admitted either to the trust's PICU at the John Meyer ward, at Springfield Hospital, or to the inpatient ward for their local CMHT. SP had periods of treatment on both John Meyer ward and on Jupiter ward, which provides inpatient beds for the East Mitcham CMHT. SP came under the care of Dr Parimala Moodley, consultant psychiatrist, while he was on John Meyer ward, and on Jupiter ward he was under the care of Dr Paul Dewsnap, consultant psychiatrist with the East Mitcham CMHT.

Hours of operation

5.15 The EIS operates from Monday to Friday between 9am and 5pm. The Merton, Sutton and Wandsworth crisis service provide cover at other times via a free phone number called Crisis Line. The crisis service directs patients and their carers to the services available outside the hours that the EIS operates. The crisis service can be alerted to cases where

the EIS suspects that the need for a response out of hours might arise. This enables the crisis service to provide a planned response.

Caseload

5.16 All the clinical staff of the EIS have always held a care coordinator caseload. Dr Singh's explanation for this was that the EIS team "*felt at the start that if we were going to be truly multidisciplinary, and if we were going to be truly non-hierarchical we must all do similar things, and that involved also sharing expertise and learning, so we did not feel that somebody's role was too precious".*

5.17 The EIS was set up to serve and work across the London boroughs of Wandsworth, Merton and Sutton with a total population of 670,000. Wandsworth, the biggest of the three boroughs, accounts for about half of the EIS caseload. While SP was a patient of the EIS, the full-time staff had a caseload of 12 patients each. Neil Hickman, as the EIS team manager, was expected to have half that number.

Management of the EIS

5.18 When the EIS was established, the trust was managed under a directorate structure and the EIS came within the adult directorate. The EIS was managed by a service manager who had responsibility for its specialist services, the crisis and home treatment team and two assertive community treatment (ACT) teams. The trust's management and services were restructured into a borough-based structure in February 2005. The EIS came under the management of the Merton Borough service. Within that service, the EIS is managed by a service manager, Eugene Jones, who also manages the Merton CMHTs.

5.19 Clinical leadership in the EIS is provided by the consultant psychiatrist. Neil Hickman, as team manager has day-to-day management responsibility for the EIS. He line-manages all members of the EIS apart from the medical staff. Neil Hickman is managerially accountable to the service manager of the Merton borough service. As an ASW, who continues to be employed by Wandsworth Borough Council, Neil Hickman receives professional supervision from its lead social worker.

5.20 While SP was under the care of the EIS, the team as a whole held a meeting, known as the multidisciplinary team meeting, each Monday morning. It began with a discussion of current casework issues, in particular:

- new referrals, how they would be handled and who would undertake their initial assessment
- the results of assessments undertaken since the last meeting
- discussion of patients on the "acute list" being patients about whom a care coordinator had particular concerns.

5.21 The meeting would then move on, on a rotation basis, to either a session for peer supervision (an opportunity to consider certain more difficult cases in greater depth), or the EIS team business or an education session. A further meeting on Thursday mornings ensured that issues relating to the "acute list" were resolved before the weekend, when the EIS did not operate. The Thursday meeting was not as well attended as the Monday meeting because some staff worked part-time.

5.22 The EIS restructured its team meetings and its process for discussing patients giving cause for concern in response to the findings of the trust's internal inquiry into the death of Matthew Carter. The EIS introduced the zoning system under which all patients are allotted to a zone - red, yellow or green, depending on the difficulties or concerns their case present. There is a daily team meeting at which patients are discussed on the basis of their zoning. The full Monday meeting continues to include the rotating sessions for peer supervision, team business, or education and a slot for any other business to discuss non-acute patient issues.

6. SP's personal history

6.1 SP was born on 27 July 1976. He is a black British man. His family is of Caribbean origin. SP is tall, well built and athletic.

6.2 SP's mother, LP, was 16 when he was born. She and SP's father were not married and their relationship ended before the birth. SP is LP's only child; they appear to have had a close relationship. SP has a large number of half-siblings by his father. LP told us he was "very close to everyone in his family". He saw his father and his half brothers and sisters often and was also close to his grandparents on both sides.

6.3 We have not been able to gather much direct evidence about SP's childhood and upbringing or his life before he came into regular contact with psychiatric services in 2004. His medical records, however, disclose that he was brought up by his mother at various addresses in South London. The psychiatric reports prepared while SP was detained at Springfield Hospital in 2004, show that he described himself as having a normal childhood, attending school and gaining seven GCSEs and three "A" levels. He is reported to have said he worked voluntarily with children, played and wrote music, as well as attending church and playing sports regularly.

6.4 LP told us SP began smoking cannabis at the age of 14. His medical records reveal that in January 1992, when he was 15, SP and his mother were seen at the Brixton child guidance unit by Dr Anula Nikapota, a consultant child psychiatrist, *"in a situation of crisis following* [LP's] *discovery that* [SP] *was smoking marijuana".*

6.5 SP attended University College, Northampton, studying for a joint honours degree in Law, Business and Politics, but at the end of the second year he decided to take a break from the course to earn some money. He returned to London, but found it difficult to find either a job or somewhere to live. Eventually, through a contact of LP, SP found a bed-sit in Tottenham. His last period of employment was from November 2003 until January 2004 and involved working "in delivery". It appears that he was sacked for being argumentative.

6.6 LP said the first indication she had that SP was suffering from mental illness came in or about late 2003 when she went with him on a shopping trip to Croydon. An argument arose between SP and a security guard. There was a scuffle and the police were called.

The police asked LP whether SP was on medication. There were a number of subsequent events which also suggested that SP was becoming ill; for example, a friend of LP's who had seen SP suggested to her that he *"did not seem himself"* and queried whether he was *"on anything"*; LP saw SP talking to birds in the garden; SP threw away his mobile phone because he believed police had bugged it; he told LP that he had been in direct communication with God. And on 26 March 2004 it was alleged that SP tried to recover his car from the Lambeth Parking Services car pound by ramming the gates and then driving off at speed, hitting a brick wall. SP was interviewed about this incident on 28 April 2004 at Brixton police station. The police record states: "*After some concern as to his mental wellbeing, a [Forensic Medical Examiner] declared that he was fit to be interviewed ...".* No charges were brought because of a lack of CCTV evidence.

7. Events in the care and treatment of SP

7.1 In this chapter we set out what we found to be the significant events in the care and treatment of SP by the EIS and other services.

7.2 LP's concerns about SP's mental state, which arose as we set out in the previous chapter, resulted in LP persuading him to move back into her house in Mitcham. At the beginning of April 2004 she went with him to see Dr Mina Patel at the Wideway Medical Centre in Mitcham. Dr Patel referred him for an assessment to the trust's East Mitcham CMHT. The referral letter, dated 28 April 2004 states:

> *"*[SP] *registered recently with our practice and is requesting a referral.*
> *He is not on medication.*
> *He is hearing voices, has noted changes in behaviour and moods…"*

7.3 An appointment was made for SP to attend at the trust's outpatient department at Clare House, St George's Hospital on Thursday 20 May 2004. SP had been due to see Dr Aileen O'Brien, at that time the SpR to Dr Paul Dewsnap, the consultant registrar with the East Mitcham CMHT. SP was reluctant to attend the appointment but was eventually persuaded to do so by LP, who accompanied him. He arrived an hour late and Dr O'Brien was engaged with another patient, so she asked Dr James Ovens, at that time the senior house officer (SHO) with the East Mitcham CMHT, to see him instead.

7.4 Dr Ovens told us it was obvious to him from the outset that SP was "*not well at all*". He was *"talking to other stimuli in the room, he was talking to the wall […] his eyes were rolling up and looking at the ceiling, and [he was] talking to himself"*. SP sought an assurance from Dr Ovens that he would not be detained in hospital and when Dr Ovens failed to give that assurance he walked out of the room. Dr Ovens had only about three minutes to assess SP. LP stayed on for a further 20 minutes or so with Dr Ovens and gave him further details of SP's history. On the basis of his interview with SP and LP, Dr Ovens diagnosed SP as suffering from an acute psychotic illness.

7.5 After Dr Oven's meeting with SP and LP, he and Dr Dewsnap agreed that SP should be referred to the EIS. Dr Dewsnap explained to us his reasons for suggesting a referral to the EIS, rather than an assessment under section 2 of the MHA as follows:

"… admission under the Mental Health Act, when you are looking at a patient's first contact with services, should not be the first thing you think of. It is in the Code of Practice of the Mental Health Act that one should treat with the least restrictive option […] we want that initial contact, which can shape a person's future pattern of engagement with services, to be as least restrictive as possible."

7.6 On 24 May 2004 the EIS team secretary rang SP to offer him an appointment on 26 May 2004 for a first assessment with the EIS. SP was extremely angry about being contacted and hung up. When Neil Hickman, the EIS team manager, spoke with LP the next day, she was very unhappy that SP had been contacted directly as it had made him more agitated. Neil Hickman's entry in the multi-disciplinary team records states that LP was "*clearly very concerned for* [SP] *but equally anxious that he is not admitted".* Following this conversation Neil Hickman wrote to LP to explain more about the EIS service. He enclosed an information leaflet and suggested that she contact him once she had had the chance to discuss the matter further with family members and with SP. LP did not respond to Neil Hickman's letter.

7.7 On Sunday 6 June 2004, while SP was at his grandmother's house, he jumped out of a window. LP told us that this led her and other family members to try to have him detained under the MHA that evening. LP told us that she had contacted the social services for that purpose but they had been unable to proceed because the police did not attend.

7.8 On the morning of Monday 7 June 2004, LP went to the Wideway Medical Centre where she explained her concerns about SP to a GP, Dr Colin Jones. Dr Jones went to LP's house and made arrangements for SP to be assessed that day by the East Mitcham CMHT. Dr Jones was not able to help in the MHA assessment because he was not an approved practitioner under section 12(2) of the MHA, and had no previous acquaintance with SP. As a result, SP was assessed by Earl Lewis, an ASW and Dr Dewsnap, who recommended an emergency detention under section 4 of the MHA. SP was agitated at the time of the assessment and admission to hospital and had to be restrained by police, with whom he struggled violently. LP said seeing her son restrained and taken away to hospital was extremely traumatic. She told us: *"It really devastated me."*

First inpatient episode 7 June 2004 - 12 June 2004

7.9 SP was admitted to the PICU at the trust's John Meyer ward at Springfield Hospital and placed in seclusion.

7.10 SP's section 4 was converted to section 2 of the MHA on 10 June 2004.

7.11 On 12 June 2004, Dr Parimala Moodley, the consultant psychiatrist for the PICU, undertook a review of SP. She prescribed medication for his psychotic and affective symptoms in the form of Olanzapine 10 mgs, daily**.** A full account of the medication prescribed for SP and his history of compliance is set out in the medication timeline at appendix E. SP refused to take the medication. Later that day, when he was in the John Meyer ward garden, he jumped over the fence and escaped from the hospital.

7.12 Dr Parimala Moodley's psychiatric report of 18 June 2004 sets out her recommendations for SP's treatment in the event of his return to the PICU. She summarised his condition during his time in the PICU as follows:

> *"He presents with affective symptoms, emotional lability, persecutory and grandiose beliefs and auditory hallucinations. He has been displaying some intimidating and threatening behaviour as well as angry outbursts and destruction of property, starting prior to his admission.*
>
> *He is felt to be a risk to others, in view of his persecutory ideas, interpretation of people's actions and disclosed anger. He is a risk to himself due to his emotional lability, a recent history of allegedly threatening to burn himself, his perceived ability to stay up in the air and a tendency to jump from heights.*
>
> *He is at risk of using illicit substances, especially in the community and clearly a high risk of absconding, and disengaging with services and not complying with medication.*
>
> [SP] *has not yet been treated with regular medication as he has refused this. Should he return to the ward he would need to be contained in a secure unit and offered treatment, which he clearly needs at this stage."*

7.13 In the same report Dr Moodley refers to SP having admitted to smoking two joints of cannabis per day but recently increasing his use of cannabis to more than this.

The period of absconding: 12 June 2004 - 4 July 2004

7.14 Immediately after SP's disappearance from the John Meyer ward, staff completed the required missing person documentation. Wandsworth police and Mitcham CMHT were told he had absconded.

7.15 On 14 June 2004 SP's father rang the John Meyer ward and reported that SP was with his grandmother (his father's mother) in Streatham. This information was passed to the police. A member of the ward staff spoke with LP by telephone on 15 June 2004. LP said that SP had been with his grandmother, but she had now gone abroad and LP did not know where SP was. On 17 June 2004 his father again spoke to ward staff and suggested that SP might be with LP. His father also suggested that LP would conceal SP's whereabouts because she was reluctant to entrust his care to the hospital. Earl Lewis, ASW with East Mitcham CMHT, visited LP at home that day but there was no reply. He then visited SP's grandmother's address where he spoke with SP's uncle who said he did not know where SP was.

7.16 Ward staff and the East Mitcham CMHT tried over the next two days to phone LP. She did not respond. At noon on 19 June 2004 LP rang John Meyer ward to ask if she could collect SP's property. Staff told her it would not be possible to release SP's property without his authorisation. She said she did not know where he was.

7.17 There was no further contact between ward staff and SP's family or the police until 22 June 2004 when Dr Ovens, SHO for East Mitcham CMHT, received a phone call from PC Jim Shearan of Wandsworth police who told him that SP was at his mother's house. Dr Ovens rang LP who denied he was there. She admitted that she knew where he was but refused to say where. She said she could not "*betray*" SP by disclosing his whereabouts to hospital staff. LP said she would ring the hospital again the next day once she had discussed things with SP. Dr Ovens noted the following plan in SP's clinical notes:

> *"1. Await response from [LP]*
> *2. Continue efforts to engage her/him*
> *3. Discuss method of re-admission/other options when* [SP] *located."*

7.18 LP did not get back in touch with ward staff. There was no further contact between ward staff or the CMHT and SP's family, or the police on the issue of his absconding. He remained absent without leave.

Readmission to hospital 4 July 2004

7.19 On the morning of 4 July 2004, while still absent without leave from the John Meyer ward, SP attended church with LP. He was agitated and refused to leave after the service. He remained at the church until late afternoon when he tried to climb the face of the church building. The police were called and they took SP back to the John Meyer ward. They told ward staff that while at the church SP had "*pulled out a door"* and "*restrained the Pastor"*. When we asked LP about this, she would not accept that SP had restrained one of the pastors but conceded that he had been "*verbally abusive*" to him and had threatened him.

4 July – 10 September 2004

7.20 SP's section 2 of the MHA expired on 4 July 2004. Next day he was put on section 5(2) and later that day this was converted to section 3. The medical staff assessed him as presenting a high risk of absconding, of harm to himself and others, non-compliance with medication and deterioration of his mental health.

7.21 SP's inpatient clinical notes show he was aggressive or violent in the following days:

- On 6 July 2004 he became aggressive towards a staff member whom he wanted to hit. He was restrained and placed in seclusion.
- On 7 July 2004 he moved threateningly towards another patient. Staff had to intervene to separate them.
- On 10 July 2004 he tried to grab keys from a staff member.
- On 11 July 2004 he punched the window in the smoking area of John Meyer ward.
- On 22 July 2004 he tried to intervene during the restraint of another patient. The emergency team was called to help ward staff.

- On 24 July 2004 he slapped another patient on the back. He also grabbed the arm of another patient and twisted it. He also tried to grab the keys from a member of staff.
- On 26 July 2004 he was seen kicking another patient. Later that day he punched the same patient and was restrained and placed in seclusion.

7.22 In addition to the two incidents of grabbing keys to the ward referred to above, SP made a number of other attempts to abscond. On 12 July 2004 he took a set of ward keys which a member of staff had left on a chair in the day room. He left the hospital but police brought him back a few hours later. On 15 July 2004 SP picked up a set of ward keys that had been left in the patient lounge area by a member of staff. Staff found the keys on SP and he was persuaded to return them. On 20 July 2004 SP jumped over the fence in the garden to the John Meyer ward and left the hospital. Police brought him back an hour later. On 24 July 2004 he tried to grab a set of keys from a member of staff.

7.23 On 10 August 2004 SP was transferred from the John Meyer ward to Jupiter ward, the inpatient ward for the East Mitcham CMHT.

7.24 SP was unwilling to comply with his medication for any significant period during his inpatient treatment, as is shown in the medication timeline at appendix E. Accordingly, on 13 August 2004 Dr Dewsnap prescribed depot antipsychotic medication. SP was transferred back to the PICU on John Meyer ward for a period to monitor his reaction to the depot medication. He went back to Jupiter ward again on 19 August 2004.

7.25 On 6 September 2004 Dr Trevor Chan, SHO, and Julia Heathcote, occupational therapist, both members of the EIS team, attended Jupiter ward to undertake an assessment of SP. Dr Chan states in his note of that meeting that SP was "*aware that he had had a severe episode of distressing experience, but puts it down to his over enthusiasm in his religious beliefs, rather than seeing it as an illness*". They asked him about the role of medication in his recovery and SP said he did not think it played a significant part. Dr Chan and Julia Heathcote felt that given a choice SP would not comply with medication. When asked whether he thought his drug use had contributed to his experience, SP said he had given up taking drugs but according to Dr Chan's note SP "*didn't establish a clear link between the drug use and the episode".*

7.26 SP told Dr Chan and Julia Heathcote that he wanted to return to live with his mother immediately after discharge from hospital but wanted to live on his own in the longer term.

7.27 Dr Chan and Julia Heathcote concluded that SP was a suitable candidate for the EIS service and recorded that conclusion in the clinical notes. On 9 September 2004 Dr Chan wrote to Dr Dewsnap giving him their summary of the EIS first assessment of SP.

7.28 On 10 September 2004 there was a meeting under section 117 of the MHA to plan SP's aftercare. Dr Dewsnap and the ward staff from Jupiter ward attended, along with SP, LP and Neil Hickman. The notes of the meeting taken by Dr Aileen O'Brien, at that time the SpR for the East Mitcham CMHT, include the following :

> *"…*[SP] *questioning need for medication. Feels that a rest was all that helped*
> *Saying that he was better without medication*
> *Mother partially agreeing with what* [SP] *is saying*
> [SP] *saying that he's a lot better and doesn't need a team looking after him. Doesn't want the stigma of being a mental patient…….*
> *Reluctantly agrees to being seen once a week at home "for a bit"…*
> *… Mother now saying that* [SP] *can't go home and that she is going out of the country for next few weeks doesn't want him discharged*
> *Mother became angry [with] Dr Dewsnap.*
> [SP] *clearly not currently detainable under Mental Health Act, and consent to treatment is due so has to be taken off section…"*

7.29 The plan agreed at the section 117 meeting was for the EIS to provide follow-up care and to continue attempts to persuade SP to accept depot medication. He was discharged the same day. Neil Hickman told us that following the section 117 meeting he spent time with SP and LP, discussing, in particular, LP's concerns about SP's financial and housing needs.

Care and treatment under the EIS 10 September 2004 - 20 April 2005

7.30 On 16 September 2004 Dr Sasha Francis, SpR and Martin Keen CPN from the EIS undertook a first follow-up visit to SP at LP's house. During that visit SP denied smoking

cannabis since his discharge from hospital. SP also said that he thought that medication had played no part in his recovery. He refused to continue with depot or any other antipsychotic medication but said he was willing to maintain contact with the EIS team.

7.31 At the EIS team meeting on 24 September 2004 Neil Hickman was allocated as the care coordinator for SP, with Dr Trevor Chan as second care coordinator.

7.32 Later that day Dr Chan and Neil Hickman undertook a home visit to do a CPA assessment of SP. Dr Chan and Neil Hickman noted no psychotic features. They also noted that SP "*continues to think that he has [an] understanding to what has happened to him, and that [it] will never happen again and so doesn't need medication, despite our explanation and persuasion".* Dr Chan and Neil Hickman's notes show that, in view of the severity of SP's psychotic episode and his non-compliance with medication, they agreed that the EIS would monitor him weekly at first. Neil Hickman undertook to help SP apply for income support. He also agreed to liaise with Karen McNeil, the EIS vocational worker, to consider SP's educational and employment options, and to take him to view supported accommodation.

7.33 Dr Chan prepared a relapse and risk management plan which states the anticipated risks in SP's case as:

> *"Low risk of harm to self and others in immediate term….Risk of disengagement with services and risk of harm to self and others may increase significantly if becomes unwell".*

7.34 On the same day, 24 September 2004, Neil Hickman also compiled a CPA record for SP using the trust's computerised eCPA system. Under the enhanced health and social care plan section of the CPA record Neil Hickman noted that it was a provisional care plan subject to review over the next four to six weeks.

7.35 Under the "day time activity" section of the plan, Neil Hickman noted:

> "[SP] *would like to gain some part-time employment as an initial plan and would also like to work towards returning to his law degree studies next year."*

7.36 The "mental health" section of the plan includes the following:

"Weekly contact with EIS
Regular medical review
Make medication available if [SP] *decides to reconsider using medication again*

Early warning signs planning
Liaison with family, GP housing agencies
Practical support with issues that [SP] *feels are important*
Support to reduce the impact of any stresses."

7.37 The following was entered under the risk history:

"Unable to complete a detailed risk history at present as notes have not yet been forwarded from Jupiter ward. We are aware that there was an alleged incident of criminal damage prior to the recent admission and that the admission [sic] several episodes of control and restraint."

7.38 The relapse and risk management plan section of the CPA record states:

"there is no evidence of any current risks of aggression, self harm or self neglect. [SP] *appears to have made a good recovery from a psychotic episode and presents as symptom free at present. However* [SP] *has been clear that he will not take medication unless legally compelled (i.e. detained) and therefore his mental state requires close monitoring in the community…*

[SP] *does appear to be at long term, moderate risk of disengagement with services. He is sensitive to the stigma of an attachment with mental health services and appears anxious to forget about the psychotic episode and subsequent admission. He is currently willing to remain in weekly contact but has been frank in his reluctance to remain in contact for any length of time.* [SP] *has been clear that he will not take anti-psychotic medication and that he feels well and is not subject to any compulsory powers."*

7.39 Neil Hickman entered a review date of 24 December 2004 into the CPA record.

7.40 Between 8 October and 10 November 2004 SP was seen by the EIS on six occasions - 8 October, 15 October, 22 October, 27 October, 5 November and 10 November. All but one of these was a home visit, and all but one was undertaken by Neil Hickman. SP appeared well during these visits.

7.41 On the 27 October 2004 visit Neil Hickman was accompanied by Karen McNeil, the EIS vocational worker who assessed SP and discussed with him his options for an eventual return to university and for finding employment in the meantime. On 5 November Neil Hickman accompanied SP and LP to view supported accommodation at 240 Links Road, Tooting (hereafter referred to as "Links Road"), where they met with the owner, Sharon Lartey, and a housing officer from Merton Borough Council. Neil Hickman recorded in his note of the meeting that "*LP mentioned that* [SP] *had been using cannabis again due to boredom - does not want* [SP] *to know she has told me"*. Neil Hickman recorded his plan as *"? Provide emergency supply of medication".*

7.42 LP attended the home visit on 10 November 2004. Neil Hickman's note of the meeting records that he went through an initial discussion of early warning signs of relapse with SP, but he comments: "*I suspect this might be a slow process as* [SP] *is sensitive about the admission".* Neil Hickman also undertook to follow up an earlier request to the physical therapies department at Springfield Hospital for SP to be allowed to use the gym.

7.43 Neil Hickman, as well as working to address SP's housing and vocational needs, undertook a significant amount of work, particularly during the autumn of 2004, to deal with SP's chaotic financial affairs. He secured income support payments for SP and resolved claims against SP by at least four firms of bailiffs in respect of unpaid parking and road traffic fines and unpaid phone bills. Neil Hickman also engaged in long correspondence that went on well into 2005, in respect of an unpaid overdraft. He applied to the social fund on SP's behalf for financial help with furnishing the accommodation at Links Road and for clothing.

7.44 On 17 November 2004 Neil Hickman made another home visit. He noted that SP was a *"little negative in presentation - appeared flat and unmotivated"*. SP had failed to carry out any of the tasks he had agreed to the previous week including joining the library and updating his CV.

7.45 Neil Hickman gave LP a copy of a carer's assessment at this meeting. Neil Hickman told us that he could not recall what was said at that time by LP about how she wanted to undertake the assessment, but in any event she did not return the form to him.

7.46 Dr Chan made a home visit on 26 November 2004. He noted a lack of motivation in SP. In particular, SP had failed to keep an appointment to attend the gym at Springfield Hospital.

7.47 On 3 December 2004 Neil Hickman made a home visit at which LP was also present. He noted that SP remained symptom-free but that there might be an issue with *"negative symptoms - sleeping 12-15 hours […] struggling with practical goals we have set […]".* On 8 December 2004 LP phoned Neil Hickman and he noted that she "*sounded ever more stressed*" as a result of SP's inactivity and lack of motivation. Neil Hickman tried to visit SP at home later that day but there was no answer. Neil Hickman wrote in his clinical notes that he planned to visit again next day and that he was unclear whether SP's current presentation was the result of low mood, negative symptoms or early warning signs. There is no evidence of a home visit having taken place on 9 December 2004.

7.48 A CPA review by Neil Hickman and Dr Chan was planned for 17 December 2004 but while they were driving to LP's house, she rang Neil Hickman and explained that SP was refusing to see the EIS. Neil Hickman's entry in the clinical notes records that LP was angry and agitated with SP: *"She did not want us to knock at the door as it would make things worse, but was also insistent that we were responsible and something needed to be done"*. Neil Hickman's note also states that there were "*no current signs of psychosis, but [LP] was evasive about questions about* [SP]*'s health […] having reviewed the notes, I suspect that these are early warning signs […] No current evidence that a [Mental Health Act assessment] would be proportionate at present particularly as given [LP's] ambivalence, s135 (1) might well be needed".*

7.49 On the same day Neil Hickman sent an email to Dr Dewsnap, alerting him to the potential early warning signs that had emerged over the previous few weeks. He concluded the email by saying: "*there is still no evidence of any clear psychotic symptoms and we'll persevere to try to avert an admission but I am not terribly hopeful."*

7.50 SP's case was discussed in the EIS multidisciplinary team meeting on 20 December 2004 when it was agreed that Neil Hickman would write to SP and would update his CPA and risk assessment.

7.51 The new entries on SP's eCPA at this time are in fact dated 17 December 2004. They include four new entries on the risk history as follows:

> *"Evidence of disengagement and early warning signs of relapse.* [SP] *DNA'd last appointment and refused to see staff for a CPA review. Described by Mother as unmotivated, showering less frequently, sleep reversal. No obvious signs of psychosis but the overall picture is similar to the lead up to the 1st admission…*
> *Prior to admission* [SP] *is reported as having jumped from the 1st floor window of the house and also made references to burning himself …*
>
> *3x descriptions of assault on other patients during admission on John Meyer ward…*
>
> *Absconded for several weeks from John Meyer ward during 1st admission."*

7.52 Under the relapse and risk management plan, the following new entries were made:

> "[SP] *appears to be disengaging and there is evidence of early warning signs of relapse (poor motivation, deterioration of self care, sleep reversal). Refusing to see MH workers. High levels of stress within the home - mother very upset and angry with him.*
>
> *ACTION PLANS*
> *[…]*
> *In addition to the existing care plan:*
> *Ongoing work regarding early waning signs and developing agreed plan with* [SP] *to manage a future relapse and avoid admission if possible.*
> [SP] *and mother have Crisis Line numbers etc."*

7.53 On 20 December 2004 Neil Hickman wrote to SP inviting him to phone to discuss the best way for the EIS to maintain contact with him.

7.54 On 21 December 2004 Neil Hickman phoned LP. She was still concerned and angry because SP was *"staying in bed all day"*. She had no additional concerns. There were no signs of unusual behaviour or statements. Neil Hickman's notes show that LP said she wanted SP moved as soon as possible and did not like being called by the EIS.

7.55 Apart from a letter to SP arranging a further visit to Links Road for 13 January 2005, there was no further contact between the EIS and SP or LP until 10 January 2005. On that day Neil Hickman spoke on the phone with LP who told him that SP had been much better over Christmas. Neil Hickman also spoke with SP whom he described in his notes as "*quiet but amenable."*

7.56 On 13 January 2005, as agreed, Neil Hickman took SP to see Links Road again. In the clinical notes, Neil Hickman recorded: "*Despite my recent concerns,* [SP] *did not present significantly differently […] reports having found the level of contact with us stressful hence recent avoidance. Agreed to renegotiate this […]."*

7.57 On 25 January 2005 there was a placement meeting at Links Road between Neil Hickman, SP, a Merton borough housing worker, and Sharon Lartey, the owner of Links Road, to finalise the arrangements for SP's placement there. SP finally moved into Links Road in the week of 5 February 2005. Two other young men were staying at the property under the supported housing scheme at that time.

7.58 From this time until the middle of April 2005, Neil Hickman made five home visits to see SP at Links Road. SP failed to attend on two of these occasions but when Neil Hickman did see SP he found him symptom-free. A CPA review meeting was planned for 13 April 2005 but it did not take place because SP had gone to Jamaica with his cousin for two weeks.

7.59 On 15 April 2005 Neil Hickman received a telephone call from LP in which she said that SP's relations in Jamaica had phoned to tell her that [SP] was unwell. Neil Hickman spoke with LP again on 18 April and she reported clearer signs that SP was unwell, including talking to himself and being verbally hostile.

7.60 SP flew home from Jamaica with his cousin on 20 April 2005. He was met at the airport by LP who phoned Neil Hickman from the car on the way home and asked him to see SP urgently. Neil Hickman went to LP's house with Sanjaya Warnatilake, a CPN with

the EIS. It was evident to Neil Hickman and Sanjaya Warnatilake that SP was acutely psychotic. He was mute, glaring in a paranoid manner, clutching his chest and jabbing his fists in the air. Neil Hickman and Sanjaya Warnatilake tried to engage SP and to encourage him to take medication. They withdrew with a view to arranging a MHA assessment. SP followed them into the front garden and launched a flying kick at Sanjaya Warnatilake's jaw, causing him to bite his tongue and mouth and sustain cuts around his jaw and pain in his neck. Sanjaya Warnatilake made clear to us that the attack was highly aggressive and unprovoked. It was obvious to us that the attack was still causing Sanjaya Warnatilake significant distress. Neil Hickman also told the panel that he had not experienced and did not expect that level of assault in the community.

7.61 After the attack on Sanjaya Warnatilake, the police were called. Dr Singh also went to LP's house and on Dr Singh's recommendation SP was detained under section 4 of the MHA and taken to the PICU at the John Meyer ward of Springfield Hospital. Both Neil Hickman and Dr Singh described the process of detaining SP as extremely difficult. SP struggled throughout with six police officers. LP too struggled with the police and tried to prevent SP's detention. A hostile crowd in the street jeered at the police.

7.62 The duty doctor who admitted SP diagnosed an acute psychotic episode and a relapse of paranoid schizophrenia.

Second inpatient episode

7.63 Dr Ansari and Dr Sasha Francis assessed SP on 21 April 2005 and recommended that he be detained under section 3 of the MHA. LP at first objected to the detention but on 22 April 2005 she withdrew her objection and the section 3 process was completed.

7.64 SP was involved in a number of incidents of violence or aggression during this period of detention as an inpatient:

- On 21 April 2005 he assaulted a member of staff and had to be restrained and placed in seclusion.
- On 22 April 2005 he slapped another patient across the face. Later that day he kickboxed the same patient and had to be placed in seclusion and tranquilised under restraint.

- On 28 April 2005 he resisted taking his medication and assaulted the nurse administering it. He was placed in seclusion and tranquilised under restraint.
- On 1 May 2005 he became angry and agitated when he saw another patient being restrained and was taken to the seclusion room. He kicked at the seclusion room door.
- On 3 May 2005 he slapped a fellow patient.
- On 6 May 2005 he kicked a fellow patient on the leg.

7.65 SP also tried twice to abscond during this period of detention. On 24 April 2005 he was seen climbing the fence in the John Meyer ward garden. Staff talked him down. On 2 May 2005 he ran out of the ward while the garden door was open and climbed the garden fence to the top. Staff pulled him down. On another occasion SP was seen trying to open the door into the garden.

7.66 SP was reluctant to take medication throughout this second period as an inpatient and said he did not need it.

7.67 On 19 May 2005 SP was transferred to Jupiter ward. At a review undertaken that day by Dr Balabhadra, the SHO to Dr Dewsnap, he noted that SP's symptoms of schizophrenia were settling. He noted SP's medication as *"Depixol 200 mgs once in 2 weeks intramuscular, Olanzapine Velotab 10mgs nocte, given on 19 May 2005 next due 2 June 2005".* Dr Balabhadra noted the following issues:

1. *"Compliance with treatment. Claims it sedates him and therefore refuses.*
2. *Concerns that neighbours had witnessed him being taken into hospital and therefore think that he is mad.*
3. *Habits of absconding."*

7.68 Dr Balabhadra's note also states: "[SP] *claims to have used cannabis during his visit to Jamaica, also a cousin's grandmother's death-lead to relapse. Claims that he would feel like using dope when he is outside. Mentioned that he does feel like leaving or absconding from the ward".*

7.69 Dr Singh also undertook an EIS review of SP on 19 May 2005. He wrote in SP's clinical notes:

"Significant improvement from time of admission but still not fully well. Some insight but claims he might smoke cannabis on discharge. Thinks medication is a 'negative problem' in his life.
Detailed discussion. I emphasised
-need for regular medication
-abstinence from illicit drugs
-compliance with team instructions
We will be in regular touch with inpatient team"

7.70 At Dr Dewsnap's ward round on 20 May 2005 it was decided to hold a section 117 meeting to plan SP's aftercare on 27 May 2005.

7.71 On 27 May 2005 the trust's MHA office gave notice to Dr Dewsnap that SP had applied to the MHA Tribunal to be discharged from detention and that the tribunal had been convened for 27 June 2005. The notice also reminded Dr Dewsnap that his report on SP had to be received by the MHA office no later than 6 June 2005.

7.72 Dr Dewsnap and his team, SP and LP and Dr Brock Chisholm, a clinical psychologist with the EIS attended the section 117 meeting held on Friday 27 May 2005. Dr Chisholm covered for Neil Hickman, who was on holiday. Dr Balabhadra's note of the meeting shows that SP's mental state was deemed to be stable. He was granted leave for the weekend and, the note states, once leave had gone off well could be discharged "*since reports on appeal against section 3 are due on 6 June 2005".* Dr Balabhadra noted that SP wanted to go to university in September 2005 and that he did not want to take medication in the community.

7.73 Dr Chisholm told us he had no direct contact with SP before the meeting on 27 May 2005, but he was aware of SP from extensive discussions of him in the EIS team meetings. These discussions and Neil Hickman's briefing of Dr Chisholm led him to believe that the section 117 meeting would not result in a decision to discharge. Dr Chisholm believed that it was unlikely that SP would be well enough to be granted leave after such a short time.

7.74 Dr Dewsnap decided at a ward round on 3 June 2005 that SP should be discharged that day.

Care and treatment under the EIS: 3 June 2005 - 18 February 2006

7.75 On 6 June 2005 SP was seen at Links Road by Dr Krishnan and Dr Chisholm. SP was calm and cooperative. He spoke about God talking to him and feeling that his thoughts were being read. He felt he did not need medication as he could prevent his illness without it but was willing to accept his depot injections "*for the time being*". He also expressed concern about the stigma of mental health professionals visiting in future. Dr Krishnan and Dr Chisholm assessed SP's risk of harm to others as high when unwell but currently low to moderate. They assessed his risk of disengagement from services as moderate.

7.76 On 10 June 2005 SP failed to attend for an appointment at Springfield Hospital to receive a depot injection from Amy Hon, a CPN with the EIS. As a result, Amy Hon spoke with LP by phone, who told her that SP had phoned Jupiter ward to cancel the appointment. LP also said that SP had told her he did not want any more injections or to continue with medication. He had changed his mobile phone number. LP would not reveal the new number as she feared it would ruin her relationship with him.

7.77 Amy Hon reported SP's failure to attend for his depot injection to Neil Hickman when he returned from holiday on 17 June 2005. On 20 June 2005 Dr Singh alerted Dr Dewsnap in an email to SP's refusal to accept medication. Dr Singh's email says:

> *"Just to forewarn you that* [SP] *has stopped his medication. He might be heading your way again.*
> *We were hoping that Sec3 would allow a sustained period of treatment on the ward but that was not to be. We will keep you informed."*

7.78 Dr Dewsnap replied the same day: *"I imagined that this would happen."*

7.79 On 24 June 2005 Neil Hickman phoned LP and she said SP was doing well. He was already looking for work and there were no signs of any symptoms.

7.80 SP failed to attend a home visit that Neil Hickman arranged for 27 June 2005.

7.81 At a home visit on 30 June 2005 Neil Hickman observed a *"concerning lack of recognition of the severity of the last relapse and assault.* [SP] *adamant that he does not*

need medication [although] seemed willing to consider the option of keeping a supply for rapid restart if needed." Neil Hickman's note of the visit also states that SP was "*reluctantly accepting follow up visits but risk of disengagement is high*". Neil Hickman recorded his plan as:

> *"Review with Dr Singh 7/7/05*
> *Discuss forensic referral for further assessment of risk*
> *Liaise* [with] *housing re options of moving* [SP] *out of a communal setting"*

7.82 On 1 July 2005 the risk assessment section of SP's CPA documentation was updated to refer to the assault and detention after SP's return from Jamaica on 20 April 2005 and also his failure to accept either the severity of his last relapse or the need for treatment after discharge on 3 June 2005.

7.83 For much of his time under the care and treatment of the EIS, SP's name had appeared on the "acute list" prepared as part of the agenda for the EIS team's Monday meeting and he was discussed at that meeting. In the agenda for the EIS team meeting on 3 July 2005, which again has SP's name on the acute list, there is also a note which says "*engagement difficulty. Refused meds - missed 2 depots since discharge. Need to assess risk."*

7.84 Planned home visits by the EIS on 7 July and 21 July 2005 did not go ahead because of other commitments in the EIS team. SP failed to attend the next visit by Neil Hickman on 22 July 2005. LP told Neil Hickman that this was because he had a job interview.

7.85 On 22 July 2005 Sanjaya Warnatilake gave a witness statement to Chris Stanger, the trust's criminal justice adviser, regarding the assault on him by SP. Chris Stanger had been approached by Dr Singh in or about early July 2005 to pursue possible charges against SP in respect of the assault. Police had taken no statements and the police had told Sanjaya Warnatilake informally that it was unlikely that there would be a prosecution.

7.86 On 8 August 2005 Dr Singh and Neil Hickman had a CPA review meeting with SP. Dr Singh's note of that meeting records:

> *"Not on any medication...*

Says that he is certain that he will never become ill again because he can control […] *symptoms*

Did not want to discuss the need for either medication or psychological intervention

Became irate and hostile when suggested that if he did not take medication then it would not be possible for us to protect him from the consequences of any behaviour related to psychosis

Says he only wants practical help with rehousing

Wants [to reduce] input from Neil…

Significant risk of relapse but patient unwilling to engage

Neil to visit fortnightly, we may have to discharge him in 2-3 months after rehousing."

7.87 Dr Singh told us that SP exhibited significant hostility towards him during the meeting and said that he did not want to see a doctor. He told us:

"I felt that if I did not leave the house he would have assaulted me, and I was glad that Neil was there because Neil diffused it. […] *It was a very intimidating encounter."*

7.88 Neil Hickman updated the risk assessment and relapse and risk management plan sections of SP's CPA documentation after the CPA review. He made the following entry under the risk assessment:

"CPA review w. Dr Singh. [SP] *continues to refuse medication or to see a Doctor again, hostile to attempts to discuss previous relapse/prognosis etc.*

Unwilling to have any contact with the team unless it is specifically to assist him to get an independent flat.

Currently mentally stable but ongoing monitoring/risk management or relapse prevention is extremely difficult.

The updated Relapse and Risk Management Plan includes the following:

[SP] *is currently stable but has been assaultative to others during acute phases of psychosis seemingly in response to command hallucinations. In the event of further relapse he would present a significant risk to others.*

[…][SP] *is hostile to any discussion regarding previous episodes of illness or relapse prevention and therefore monitoring and risk management is severely limited.*

[…][SP] *continues to refuse to consider or discuss using anti psychotic medication when he is not detained in hospital. He is at high risk of dis-engaging entirely...*
In addition to existing care plan:
[…] *ongoing direct monitoring by care coordinator where possible and regular contact with family (mother).*
In the event of evidence of relapse then [SP] *should be formally assessed under the MHA at an early stage, is likely to require police involvement to contain any risk to others*
To pursue non supported, non-shared accommodation
Risks of relapse and subsequent risks to [SP's] *health and safety and risks to others are not currently reduced by his very limited engagement with services* […]
[SP] *and his mother have Crisis Line numbers* […]"

7.89 On 22 August 2005 Neil Hickman made a home visit but SP said that he was on his way out and would talk with Neil Hickman for only 10 minutes. Neil Hickman observed in his entry in SP's clinical notes that although SP maintained that he was well it was hard to make a realistic assessment given his refusal to engage. He also expressed his concern that he was unable to contribute to any relapse prevention.

7.90 SP was not at home when Neil Hickman visited him on 5 September 2005. Neil Hickman had written to SP to tell him that he would visit again on 21 September 2005 but SP did not attend then either. Neil Hickman said in his note of 21 September 2005 "*it appears that* [SP] *is disengaging completely and therefore it is impossible to make any ongoing risk assessment* […] *My initial view is that* [SP] *should be discharged from the supported living scheme but this needs careful planning* […]*".*

7.91 After receiving no response to various letters and phone calls, Neil Hickman eventually managed to book a home visit with SP on 13 October 2005. Neil Hickman noted on that occasion that SP was unwilling to engage in anything more than general questions about his health. He also noted "*does not appear to have wilfully disengaged but it turns out that he has returned to his studies at South Bank University* […] *Agreed a plan to maintain contact in an acceptable way to* [SP] […] *he would prefer to meet at* [Springfield hospital] *when he comes to use the gym on Wednesdays* […]". Neil Hickman undertook to correspond on SP's behalf with Northampton University about outstanding fees and to make an application for independent housing. SP did not attend for the next agreed appointment at Springfield Hospital on 26 October 2005.

7.92 Neil Hickman spoke with Bernadette Nicholas, the housing support manager at Merton Borough Council, to discuss options for independent accommodation available to SP, and in particular whether he might be eligible for one of the properties available under a quota system for tenants with mental health needs. On 31 October 2005 Neil Hickman wrote to Bernadette Nicholas enclosing certain documentation including a social circumstances report, a special quota application form and SP's CPA. He wrote:

> *"It will quickly be clear that this is not a straight forward referral* [...] *given the complexities of trying to provide* [SP] *with support; the risks that arise when he is unwell; and his likely disengagement form services if he is offered a tenancy* [...]. *As we discussed briefly, although I have strong suspicions that* [SP] *will disengage if he is offered a tenancy, I do have some confidence that his mother would alert services in the event of a further relapse* [...]."

7.93 Neil Hickman phoned SP on 2 November 2005 and, according to Neil Hickman's note, SP *"sounded fine".* He asked for help obtaining a medical certificate and with obtaining income support while at university. Neil Hickman spoke again with SP by phone on 11 November 2005.

7.94 On 21 November 2005 the EIS multidisciplinary team reviewed SP's case. Neil Hickman reiterated in his note of that meeting that there was a *"risk of aggression if* [SP] *becomes remotely unwell"*. The team's agreed plan is given as:

> *"Continue limited contact when possible*
> *?discuss referral back to CMHT-invite to review?*
> *Cannot discharge as in supported accommodation."*

7.95 Neil Hickman spoke with LP by phone on 25 November 2005. She said she thought SP was well and achieving good results at university. Neil Hickman's note records that she was aware of his limited contact with services but said she was reasonably happy that access to services was available if she was concerned. Neil Hickman spoke with SP by phone later that day and agreed to bring him emergency cash.

7.96 On 8 December 2005 Neil Hickman visited SP at home. The note of that meeting says SP appeared well and that they discussed Neil Hickman's continuing attempts to

obtain income support and housing benefit for SP. They agreed that the next home visit would be in the New Year. This was the last time the EIS had face-to-face contact with SP.

7.97 At the beginning of January 2006, the EIS received a number of calls from LP who was worried about the electric wiring at Links Road and wanted the EIS to have repairs carried out via the Merton supported housing office.

7.98 On 23 January 2006, LP phoned Neil Hickman to say she was worried that SP was showing early signs of relapse. She said he was less fluent in his speech and more distracted. Neil Hickman's note of that conversation states: "[LP] *reports* [SP] *is amenable towards her but she is wary of mentioning any concerns to him. She is very anxious for him not to deteriorate to the point of needing admission"*. Neil Hickman recorded the care plan as being to liaise regularly with LP; that SP's brother planned to try to discuss medication with SP; to telephone SP as planned on 25 January; to speak with Sharon Lartey and SP's housing support officer; and to discuss SP with Dr Singh and in the EIS team meeting. Neil Hickman also noted the following as complexities:

> *"LP not willing to broach concerns with* [SP] *or to let him know that she has called us. Will also object to admission if this becomes necessary*
> [SP] *v. likely to avoid contact*
> *Difficult to know at what point we should consider it unsafe to visit* [SP]*-therefore difficult to make any assessment*."

7.99 Neil Hickman spoke with Nigel Bates, SP's housing support officer, on 25 January 2006. He had recently visited Links Road but had not seen SP. He had no reports of concerns about SP. Neil Hickman spoke with Sharon Lartey the same day. She told him she had given SP notice of the termination of his licence at Links Road because she was planning to close the house. Sharon Lartey said SP was "*fine*" and she had no concerns about him. Neil Hickman ensured that Sharon Lartey had the crisis line number should she need it.

7.100 LP rang Neil Hickman again on 25 January 2006 and said she believed that SP was screening his phone calls. She was planning to see him and would ring again if she had further concerns.

7.101 SP was discussed at a meeting of the EIS multidisciplinary team including Dr Singh on 26 January 2006. The care plan agreed was "*to maintain liaison with relevant people. Continue to try and speak to* [SP]*. No impromptu visits at present. Crisis Service alerted. EIS to consult [Dr Singh or Neil Hickman] before any intervention".*

7.102 On 31 January 2006 Neil Hickman phoned SP. Neil Hickman's note says he sounded "*absolutely fine"* and goes on "*Amenable to seeing me and wanting assistance with current housing problems* […]. *Clearly no grounds to consider any formal assessment".*

7.103 On 3 February 2006 Neil Hickman phoned LP for an update. According to his notes, LP also felt that SP had settled, having had a week's rest.

7.104 Dr Singh resigned from the trust with effect from the end of February 2006, but he took leave and did not work at the trust after January 2006. The trust was unable to provide us with evidence about cover arrangements after Dr Singh's departure but he and his SpR Dr Ferdinand Jonsson told us that consultant cover for the EIS was provided by Dr Alistair Forrest, a consultant psychiatrist with the trust's assertive outreach team, and that Dr Jonsson continued to provide day-to-day medical cover in the EIS. Dr Jonsson was, however, on leave between 27 January and 12 February 2006. Dr Jonsson became the Locum Consultant with the EIS from the end of February 2006.

7.105 The clinical notes show that Neil Hickman had planned to see SP on 8 February 2006. SP's last CPA on 8 August 2005 set 8 February 2006 as the review date. There is no mention in SP's clinical notes that that meeting was to be other than an ordinary home visit by Neil Hickman alone. Neil Hickman told us this meeting did not in fact take place because he was off sick, although the notes do not record this.

7.106 In any event, on 8 February 2006 SP was stopped by the police while driving a car in Croydon. He was arrested and charged with a motoring offence and with resisting arrest. He was agitated and upset at the police station, where he punched a cell door. He was seen by the duty FME, Dr Felicity Nicholson, in the company of LP. Dr Nicholson told us that SP was agitated and tearful when she first saw him but that LP calmed him down. LP and SP told Dr Nicholson of SP's mental health problems and his contact with the EIS. SP also told her that he smoked cannabis regularly and had done so that day. LP told Dr Nicholson "[SP] *is doing well, I'm pleased with how he's doing, he's been stable and he's eating well and studying*". Dr Nicholson concluded that SP was not psychotic and did not ask the emergency duty team to attend for a MHA assessment.

7.107 On Thursday 9 February 2006 LP rang Neil Hickman and told him about the events of the day before. According to Neil Hickman's note of that conversation, LP maintained that SP had early signs of relapse, that he was distracted and talking to himself but able to function and contain the signs when seen by professionals. The note also states that LP was absolutely opposed to admission to hospital. She asked for a prescription so that SP's brother could try to persuade him to take medicine. LP reluctantly agreed that Neil Hickman could tell SP he knew about his arrest in Croydon.

7.108 Neil Hickman obtained the prescription asked for by LP and delivered it to her later on 9 February 2006.

7.109 Neil Hickman tried without success to contact SP by phone and by text message during 9 February 2006.

7.110 On Wednesday 15 February 2006 LP phoned Neil Hickman and described SP as stable but with early warning signs. LP said that he had reacted angrily when she tried to talk to him about starting medication on the previous day and had not responded to her calls since then. He continued to attend university and to play football. Neil Hickman noted that he would write to SP to offer support with his hearing in respect of the recent arrest. He also noted "*Again no clear evidence that a* [Mental Health Act assessment] *would be justified".*

7.111 Later on 15 February 2006 Neil Hickman spoke to SP by phone. Neil Hickman's note, made after the events of the night of 18/19 February 2006, record that SP sounded calm and rational but evasive about arranging contact with the EIS. SP did not want to be supported at the coming hearing and they agreed that Neil Hickman would contact SP again immediately after the court hearing on 22 February 2006.

7.112 LP told us she phoned Neil Hickman on 17 February 2006 and asked him if he had seen SP because she knew that he "*needed to be seen*". There is no record of a conversation between LP and Neil Hickman in the clinical notes, nor any record in the EIS team message book of LP having tried to contact Neil Hickman on 17 February 2006. Neil Hickman was training staff at a development session that day and told us he had no contact with LP.

The homicide

7.113 LP told us about the first part of the events of Saturday 18 February 2006. She said SP was brought to her house at about midnight by his brother and his uncle who were having difficulty controlling him. LP tried unsuccessfully to persuade SP to take the medicine prescribed for him on 9 February 2006. SP was extremely restless, and she tried to drive him back to Links Road but abandoned the attempt as he kept trying to open the car door. Eventually he left LP's house and she was so concerned about his condition that she phoned 999. She said when she saw SP on the night of Saturday 18 February 2006 it was "*the worst I have ever seen him".*

7.114 Detective inspector (DI) Andy Booth was in charge of the investigation into the killing of Matthew Carter. He told us about the rest of the events of the night of 18/19 February 2006. He said that SP had left his mother's house and run 200 yards when he came across four youths. They described SP as calm but acting strangely, walking up and down and in and out of the road. He approached the youths and asked for a cigarette. They were concerned for their safety, so they drove off in a car. SP then continued on towards his home and came across Matthew Carter, a stranger to him. Matthew Carter was 22. He was a fitness instructor. He was returning home after a night out with a friend. No one appears to have seen the start of the attack, but a passing motorist saw SP stamping on and kicking Matthew Carter as he lay on the ground**.** The motorist called 999 at about 1.30am, soon after the call from LP.

7.115 Police dealing with another incident in the area attended the scene. They said SP was so aggressive that he could not be properly examined by forensic medical services. Tests showed that SP had low levels of alcohol and cannabis in his system.

7.116 At the Old Bailey on 28 July 2006 SP pleaded guilty to manslaughter on the grounds of diminished responsibility. He was ordered to be detained in hospital, subject to a restriction order without limit of time, under part III of the MHA. SP remains in Broadmoor Hospital at the time of writing.

PART 2: ANALYSIS AND COMMENT

In this part of our report we analyse and comment on the issues which arise from our investigation into the services with which SP had contact and the circumstances and events of his care and treatment by them.

8. Issues relating to the EIS

The mental health policy implementation guide

8.1 Dr Singh was establishing the EIS as we describe in 5.2 while the DH was finalising its guide to the delivery of mental health policy objectives called the mental health PIG. Section five of the PIG offers national guidance on the establishment of services for early intervention in psychosis in line with the National Service Framework for Mental Health. Section five of the PIG is attached to this report as appendix F.

8.2 Chapter 5.2 of the PIG sets out the principles of care for a service for early intervention in psychosis as follows:

> *"Evidence indicates that the following principles of care are important:*
> *Culture, age and gender sensitive*
> *Family orientated*
> *Meaningful and sustained engagement based on assertive outreach principles*
> *Treatment provided in the least restrictive and stigmatised setting*
> *Separate, age appropriate facilities for young people*
> *Emphasis on normal social roles and service users development needs, particularly involvement in education and achieving employment*
> *Emphasis on managing symptoms rather than diagnosis*
> *A typical early intervention service will aim to meet the needs of a million total populations. The service will comprise 3 or 4 teams and appropriate respite facilities…"*

8.3 Under the heading "caseload", the PIG makes further comment on the suggested size of a service for early intervention in psychosis:

"Ideally each Early Intervention Service should manage 150 new cases per year and have a total caseload of approximately 450. It is envisaged that each Early Intervention service will cater for a population of around 1 million people….

Teamwork is vital for success. Dividing the service into a number of teams (three or four), each managing a caseload of 30 to 50 new cases per year and 120 to 150 in total, optimises the benefits of working within a team framework. Each service should therefore consist of a number of teams."

8.4 Table 5b of the PIG gives details of suggested staffing levels and skill mix for a team with a caseload of between 120 and 150 cases. The suggested number of full-time care coordinators is 10, each to have a maximum caseload of 15. The PIG suggests that a team should include a half-time consultant psychiatrist and a full-time non career-grade psychiatrist as well as other team members.

The size, structure and staffing level of the EIS

8.5 The EIS has 14 established staff posts although there are a number of vacancies. As we describe in 5.17, the EIS serves 670,000 people across the London Boroughs of Wandsworth, Merton and Sutton. In order to comply with the PIG, an early intervention service for a population of this size would have to comprise three teams of at least 10 care coordinators plus administrative and medical staff.

8.6 When the EIS was established and while SP was a patient, the care coordinators' caseload was kept to 12 patients each. However, subsequent pressure on the service meant that the EIS care coordinators had to agree to increase their caseload to 15. Neil Hickman told us that notwithstanding this increase in individual caseloads, waiting times for the EIS had risen over the previous year to about three months. Neil Hickman said this waiting time generated *"a lot of external pressure and frustration for the CMHTs".* Given the purpose and aim of the EIS, which is principally to initiate effective treatment for psychosis at the earliest possible stage, we agree with Neil Hickman that a waiting list for that service "*defeats the object a little".*

8.7 Furthermore, although the caseload for each of the care coordinators in the EIS generally conforms to the number the PIG suggests, Neil Hickman told us that a single team serves the whole of Wandsworth, Sutton and Merton. This meant that care

coordinators spent a significant part of their working day making long and difficult journeys to visit their patients. One CPN told us that time taken up with travelling meant he often had to stay behind after working hours to finish his work. Neil Hickman said that the EIS team would identify the size of its catchment area as its greatest problem. He said "*it dilutes the service enormously in that it takes well over an hour getting to visit somebody who may not be in, and then the same time getting back".*

8.8 SP had prompt access to the EIS. He was discharged from hospital on 10 September 2004 after his first episode of inpatient treatment directly to the care of the EIS. We have no evidence to suggest that SP's care and treatment thereafter was adversely affected by any deficiency in the resources and structure of the EIS. Nevertheless, it is clear that the present size and staffing of the EIS and its management as one team covering three boroughs are placing pressures on the service which may compromise the standard of care given to patients in the future.

8.9 Mark Clenaghan, the service director of the trust's Merton service, who has responsibility for a number of the trust's specialist services including the EIS, told us the trust was reviewing staffing levels, management structure and the service model of the EIS. He said there would be a significant increase in its resources over the next two years. He also suggested that there was a growing consensus in the trust for the EIS to move towards a management structure of two borough-based teams, one for Wandsworth and one for Merton and Sutton.

Recommendation

R1 The trust should continue to work towards the expansion of the EIS in line with the DH policy implementation guidance and the creation of a borough-based early intervention service.

The role of the team manager

8.10 The team manager for the EIS, Neil Hickman, has responsibility for the day-to-day management of the EIS and is line manager of all non-medical members of the team. He told us his role included managing referrals to the EIS and undertaking an initial screening and checking process; collecting and presenting audit information; and attending planning meetings. He told us his management supervision of team members involved meeting

each member of staff once every four weeks. These meetings discussed issues arising in relation to team members' cases and workload, as well as issues relating to training, development and appraisal. One day a week Neil Hickman acts voluntarily as the duty senior ASW on a rota for Wandsworth Borough Council. This involves taking referrals for ASW assessments and offering telephone support and advice to other ASWs on duty.

8.11 This work is in addition to his role as the ASW for the EIS and his own caseload as an EIS care coordinator. It was agreed at the time that Neil Hickman was appointed as team manager that he would hold a half caseload. He told us that he "*didn't think that it was ever less than half and it was generally more, eight or nine clients* […]". Neil Hickman believed that he had a caseload of nine patients while he was acting as care coordinator for SP.

8.12 Neil Hickman told us that he had always been anxious about "*being spread too thinly*". He said "[…] *between caseload, trying to support and manage people in the team, the external demands and the ASW role, the anxiety is always that everything is diluted* […] *the reality is that it is an extremely busy job and I think all my peers would say the same. I think the view would be shared amongst the team because the frustration for them is the difficulties in doing anything progressive or developmental or work that is above and beyond the statutory role".*

8.13 The trust has issued instructions to team managers as a result of a number of recent investigations into untoward incidents at the trust that they should hold no more than five cases. Neil Hickman told us that he had been trying to reduce his caseload in line with those instructions. Mark Clenaghan told us that the issue of whether team managers should hold a clinical caseload continued to be a matter of debate in the trust.

8.14 A number of Neil Hickman's colleagues in the EIS commented to us about his workload. Julia Heathcote, OT, and Dr Brock Chisholm said they thought that his managerial and administrative duties were "*unmanageable*", but they were emphatic that Neil Hickman did not allow his managerial work to impinge on his clinical responsibilities.

8.15 All of the members of the EIS we spoke to had high praise for Neil Hickman's qualities and dedication as a clinician. They also spoke highly of his personal qualities, as well as his qualities as a team leader. We also found him a thoughtful and caring person and we were struck by his dedication and concern for his clinical responsibilities.

8.16 The staff of the EIS highlighted for us the strong team spirit in the EIS. Some said it was the best team they had ever worked for. We think this positive assessment of the EIS team is supported by the evidence we saw and heard. We learned that EIS team members were willing to cover for or undertake duties on behalf of each other and that staff turnover was low. We believe that this evident team spirit and cooperation in the EIS, which is clearly to the advantage of patient care, is attributable in large part to Neil Hickman's leadership.

8.17 We found no evidence to suggest that Neil Hickman's workload adversely affected the care he offered to SP.

Recommendation

R2 The role of the EIS team manager should be kept under regular review. This will help ensure that the role is manageable and that the quality of any clinical work to be undertaken by the team manager is not put at risk in the future by the burdens of the team manager role.

Out-of-hours cover for the EIS

8.18 The PIG states under the heading "hours of operation":

> *"Core working hours should be 8am to 8 pm, 7 days a week*
> *Out of hours (8pm to 8am) advice should be available from staff at the community respite facility or alternative (either by telephone or by visiting the unit) or from an on call member of the Early Intervention Team"*

8.19 The EIS service, which operates from 9am until 5pm on weekdays, does not comply with these recommended working hours. Nor do patients of the EIS and their carers have the out-of-hours access to advice from a member of the EIS staff that the PIG envisages. It was explained to us that the trust's crisis line is a generic helpline service which seeks to offer advice and, in an emergency, directs callers to available help and interventions.

8.20 LP told us that the only time she rang the crisis line was while SP was in Jamaica in April 2005 and showing signs of relapse. She recalled that the crisis line staff had said

there was nothing they could do while he was out of the country. This experience appears to have given her little confidence in the crisis line service. She told us that on the night SP attacked Matthew Carter, she chose to phone the police (as we describe in 7.113) rather than the crisis line, because "*at the end of the day Crisis was going to talk, the police would have acted quicker".*

8.21 In the circumstances LP found herself in on the night of 18/19 February 2006, and as the events of that night proved, she was clearly justified in ringing the police. We do not suggest that the availability of a crisis line staffed by members of the EIS team would or could have made any difference to the events of that night or to any other episode in the care and treatment of SP. We believe however that a crisis service offering the opportunity of contact with EIS staff would offer the prospect of greater continuity of care and is likely to add to patient and carer confidence in the EIS and their engagement with it. The same can be said of an extension of the hours of the EIS service to those suggested by the PIG.

Recommendation

R3 The hours of operation of the EIS and the provision of an out-of-hours service should be part of the current review of the EIS resources.

The cultural make up of the EIS team

8.22 One of the principles of care offered by an early intervention service, set out in chapter five of the PIG, is that the service should be sensitive to culture, age and gender. Table 5a states*: "The high prevalence of diagnosed psychosis in certain groups emphasises the importance of culturally competent services".*

8.23 Paragraph 9 of the EIS operational policy dated July 2003, headed "allocation/role of care coordinator", states at 9.1:

> *"Caseload allocation will be discussed at the multi disciplinary meeting and allocated flexibly according to caseload capacity, geographical location of the patient, skilled interventions needed and skill mix within the panel, and with sensitivity to the patient's gender, culture and preferences where appropriate"*

8.24 There appears to have been no consideration of SP's cultural background or his preferences when deciding who to allocate as his care coordinator. Rather, as Neil Hickman explained to us, he became SP's allocated care coordinator in September 2004, principally because he had met SP and LP at the discharge planning meeting on 10 September 2004 and felt that he had begun to establish a satisfactory working relationship with them.

8.25 We have received no evidence that Neil Hickman was not a suitable choice as SP's care coordinator, or that a care coordinator from a different cultural background would have found it any easier to engage SP than he did. SP himself told us he liked Neil Hickman and thought he understood him. Members of the EIS we questioned on the subject all said they had the impression that Neil Hickman established a rapport with SP. Further, LP was reluctant to express any view on whether SP might have responded better to a black care coordinator. She said she thought Neil Hickman and SP got on "*alright*". She said "*Even I got on with him and that was good because whoever it was I needed to be able to communicate with them also and feel that I could talk to them, so that was good. He was a gentle sort of person so he was alright".*

8.26 In the circumstances, we do not believe that Neil Hickman's cultural background or that of other EIS staff had any bearing on the care and treatment of SP. As a result, we do not feel it necessary to consider whether the EIS is generally able to offer a culturally competent and sensitive service; a subject that has given rise to much debate in respect of services elsewhere.

8.27 Nevertheless, it was brought to our attention that there have been no black members of the EIS staff since the end of 2003 although a high proportion of EIS patients are young black men. Some members of the EIS acknowledged to us that having staff members from an African or Afro-Caribbean background might have advantages, including offering insights and understanding that the team may not have; offering confidence in the sensitivity of the service to patients and carers and enabling the team to deal more effectively with patients who exhibit difficulty in engaging with white mental health professionals.

8.28 Mark Clenaghan told us the trust audited the cultural background of its patients, the cultural make-up of the population it serves and the cultural background of its staff.

He also told us that the trust had appointed community development workers to help it work with and understand the needs of the communities that it serves.

Recommendation

R4 The trust should continue and expand its work on ensuring that its workforce, in its make-up, training and development, is able to respond properly to the cultural needs of the population that it serves.

The lack of EIS beds

8.29 The EIS does not have its own inpatient facilities. EIS patients in need of hospital treatment are admitted either to the trust's PICU on John Meyer ward or to a ward providing beds for their local CMHT. During SP's two episodes of inpatient treatment he was treated on both John Meyer ward and Jupiter ward which provides beds for the East Mitcham CMHT.

8.30 The EIS operational policy states at paragraph 12.3: "*During the inpatient stay, the CMHT catchment area consultant will be the RMO. While the patient is in hospital, ward rounds and care meetings will be attended by the [EIS] key worker."*

8.31 EIS and CMHT staff explained to the panel that the quality and frequency of contact between the EIS and the inpatient teams in respect of a particular patient varied according to the practice of the individual care coordinator and their views of the needs of their patient. But in any event, most of the EIS and CMHT staff we spoke to conceded that the fact that the EIS did not have its own beds created a discontinuity in patient care.

8.32 In SP's case, that discontinuity came into focus when Dr Dewsnap and the CMHT decided to discharge SP from Jupiter ward in June 2005. The EIS were concerned by the severity of the relapse that had caused SP's readmission to hospital; by the risks they felt SP presented; and by the difficulties they had in engaging him with treatment in the community. As a result, the EIS took the view that SP needed a longer period of inpatient treatment. Dr Singh told us that for the reasons just referred to he considered that the decision to discharge SP from inpatient treatment under the MHA was "*premature"*. Dr

Singh also said that decision and Dr Dewsnap's failure to discuss it directly with him had made him "*cross*". We asked Dr Dewsnap about the benefits of the EIS team having its own beds. He too referred to the difference of views that had arisen between the CMHT and the EIS in respect of SP's discharge in June 2005.

8.33 He acknowledged: *"By and large, it is better to have the same community team and Community RMO and the same inpatient RMO* […] *it is about continuity and it is about bringing a broader and contextual understanding to issues that have arisen* […]*"*

8.34 We think that, if the EIS had its own inpatient beds, it would be able to make its own decisions on inpatient treatment in the light of its particular understanding of its patients. It could also form views on treatment in the light of its own understanding of the challenges of engaging such patients and the community services available to them on discharge.

8.35 The fact that the EIS does not have its own inpatient beds also presents practical difficulties for the team. For instance, we were told there can be delays of a few weeks after the discharge of a patient before the EIS team receives inpatient notes from the ward. Such a delay occurred after SP's discharge from Jupiter ward on 10 September 2004. When Dr Chan and Neil Hickman saw him on 24 September 2004 to undertake a CPA review, they had still not received the inpatient notes and were unable to complete a full risk history. The evidence we have heard makes clear that the EIS had an understanding of SP's risk history and the risks he posed at this stage, but we find that this gap between services presents a risk where staff are not so well informed.

8.36 It was also explained to us that the trust covers a large area and does not have all its inpatient beds in one location, so an EIS patient could be moved to the trust's Tolworth site 45 minutes' drive from Springfield Hospital. This is a disincentive to EIS staff to visit their patients there.

8.37 As well as the issues of continuity and the practical difficulties of EIS patients being admitted to the trust's CMHT wards, we also considered the suitability of those wards for the treatment of EIS patients.

8.38 Table five of the PIG, which sets out and makes comment on the key components of an early intervention service, it states:

"If hospitalisation is needed

- *Separate age, gender and culture appropriate accommodation should be provided* […]
- *Avoidance of trauma and stigma associated with hospitalisation is important to reduce harm and ensure long term engagement"*

8.39 Many of the those we spoke to in our investigation referred us to the inpatient facilities of the Lambeth early onset (LEO) service, provided by the South London and Maudsley NHS Foundation Trust, as a model of EIS inpatient provision as envisaged by the PIG. We could not view those inpatient facilities but we interviewed David Grafton, a manager with the LEO service. He told us the LEO inpatient facilities were "*youth friendly*" and dedicated to the care and needs of younger patients with early onset psychosis. David Grafton also told us that if patients had an anxiety about their relatives being admitted to hospital, they could look round the facilities and "*get to know*" the unit as a "*proactive trust building exercise*".

8.40 We received no evidence to suggest that a dedicated inpatient facility, along the lines of that provided by the LEO service, would have improved the chances of SP engaging with treatment by the EIS. A dedicated inpatient facility would however have improved the inpatient experience for SP and might have helped to reduce LP's resistance and anxieties about his being treated in hospital. LP spoke to us of her dissatisfaction with the environment on the wards on which SP was treated. She spoke of the lack of activities and exercise available to him as an inpatient. We also received unfavourable comment from both EIS and ward staff on the environment of the John Meyer and Jupiter wards, and their unsuitability as a care setting for treating younger patients reluctant to engage with services. Neil Hickman explained the drawbacks of treating EIS patients on CMHT wards:

"There are issues for our client group, given that they are likely to be around much older patients, possibly patients with much more chronic conditions. A lot of EIS models and papers talk a lot about engendering optimism in people, and the inpatient settings can have the opposite effect and it gives quite a bleak message as to what the future holds."

8.41 We visited visit John Meyer and Jupiter wards. Our observations allow us to agree with the adverse comments of others about them. Neither ward is an attractive or

pleasing environment either for patients and visitors or for staff. They need thoroughly redecorating. John Meyer ward, which was reconfigured from two floors to one after SP's second episode of inpatient treatment, is now particularly cramped. Neither ward has direct access to outside space. Jupiter ward accommodates both men and women. The women's rooms are at one end of the ward, but they are divided from the men's accommodation only by an unlocked door that cannot be seen from the nursing station. We do not consider that either ward is a suitable care environment for EIS patients. We understand a new facility is to be provided for the PICU and we saw the building work underway.

8.42 We find that the shortcomings we identify in the present provision of inpatient facilities for the patients of the EIS indicate the need for dedicated EIS beds.

Recommendation

R5 The trust, in reviewing the service model of the EIS, should consider the best model for providing appropriate dedicated EIS beds.

9. Clinical care issues

9.1 In this chapter we consider the clinical care issues that arose from our consideration of SP's care and treatment by the mental health and other services with which he had contact.

The allocation of the care coordinator

9.2 It was initially envisaged that SP would have a CPN as his allocated care coordinator because he had been prescribed depot medication. Neil Hickman also considered that in view of what he described as SP's "*chaotic*" personal circumstances at that time, he should be "*joint worked*". When it became apparent that SP was not willing to accept medication, it was agreed that Neil Hickman alone would act as care coordinator. Neil Hickman told us he felt he was the appropriate person to work with SP because he had met him and LP at the discharge planning meeting on 10 September 2004 and believed he had established a relationship with them. Dr Chan was appointed as SP's second care coordinator. The role of the second care coordinator was not to assume joint responsibility for a patient but rather to act as substitute when necessary.

9.3 As we describe in 8.25, both SP and LP have said they liked Neil Hickman and felt they could get on with him. Neil Hickman, as an experienced social worker, was perhaps better equipped than other members of the EIS to deal with SP's significant social needs. We are impressed by the amount of work Neil Hickman evidently put into resolving SP's social problems, particularly his financial needs. We describe that work in greater detail in 7.43. LP evidently appreciated Neil Hickman's efforts. She told us he "*was good at really sorting things out".*

9.4 However, the challenges SP's case presented were greater than his mere social needs and greater than many other cases the EIS dealt with. The history of events in SP's care and treatment shows that he exhibited a significant reluctance to engage with mental health services, other than for help with his social needs, for most of the time he was under the care of the EIS. He told us that when he was discharged from hospital in September 2004, he "*didn't want to meet the intervention team. I wanted to go back to the life I was leading before".* SP's attitude to the EIS does not appear ever to have moved from that position. We understand that it is not unusual for patients of the EIS to

resist engaging with mental health services and taking medication but Neil Hickman told us that SP was unusually intractable in this respect.

9.5 By the autumn of 2005, after his discharge from hospital for the second time, SP presented a high risk of relapse and was a high risk to himself and others when unwell; he was consistent in his refusal to comply with medication; and he was disengaging from mental health services. We asked Dr Singh to estimate what proportion of EIS cases present with these difficulties. He replied 5-10%. The agendas for the EIS multidisciplinary team meetings offer further support for the view that SP's was a particularly demanding case. They show that he appeared on the "acute list" for a significant part of the time he was under the care of the EIS. Dr Singh acknowledged to us that SP was one of two cases the EIS team discussed most frequently.

9.6 In dealing with SP's case, Neil Hickman also had to manage the obvious ambivalence LP felt towards SP's treatment by mental health services. LP contacted the EIS when she had concerns about SP's condition (although she was usually anxious for the EIS not to let SP know), and at several points in the history of his care by the EIS it was only through LP that Neil Hickman was able to maintain contact with him. However, LP showed a marked reluctance to help the mental health services when the need for inpatient treatment arose. On both the occasions SP was detained under section, LP initially declined to give her consent to the sectioning. She explained "*I didn't agree but I didn't disagree because I didn't want to be the one to section him. I left it to them because I felt that it would have been another pressure on me and I would have to live with the fact that I got him sectioned".*

9.7 LP's ambivalence towards the mental health services and their treatment of SP appears principally to have resulted from her fear of damaging her relationship with him, and from her own anxieties about his being detained in hospital. It may also have stemmed in part from a failure fully to understand, or an unwillingness to acknowledge, the nature of his condition. LP's confusion in this respect was made evident to us when we asked about her apparent agreement with SP at the section 117 meeting in September 2004 when he said that he was better without medication. She told us *"He had responded to the medication that they were giving him and he recovered well. My opinion was [that] the recovery was due to the fact he hadn't been smoking".* When pressed on whether she thought the medication given to SP had helped him, LP said "*I can't really say that* [I] *thought it was the cannabis and stuff that was affecting him and because it was out of his*

system and there was nothing in his system. I didn't have a full understanding of what the illness was. Nobody sat me down and explained it to me. I don't think to this day it was really explained to me […]".

9.8 Neil Hickman denied to us the suggestion that he had not explained to LP the nature of SP's illness and its implications. He told us he had a lot of conversations with LP "*about the illness and what* [SP] *needed".* We consider this conflict of evidence under 9.34. For present purposes, it is enough to observe that whatever LP was told, Neil Hickman was not fully able to obtain LP's understanding or acceptance of SP's condition, nor ensure her full confidence in the care mental health services offered him.

9.9 Given the difficulties of SP's case and the attitudes of SP and LP towards mental health services, we find there was a case for SP being joint worked by Neil Hickman and another care coordinator. We do not suggest any criticism of Neil Hickman's professional abilities nor that the appointment of another care coordinator would necessarily have resulted in any greater success in engaging SP. But we think involving another practitioner, preferably from a different professional background, would have provided another perspective and further dedicated input into the case which might have led to greater engagement with SP and LP. In particular, a CPN might have had more resources to draw on in offering training to LP about SP's condition and mental health issues.

9.10 Following a recommendation of the internal inquiry into the care and treatment of SP, the EIS operational policy now says:

> *"Consideration will be given to changing the care coordinator when it is felt that this may improve engagement with the service."*

Recommendation

R6 The EIS operational policy should be amended to provide that where a patient is proving hard to engage, the EIS should consider whether it would be appropriate for the patient to be joint-worked by two care coordinators while remaining the responsibility of a single named care coordinator for CPA purposes.

Peer review

9.11 The difficulties of SP's case, to which we refer above, also lead us to the conclusion that there would have been merit in subjecting the case to wider professional scrutiny and input by means of external peer review. This view is supported by the evidence of Neil Hickman to suggest that the demands of daily practice and case management worked against a more reflective approach to SP's case. Neil Hickman told us he did not believe that he and Dr Singh ever had a "*stepped back lengthy discussion*" about SP's case. He thought that they had lots of discussions about the case but they tended to be about "*changes, or specific issues or what we do next*".

9.12 We cannot say that a peer review by professionals outside the EIS would necessarily have resulted in any new or more effective interventions but it would have provided an opportunity to ensure that all possible avenues of treatment and professional intervention had been considered.

9.13 The internal inquiry report into the care of SP recommended that peer review should be considered where a service user has been assessed as being in the "red zone" for six months. We understand that no peer review system is yet in place for the EIS.

Recommendation

R7 The EIS should have an external peer review system, available in all cases thought likely to benefit from it, regardless of whether, or for how long, the service user in question has been in the "red zone" (the acute list).

Discharge by the East Merton CMHT in June 2005

9.14 The events relating to SP's discharge from hospital on 3 June 2005 are described in 7.72 to 7.74.

9.15 SP had had two episodes of acute psychosis requiring inpatient treatment. As Dr Dewsnap explained to us, that meant that SP had recurring psychosis which required him to be permanently on medication in order to minimise his chances of relapsing into psychosis. He had, however, exhibited on many occasions his reluctance to comply with

medication, including at the section 117 after-care meeting on 27 May 2005. SP's risk of relapse was also heightened by his continuing use of cannabis.

9.16 As well as the risks of relapse SP presented, he was assessed as being at significant risk of harm to himself and others when unwell. During both his episodes of inpatient treatment he had assaulted several people. At the time of his detention on 20 April 2005, he had assaulted Sanjaya Warnatilake, a CPN with the EIS, in an attack of significant and unusual severity.

9.17 He had shown a marked reluctance to address his mental health issues or engage with mental health services other than for the purposes of meeting his social care needs.

9.18 We agree with the view of Dr Singh and other members of the EIS team, that in the circumstances it would have been beneficial to SP's treatment if, after his inpatient treatment, he had remained under section but had been granted extended leave of absence under section 17 of the MHA rather than being discharged from the provisions of the MHA. Dr Singh outlined the benefits of such a course of action as follows:

> […] *the added value is to see his behaviour in an unsupervised setting. People on the ward quickly learn what things to say to get out, so people can mask their symptoms* […] *and present a much more well state of affairs than is actually going on. So the first thing you do is you say, 'Well, is this person ready to be out in the community?' That is a big test. Second, 'Is this person going to comply with medication, and comply with other restrictions?' Thirdly, 'How are they going to get along? What are the risks?' So it allows you to monitor all of that. Section 17 allows you to do that with the safety network of being able to bring them back by the police if necessary. I think section 17 is a very good way of testing all those things out.*

9.19 When SP's discharge was considered in late May 2005, he was free from psychotic symptoms and his appeal against detention under section was due before the MHA Tribunal. Dr Dewsnap told us he would have liked to extend the time that SP was given leave in the community subject to the restrictions of section 17 of the MHA but he felt that there was a strong likelihood of SP's appeal being successful and that, in effect, his hands were tied by the MHA.

9.20 We think it would have been arguable before the MHA Tribunal that SP continued to have a condition of a nature and degree that made it appropriate for him to continue to be subject to section 3 of the MHA. We take this view because:

- SP had established mental health problems
- There was evidence that he was unlikely to take medication
- It was likely that he would continue to smoke cannabis
- He posed a risk to others when unwell

We do not suggest that that argument would necessarily have succeeded. Nor can we say that the course of events in this case would have been altered if SP had remained subject to the MHA for a longer period in 2005. However, given the benefits of SP remaining subject to section for a longer period, we think the matter should have been put to the MHA Tribunal to decide and that the decision not to do so was a missed opportunity.

The engagement of SP by the EIS

9.21 The key difficulty for the mental health services in dealing with SP's case was his failure to accept his mental health problems and his unwillingness to engage with services.

9.22 Neil Hickman explained the initial strategy for dealing with SP's reluctance to engage with treatment:

> *"Back in the early days of our involvement, the compromise position we tried to reach was to say may be what we need to talk about is how we manage early warning signs, how to prevent a relapse coming back, given that you have no protection from medication…I don't think that work was successful but that was the strategy certainly at the beginning."*

9.23 Neil Hickman suggested to us that there were two difficulties in getting SP engaged through this strategy. First, his unwillingness to discuss the lead-up to his admission to hospital and potential early warning signs for the future because "*he viewed any of those conversations as negative and depressing and he wanted to put it aside and move forward, so in reality any early warning signs work was pretty much impossible".* Second, SP "*made a good recovery and stayed well for quite protracted periods without*

medication, so it became even more difficult to talk […] *about going back on medication."*

9.24 In the absence of success in persuading SP to address his mental health issues directly, Neil Hickman maintained engagement with SP by responding to his social care needs. Neil Hickman explained this approach: *"I suppose with all our cases working with the presenting need is part of trying to engage with people, and the hope is that in the context of that we may make some progress in talking to people again about medication, about relapse early warning signs".* But Neil Hickman said he was in fact never able to make real progress in getting SP to acknowledge his mental health issues, including the need for him to take medication and consider early warning signs of relapse.

9.25 Between SP's first and second episodes of inpatient treatment, apart from one period of disengagement at the end of 2004, the EIS maintained fairly regular contact with him. But it is clear from the entries in his clinical notes that from the moment he was discharged from hospital in June 2005, his unwillingness to maintain that contact became more evident and his disengagement became an increasing cause for concern to the EIS. Neil Hickman tried to maintain a regular pattern of meetings with SP, but SP often failed to keep appointments. In an entry to the notes dated 13 October 2005, Neil Hickman noted that SP "*does not appear to have willfully disengaged but it turns out that he has returned to his studies at South Bank University* […] *Agreed a plan to maintain contact in an acceptable way to* [SP] […]*".* Neil Hickman said that on reflection it was unrealistic of him to have accepted this explanation for SP's failure to maintain contact with the EIS. There were no face-to-face meetings between Neil Hickman, or any other member of the EIS team, and SP after 8 December 2005.

9.26 Faced with the difficulty of making contact with SP after his discharge from hospital in June 2005, Neil Hickman made a number of telephone calls to LP for updates on his whereabouts and his mental state.

9.27 Neil Hickman spoke with SP by telephone on two occasions after their last meeting on 8 December 2005. These conversations were on 31 January 2006 and 15 February 2006. He also spoke on 25 January 2006, with Sharon Lartey, SP's carer under the supported accommodation scheme. She said she had no concerns about him. Otherwise, the only contact the EIS had with SP in this period was in telephone conversations with LP.

9.28 We accept that trying to engage SP posed great difficulties for the EIS. We accept too that LP had shown during SP's treatment that she would contact the EIS if she had concerns about his mental state, as she did again on 23 January 2005. Nevertheless, significant risks were associated with the EIS's reliance on LP as a means of monitoring SP's progress. Both Dr Singh and Neil Hickman said that, however reliable a third party might have been in assessing SP's mental state and communicating it to the EIS, they could offer only a poor substitute for a face-to-face assessment by mental health services.

9.29 Furthermore, LP's reliability as the means of maintaining contact with SP must be seen in the context of her complicated and ambivalent attitude to mental health services. We asked Neil Hickman to describe his relationship with LP. He told us:

> *"I would say we had a reasonably good relationship. I say that slightly hesitantly, and I know* [LP] *was possibly viewed within services as potentially quite difficult and quite volatile and emotional about certain issues. We had quite a lot of contact* […] *I worked quite hard with that relationship with* [LP]*. Over the issue of admissions, I don't think that changed, that was always very difficult, but her hostility or suspicion towards mental health services in general improved over the time we worked together."*

9.30 On the question of LP's reliability as a point of contact, able to keep the EIS adequately informed of any problems with SP's mental state, Neil Hickman told us that that channel of communication:

> "[…] *may possibly have become less reliable if the prospect of admission was imminent. I think that's where the ambivalence kicked in.* [LP] *would call and describe what was happening and let us know how things were going, but possibly may be less reliable because of anxiety about another admission."*

9.31 Dr Singh described to us the particular difficulties he felt LP had in dealing with mental health services. He referred to the fact that she wanted to tell services about SP's progress and mental state but was worried about how it would affect her relationship with him. Equally, LP was distressed by seeing SP detained by police under the MHA. This too gave her a dilemma about what to tell mental health services. Dr Singh told us that these are common responses for the relatives of service users. He said: "*the families can't*

quite find a balance. They will underplay it one week and then over-emphasise it the other".

9.32 Further, the reliance on LP as a "therapeutic partner" also had to be placed in the context of her lack of understanding or unwillingness to accept the true nature of SP's mental illness and the treatment required for it. For instance, we asked Neil Hickman whether LP had difficulty accepting the high risks SP posed to other people when unwell, he replied "*Yes, I think so. Thinking of some of the discussions after the assault on Sanjaya* [Warnatilake], *I think* [LP] *found it quite difficult to equate that with* [SP]*".*

9.33 Given the degree of the reliance placed on LP by the EIS, and the risks associated with it, it was important that LP was sufficiently educated and equipped to respond to SP's mental illness. As we describe in paragraphs 9.7 and 9.8 above, there is some conflict in the evidence of LP and Neil Hickman on this point.

9.34 When LP gave her evidence, she found many matters and incidents relating to SP's care and treatment by the EIS either difficult to recall or she was confused about them. She clearly found it distressing to have to revisit the issues and events. On the other hand, we found Neil Hickman had good recall of SP's case and was careful and considered in his answers to our questions. He did not shrink from giving us answers that might have shown him or the EIS team in an unfavourable light. For these reasons we accept Neil Hickman's evidence and find on balance that he did explain to LP the nature of SP's mental illness and the implications and treatment of it. Nevertheless, when we asked Neil Hickman to recall the conversations that he had with LP to explain SP's mental health issues, he said they happened only on an *ad hoc* basis. He told us: "*Quite often there would be dialogue with* [LP] *before* [SP] *came down from his room".* We are not convinced that such conversations would necessarily have been adequate to ensure that LP gained a proper understanding of SP's condition.

9.35 We are also concerned that the EIS did little to assess LP's own needs and to support her in the role she began to assume as the principal link between the EIS and SP. Neil Hickman put her in touch with the Merton carers group, but she told us its meetings gave her bleak insights into mental illness and she found them depressing. The clinical notes disclose too that Neil Hickman gave LP a copy of the carers assessment form, during a home visit with SP on 17 November 2004. The carers assessment form is a simple list of questions for completion by the carer. Neil Hickman could not recall what LP said at that

time about how she wanted to undertake the assessment, but in any event she did not return the form. There is no evidence that Neil Hickman, or anyone else from the EIS spent any dedicated time alone with LP talking through and considering her needs or, once she became the major link between SP and the EIS, considering with her what support she might need to fulfill that role.

9.36 We believe that LP should have been the subject of a planned programme of work, including dedicated time alone with EIS staff, aimed at developing her understanding of SP's mental health issues and ensuring that she had adequate support to fulfill her role as SP's carer and later as the principle link between SP and the EIS.

9.37 We have no grounds for suggesting that it would necessarily have had a bearing on the events of February 2006 if LP been offered the training and support referred to but it might have improved LP's experience of having to cope with SP's mental illness. We believe that the same would be true for all carers of EIS service users. We also believe that it might have enabled LP to give the EIS more help in engaging with SP.

Recommendation

R8 The EIS should ensure that all carers are offered dedicated time for education and training about the mental health issues faced by the patients they care for and also dedicated time to consider their own needs and any support they may require in acting as a link between the service user and the EIS.

9.38 We are concerned that there was no documentation in SP's CPA of the role played by LP and the risks associated with it. We find that the reliance the EIS placed on her from the autumn of 2005 to maintain its contact with SP was a significant feature of his care plan and should have been made explicit in his CPA plan. There should also have been documentation of the steps to be taken as part of the care plan to ensure that LP was adequately briefed and supported to fulfill her role as the main point of contact between the EIS and SP.

Recommendation

R9 The trust should remind staff of the need to ensure that CPA documentation gives a comprehensive outline of a patient's care plan, and where necessary the plan should set out the role to be played by carers and any support they may require.

Engagement with SP after 8 December 2005

9.39 During the latter part of 2005, contact between SP and the EIS was limited. Neil Hickman made regular appointments to meet SP at Links Road, but he was often out when Neil Hickman arrived. After meeting with SP at Links Road on 22 August 2005, Neil Hickman managed only two more face-to-face meetings with him. These were on 13 October 2005 and 8 December 2005. Neil Hickman spoke with SP by telephone on 2 and 11 November 2005 and with LP on 25 November 2005. At their meeting on 8 December 2005, Neil Hickman noted that SP appeared well. They agreed that the next home visit by Neil Hickman would be in the New Year.

9.40 There were a number of telephone calls to the EIS from LP in early January 2006 about the state of the electric wiring at Links Road. On 23 January 2006 LP rang Neil Hickman to tell him of her concern that SP was showing early signs of relapse. He was less fluent in his speech and more distracted. In response to this conversation, Neil Hickman alerted the trust's crisis service. He also spoke with Nigel Bates and Sharon Lartey, neither of whom reported any concerns about SP. It is clear from the entry by Neil Hickman in the clinical notes on 23 January 2006 that he was conscious of a number of difficulties in handling any possible change in SP's condition. He noted the following as "complexities":

> *"LP not willing to broach concerns with* [SP] *or to let him know that she has called us. Will also object to admission if this becomes necessary*
> [SP] *v. likely to avoid contact.*
> *Difficult to know at what point we should consider it unsafe to visit* [SP]*-therefore difficult to make any assessment.*"

9.41 On 26 January 2006 Neil Hickman discussed SP's case with the EIS team and Dr Singh at their multidisciplinary team meeting. Neil Hickman's note of the meeting states: "[SP] *not contactable* […][SP] *remains in contact with his family which is encouraging. Concern re risks to mental health staff of impromptu visits without getting more of a sense of* [SP's] *mental state* […]. *Plan: maintain liaison with relevant people. Continue to*

try and speak to [SP]. *No impromptu visits at present. Crisis Service alerted. EIS to consult* [Dr Singh or Neil Hickman] *before any intervention".*

9.42 We asked Dr Singh whether the EIS had considered undertaking a MHA assessment at this stage. He said:

> *"No. If I remember correctly, what we discussed was, have we reached the threshold where we now need to go and do a Mental Health Act assessment, or should we see how this unfolds. If you remember, in the past he has had blips which are very short lasting and then comes out* […]. *So we decide that we'll keep a close contact with the mother, and I was to be informed at all times how things were unfolding. As soon as we feel that the threshold has been reached, we will go and assess him* […]*"*

9.43 In answer to our question about what would have been the threshold for undertaking a MHA assessment, Dr Singh said:

> *"The easiest one would have been the mother says 'I want him seen'. That would have been the easiest, when she says she can't cope. But if there was any sign that he was clearly psychotic, for instance if he started talking to himself, he is hallucinating, he is deluded, he is acting out, then he clearly meets the criteria for a Mental Health Act assessment. At this point all we have is, if I remember, that he is a little distracted and he is not talking much to the* mother […]. So *at this point we felt justified in not going in and doing a Mental Health Act assessment straight away, but we are very alert to the possibility that something is happening and we may have to do it."*

9.44 On 31 January 2006, Neil Hickman spoke with SP by telephone. Neil Hickman recorded that he sounded "*absolutely fine"* and amenable to seeing him. Neil Hickman made a note: "*reconsider home visit in consultation with RMO".* On 3 February 2006 Neil Hickman also spoke with LP, who told him she felt that SP had settled having had a week's rest. The note of that conversation refers to a planned home visit on 8 February 2006. This date is mentioned in SP's CPA as the date for his CPA review, but there is no evidence to show that Neil Hickman planned to undertake a CPA review on that occasion.

9.45 The next contact the EIS had about SP was a telephone call from LP on 9 February 2006, in which she told Neil Hickman of SP's arrest the previous day in Croydon. Neil Hickman's note of that conversation states:

> *"*[SP] *stopped by police in Croydon yesterday driving a car given to him by an uncle.*
> *Has been charged with no insurance and resisting arrest. Seen by Forensic Medical Examiner who did not appear to have identified any mental health issues. LP maintains he has got signs of relapse–distracted, talking to himself at times but able to function and contain this when seen by professionals.*
> *LP absolutely opposed to admission (as are father and brother reportedly)."*

9.46 The note also shows that LP asked for a prescription so that [SP]'s brother could try to persuade him to take it. Neil Hickman noted a plan of giving LP the requested prescription and of continuing to try to speak to SP. It was also noted that LP reluctantly agreed that Neil Hickman could tell SP he knew about his arrest in Croydon.

9.47 Neil Hickman obtained the prescription LP asked for and delivered it to her later on 9 February 2006.

9.48 On Wednesday 15 February 2006, LP phoned Neil Hickman and described SP as stable but with early warning signs. LP said he had reacted angrily when she tried to talk to him about starting medication the day before and had not responded to her calls since. She said he continued to attend university and to play football. Neil Hickman noted that he agreed that he would continue to try to speak with SP on the telephone and would write to him to offer support with his hearing in respect of the recent arrest. He also noted: "*Again no clear evidence that a* [Mental Health Act assessment] *would be justified".*

9.49 Later on 15 February 2006, Neil Hickman phoned SP. Neil Hickman's note, made after the events of the night of 18/19 February 2006 records that SP sounded calm and rational although evasive about arranging contact with the EIS. [SP] did not want to be supported at the coming hearing and they agreed that Neil Hickman would contact SP again immediately after the court hearing on 22 February 2006.

9.50 Neil Hickman's notes, made after the events of the night of 18/19 February 2006, show that the multidisciplinary team discussed SP at their meeting on Thursday 16

February 2006. At that meeting it was agreed that rather than undertaking a further home visit, Neil Hickman would try to persuade SP to attend at Clare House, Springfield Hospital to see Dr Ferdinand Jonsson, who by this time was providing the day-to-day medical cover in the EIS. Dr Jonsson explained the thinking: "[…] *we wanted to see him and we felt it was much better to see him at Clare House; it would be a safer environment and if there were massive problems we would be able to get help."*

9.51 LP told us she phoned Neil Hickman on 17 February 2006 and asked him if he had seen SP. She told the panel: "*My concern was asking Neil if he had been to see my son because I knew that my son needed to be seen. … I was insistent, yes".* There is no record of LP ringing to insist that Neil Hickman should see SP on 17 February 2006 or at any other time either in the clinical notes, or in the EIS team message book. Neil Hickman was training staff at a development session on 17 February 2006 and told us he could not have had contact with LP that day. He denied that LP had told him that SP needed to be seen.

9.52 It was clear to us when LP gave her evidence that she had difficulty recalling specific events relating to the care and treatment of SP by mental health services. She was also evidently distressed by having to go through those events for the investigation. On the other hand, Neil Hickman had a good recall of the events relating to the care and treatment of SP. When he had doubts about his recall, he was happy to acknowledge them. We also note that Neil Hickman and the rest of the EIS team appear to have been conscientious in recording events in the clinical notes. Further, Dr Jonsson told us he did not believe that LP ever rang the EIS to insist that SP needed to be seen. For these reasons we find on balance that LP did not make further contact with Neil Hickman or the EIS after the telephone conversation on 15 February 2006, and that she did not explicitly insist at this time that the EIS had to see SP.

9.53 At the beginning of February 2006, contact with SP had become limited; he had not been seen by any member of the EIS for about 10 weeks; he was on enhanced CPA and a CPA review of his mental health needs was due. By that time LP had alerted the EIS to the possibility that he was beginning to relapse As the EIS knew, SP would present a significant risk to himself and others when he was unwell. Dr Singh described SP as "*potentially very, very dangerous"* when acutely psychotic and the care plan set out in the Relapse and Risk Management section of SP's CPA stated: "*In the event of evidence of relapse than* [SP] *should be formally assessed under the* [MHA] *at an early stage".* We find that these

matters taken as a whole should have indicated to the EIS the necessity of undertaking a face-to-face assessment of SP.

9.54 We find that, notwithstanding the obstacle of the reluctance of SP's family to his being admitted to hospital, or to allowing SP to know of their contact with the EIS, the case for undertaking an assessment, if necessary under the powers of the MHA, became absolutely clear after the telephone conversation that Neil Hickman had with LP on 9 February 2006.

9.55 Neil Hickman was told on 9 February 2006 of the events of the previous day in Croydon, including the fact that SP had resisted arrest. LP also told Neil Hickman that SP had "*got signs of relapse – distracted, talking to himself at times but able to function and contain this when seen by professionals".* She requested a prescription for SP. We know from the evidence of Neil Hickman and Dr Singh, referred to elsewhere, that LP was considered to be reliable in alerting the EIS to concerns about SP's health, but liable to play matters down if she thought there was a danger of admission to hospital. Accordingly, we believe that her concerns should have been taken as strongly indicative of a relapse. They also accord with the indicators for a MHA assessment suggested by Dr Singh when he told us in respect of the situation two weeks earlier: "*if there was any sign that he was clearly psychotic, for instance if he started talking to himself, he is hallucinating, he is deluded, he is acting out, then he clearly meets the criteria for a Mental Health Act assessment".*

9.56 Dr Singh had resigned from the trust by the time of SP's arrest in Croydon on 8 February 2006, but we asked him to comment on its significance. He told us:

> *"I wouldn't have expected the police surgeon assessment to be that accurate. That would certainly have concerned me. Again, it depends on what is happening. Say I turn up at my team base and I am told that one of my patients has been picked up by the police, seen by the police surgeon, not thought to be ill. We would certainly insist on seeing him ourselves. Something has happened, something has shifted".* He went on to say: "*The threshold has certainly been reached for us to do something. That would begin with gathering as much information as possible, say finding out from the police what the circumstances were, finding out from the mother what the circumstances were. That would be the starting point, and I think it would end up in assessment."*

9.57 It is clear that the EIS were concerned that they would damage their relationship with SP and with LP if they were forced to invoke the powers of the MHA to undertake an assessment of him which might make engagement even more complicated for the future. Further, the warnings LP was giving about SP's condition were not as urgent as they were immediately before his previous admissions to hospital. The EIS was also aware that he was continuing to function and undertake his normal activities, such as going to university and playing football. LP had also reported that Dr Nicholson, the FME, who saw SP on 8 February 2006, did not consider that he was psychotic. Nevertheless, in our opinion, these issues should not have been allowed to outweigh the indicators of the pressing need to undertake a mental health assessment. In coming to this opinion, we have weighed up the circumstances that the EIS were presented with at the time and believe that we have been able to put aside the influence of hindsight.

9.58 We asked Neil Hickman about the failure to undertake a face-to-face mental health assessment. He told us:

> *"Certainly, with some clients if we had a similar call from a relative we would jump in the car and go round and do [an assessment]. The complexity was two-fold with* [SP]*'s case. One that LP didn't want us to do that because she thought it would tip* [SP] *off about her communication with us, and we had some uncertainty about how safe it was to do that. We were trying to have precisely that contact with me and ideally with one of the medics in the team, but in a planned way so it didn't feel like we were door-stepping* [SP]*. That was the intention."*

9.59 We think this answer indicates the extent to which decision-making about how to respond to the indications that SP was relapsing was unduly focused on SP's own wishes and desires and those of his family rather than on the risks he posed to himself and to others when he was unwell. We hope that the case of SP and the matters set out in this report will help to ensure that the EIS and other practitioners will give sufficient weight in future deliberations to how to manage such patients and the risks they pose.

9.60 We cannot say for certain that, even if a face-to-face mental health assessment had been done prior to 18 February 2006, it would necessarily have resulted in SP's detention and so prevented the events of 18/19 February 2006 from happening.

9.61 Dr Singh described SP's relapses as "*very dramatic and over a matter of hours* […]*".* The evidence of Dr Nicholson was that she did not consider him to be psychotic. She told us: "*His speech pattern initially when I saw him was a little agitated and rapid, but it did calm down very quickly once we were in the medical examination room, and he became quite cooperative and compliant with me and his mother, and he was really quite calm".* About a week later SP visited his mother, as she described to Neil Hickman in her telephone call on 15 February 2006. She told us that during that visit: "[SP] *was calm until you mentioned the medication, because he came in and I could see he wasn't well when he came in but he could still communicate with you".* She suggested that although SP was obviously not well at this time, his condition was not yet as acute as on the previous occasions when she had seen him detained under the MHA and not as acute as it became by the time she saw him again late on Saturday 18 February 2006.

9.62 We asked Dr Singh to speculate whether, assuming that SP was showing signs of relapse but had not yet become acutely and floridly psychotic, he would have been liable to be detained under section 3 of the MHA. He said:

> *"This is one of the trickiest dilemmas we have in applying section 3, and I have seen a lot of patients who are clearly deteriorating and the families are concerned but they are told he is not ill enough to be detained, and things have to get worse before the person can be detained. Over the years I have changed my approach to this, and I have felt that the Mental Health Act allows us to detain people, even if they are not fully floridly psychotic, and the criterion is the risk of deterioration* […] *the absence of absolutely florid psychosis would not have been the sole determining criterion in my mind. I might have said, 'something is shifting, and we know how quickly he becomes unwell, and there is risk of deterioration, let's go for a section'. But I am guessing, I am not certain I would have done that, and my second opinion colleague may not have agreed, the social worker may not have agreed. My threshold generally is lower for the Mental Health Act."*

9.63 We accept Dr Singh's comments on the uncertainty of whether or not SP would have been detained if he had been assessed under the MHA before 18 February 2006. His evidence however confirms that there was at least a possibility that the requisite practitioners would have deemed SP to be suffering from mental illness of a "nature or degree" allowing for his detention under section 3 of the Act and would have brought it about.

9.64 We are critical of the fact that there was no face-to-face assessment of SP in the 10 weeks prior to 18 February 2006. We believe that the failure to undertake a mental health assessment on or after 9 February 2006 was a professional misjudgement by Neil Hickman as SP's care coordinator and by Dr Jonsson who was providing day-to-day medical input to the EIS after his return to work on 12 February 2006. We cannot say for certain that if a mental health assessment had been done it would have resulted in SP's detention, but the failure to undertake an assessment means the EIS may have missed a potential opportunity to detain SP and so avert the tragic events of 18/19 February 2006.

The failure to refer SP for a forensic examination

9.65 On 30 June 2005 Neil Hickman noted in SP's clinical notes as part of the continuing treatment plan for him: "*Review with Dr Singh 7/7/05. Discuss forensic referral for further assessment of risk*". No such referral was ever made. Neil Hickman told us that he and Dr Singh discussed the possibility of referring the case to the forensic services, but neither he nor Dr Singh could recall the conversation nor why the EIS did not go ahead with the referral. Neil Hickman suggested to us that the reason for their not proceeding with a forensic referral may have been because a CPA meeting took place shortly after on 8 August 2005 at which SP became aggressive with Dr Singh and told Neil Hickman he was not prepared to see any more doctors.

9.66 Dr Dewsnap questioned whether the trust's forensic service would have been prepared to accept a referral in SP's case. He suggested that it was known that SP was a risk only during periods of acute psychosis and that this settled with medication, so it may be argued that the strategy for dealing with risk in SP's case was evident and there was nothing the forensic services could add. Neil Hickman too expressed doubts about the value of a forensic referral in SP's case. He said: "[…] *generally when we have referred for* [a forensic] *opinion, often the conclusion is, 'Mr Smith needs to stay on medication and is at risk if he relapses'. I don't know how much it would have added but it is something I wish we had pursued".*

9.67 In undertaking this investigation into the care and treatment of SP, we received advice and help from consultant forensic psychiatrist Dr Jayanth Srinivas, MRCPsych, Dip (Mental Health Law)**.** He advised us that a properly conducted forensic assessment of SP should have resulted in a risk assessment and risk management plan. He believed that a

forensic risk assessment and plan would have placed a greater focus than the EIS did on the risks SP posed and the consequent need for greater engagement of him and greater control of his care. Dr Srinivas also told us that, as part of the risk management plan, he would have expected forensic services to have recommended the EIS and the trust to press for SP's prosecution for the assault on Sanjaya Warnatilake on 20 April 2005. We cannot say what the outcome of such a prosecution would have been, and whether it would have resulted in SP being made the subject of a hospital order or being placed under restrictions pursuant to part III of the MHA. However such a prosecution would at the least have formed a part of SP's risk history and would have made explicit for SP and for those dealing with him the dangers that he posed when unwell.

9.68 The evidence of the CMHT and EIS staff suggested that they consider that the forensic services are of limited value and relevance to their work. As the case of SP demonstrates, we think that this perception can lead to the neglect of a potentially beneficial approach to the care and management of a patient. We therefore welcome the fact that the trust is presently reviewing its forensic services including the links between the forensic and community services.

Recommendation

R10 The trust should ensure as part of its current review of forensic services that those services can offer the community teams the support and advice they need. Arrangements should be put in place for effective liaison between the forensic and community services.

10. Inter-agency issues

Absconding

10.1 During both of his episodes of inpatient treatment on John Meyer ward, SP tried several times to abscond. During the first episode he climbed the garden fence and ran away from Springfield Hospital on two occasions. During the second inpatient episode he was found on two occasions trying to climb over the garden fence, once reaching the top. We asked trust staff about the adequacy of the arrangements for containing patients in the garden of John Meyer ward but, as we saw when we visited Springfield Hospital, this will not be a continuing issue because the PICU is moving into a new building presently being constructed.

10.2 We were also concerned to have discovered that, as we describe in 7.22, there were a number of occasions during the first episode of inpatient treatment on John Meyer ward, when SP was able to pick up keys to the ward that a staff member had not secured. We were told that these events were lapses in procedure by one member of staff the trust no longer employs.

Recommendation

R11 The trust should review its policies and procedures regarding the safeguarding of keys to its facilities.

10.3 SP absconded from John Meyer ward by climbing over the garden fence on 12 June 2004. Initially, finding him and trying to bring him back to hospital was undertaken by the staff on John Meyer ward, but on or about 20 June 2005, the matter was handed back to the East Mitcham CMHT based on Jupiter ward.

10.4 On 22 June 2004, Dr Ovens, at that time the SHO with East Mitcham CMHT, received a phone call from the police telling him that SP was at LP's house. As a result, Dr Ovens rang LP. She denied he was with her. She admitted that she knew where he was but she refused to "betray" SP by telling hospital staff. LP said that she would ring the hospital again next day once she had discussed things with SP. Dr Ovens noted the following plan in SP's clinical notes:

"1. Await response from [LP]

2. Continue efforts to engage her/him

3. Discuss method of re-admission/other options when [SP] *located."*

10.5 LP did not get back in touch with ward staff and there was no further contact between trust staff and SP's family, or the police until the police returned him to the PICU after the disturbance he caused in church on 4 July 2004.

10.6 The trust's missing person and AWOL policy is dated September 2002 and has a review date of September 2006, although we are not aware of any updated version. Paragraph 4 of the policy is headed "*Definition and Action Necessary for Service users who are Absent Without Official Leave".* Its provisions include:

> *"If the service user risks are high and or their legal status is detained and:*
> *Does not return within an agreed time and the exact whereabouts is unknown and is refusing to return to the ward it is the responsibility of the team to identify current risks. If deemed high further discussion with the care co-ordinator, Consultant psychiatrist and any relevant others including relatives / carers, as to whether to visit and attempt to persuade the patient to return. The associated risk factors must be considered carefully and taken into account with this course of action.*
> *Further attempt to persuade the patient to return to the ward by telephone or home visit in agreement with the Consultant Psychiatrist.*
> *Agree further action with the Consultant Psychiatrist. This is dependent on the risk factors associated with the individual patient and the particular circumstances and may include the following:*
> *Contact the police to ask if they would enforce immediate entry to the known premises due to the associated risk factors and expressed concern* […].
> *Contact the relevant approved duty social worker to arrange for information to be provided to a magistrate so that a warrant may be issued to a police officer to enter premises to retake the service user* […]*."*

10.7 It is not clear from the amendments to the nursing care plan made when SP absconded, nor from the incident form completed in respect of his absconding, whether he was accorded high-risk status at this time, but as a patient under detention, he would have been subject to the prescribed action plan referred to in 10.6. The terms in which

the action plan is drafted suggest that it depends on the trust staff knowing the whereabouts of the absconding patient. It also appears to suggest that attempts must be made to persuade a patient to return to the ward before further action, including seeking police help to return the patient, can be taken.

10.8 We asked Dr Ovens whether he was aware at the time of SP's absconding of the trust's missing person and AWOL policy. He told us: "*I cannot recall ever having read it, although I think when I started as an SHO, I did a lot of discussing with the duty nurse when I was on call and that sort of thing what my role was, what my duties were"*

10.9 In any event, it appears that Dr Ovens and other trust staff acted on the basis that in order to secure SP's return to hospital, they had to find out exactly where he was, and enter into a dialogue with him and his family in the hope of persuading him to return voluntarily. This appears to have been the thinking behind the plan Dr Ovens recorded in the notes on 22 June 2004. It also explains why, although trust staff had strong grounds for suspecting that SP was staying with LP they did not take any decisive action to secure his return to hospital, either by asking the police to pursue and return SP or by seeking a warrant under section 135(2) of the MHA.

10.10 We asked Dr Ovens about the role of the police in helping to return an absconding patient. He suggested that, on this issue too, he was uncertain. He told us:

> "[…] *I am aware* […] *that any absconded patient from any of the wards at Springfield will be reported to the police, whether they are sectioned or not, and it is essentially then treated as a missing persons inquiry. You are reporting somebody vulnerable or potentially risky* […] *and the police then follow their duties* […] *which may be that they go and find somebody at home and they are not going to do any more than that, they feel they have no powers to bring people back to hospital* […]"*.*

10.11 The matters we have just referred to suggest to us that Dr Ovens and other trust staff may have been confused about the respective roles of the police and trust staff in dealing with absconders and may have had only a partial understanding of the powers available to deal with an absconding patient.

10.12 It is clear from the wording of section 135 of the MHA, which makes provision for issuing warrants to search for and remove patients, that obtaining a warrant does not require absolute proof of the whereabouts of a patient, but rather only "reasonable cause to believe" that a patient is at particular premises. There is no requirement to try to persuade a detained patient to return voluntarily to hospital as a precondition of obtaining a warrant. Section 135(2) of the MHA says:

> *"If it appears to a justice of the peace, on information on oath laid by any constable or other person authorised by or under this Act* […] *to take a patient to any place, or take into custody or retake a patient who is liable under this Act* […] *to be so taken or retaken --*
> *that there is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice, and*
> *that admission to the premises has been refused or that a refusal of such admission is apprehended, the justice may issue a warrant authorising any constable* […] *to enter the premises, if need be by force, and remove the patient."*

10.13 It would seem good practice to try where possible to persuade an absconding patient to return to hospital voluntarily, as suggested by the trust's missing person and AWOL policy, but we believe that the trust's missing person and AWOL policy is not explicit about the need in all cases to consider above all else the risks posed by an absconding patient, and to make all reasonable attempts to ensure that patients who pose a risk to themselves or others are returned to hospital as promptly as possible, if necessary under the powers of section 135 of the MHA.

Recommendation

R12 The missing person and AWOL policy should be reviewed by the trust and circulated to ensure that staff are clear about their responsibilities in the event that a patient absconds.

10.14 SP absconded only five days after his admission to hospital on 7 June 2004 experiencing an acute psychotic episode. When attempts to engage him and his relations so as to secure his return to hospital did not succeed, the trust staff appear to have let matters drift, particularly after 22 June 2004, and nothing more happened until SP was detained as a matter of crisis on 4 July 2004. Dr Moodley said in her psychiatric report

dated 18 June 2004 setting out her recommendations for SP's treatment in the event of his return to the PICU, that he was:

> "[…] *felt to be a risk to others, in view of his persecutory ideas, interpretation of people's actions and disclosed anger. He is a risk to himself due to his emotional lability, a recent history of allegedly threatening to burn himself, his perceived ability to stay up in the air and a tendency to jump from heights.*
> *He is at risk of using illicit substances, especially in the community and clearly a high risk of absconding, and disengaging with services and not complying with medication."*

10.15 We find that as a matter of good practice, and especially given the risks SP posed to himself and others, trust staff should have been more active in their attempts to get him returned to hospital. In particular, we think that, having been told by police of SP's whereabouts on 22 June 2004, Dr Ovens should have considered with either Dr Dewsnap or Dr Moodley whether or not to ask the police to pursue and detain SP or seek a warrant for SP's return to hospital under section 135 of the MHA.

The aftermath of the attack on Sanjaya Warnatilake CPN 20 April 2005 - liaison with the police and Crown Prosecution Service (CPS)

10.16 After the attack on Sanjaya Warnatilake, CPN with the EIS, on 20 April 2005, the case was handled by PC Hirsch who was based at Wimbledon police station. PC Hirsch was one of the officers who had attended the scene of the attack. On 30 June 2005 he passed the crime report to PC Alex Henderson at Wimbledon police station who assumed responsibility for the matter. PC Henderson told us that police records disclose that PC Hirsch had made a number of inquiries about the case during the two months or so he was handling it, but we do not know what those inquiries amounted to. PC Henderson told us he was aware that PC Hirsch had told Neil Hickman that the chances of the CPS proceeding with a prosecution of SP were slim.

10.17 PC Henderson also told us that on 1 July 2005, the day after he received the crime report, he spoke with both Sanjaya Warnatilake and Chris Stanger. He told them it was unlikely that the CPS would decide to prosecute SP but Sanjaya Warnatilake and Chris Stanger said they nevertheless wanted PC Henderson to pursue the matter with the CPS.

Chris Stanger also volunteered to take witness statements from Sanjaya Warnatilake and Neil Hickman.

10.18 On 12 July 2005, PC Henderson told Chris Stanger that the CPS had advised that they would need a letter from Dr Singh giving an opinion of SP's mental condition and whether or not a prosecution should be brought.

10.19 PC Henderson explained that once he had the available evidence relating to the attack on Sanjaya Warnatilake, he arranged an appointment with the CPS representative at Wimbledon police station. The CPS representative decided not to prosecute.

10.20 According to PC Henderson, he rang Chris Stanger soon after the appointment and left a message for Chris Stanger telling him about the CPS decision. He failed to document the call in the crime report. It was Chris Stanger's evidence, however, that he and the trust found out about the CPS's decision only in February 2006 when he contacted PC Henderson having been prompted by Sanjaya Warnatilake. Chris Stanger's account is supported by Sanjaya Warnatilake's version of events and we accept it.

10.21 Chris Stanger told us that after his conversation with PC Henderson in February 2006 he considered approaching the Legal Protection Unit of the NHS SMS with a view to the NHS taking a private prosecution against SP for the attack on Sanjaya Warnatilake. The events of 18/19 February 2006 occurred before he had the chance to pursue the matter.

10.22 We were concerned to learn of the delay in taking witness statements relating to the assault on Sanjaya Warnatilake. However remote, there is a possibility that this could have compromised the investigation of those events and any prosecution. It was regrettable too that PC Henderson did not inform the trust directly of the CPS's decision not to prosecute until Chris Stanger pursued the matter five months later.

10.23 The decision not to prosecute SP for the attack on Sanjaya Warnatilake was a great disappointment for EIS staff. Dr Brock Chisholm explained why he felt that there should have been a prosecution: "[…] *In my experience and from the literature, people who are prosecuted who have been violent, even when they are unwell are less likely to do so again* […] *I guess the downside might have been that it would harm engagement even further, but I still think that is a risk worth taking".* EIS staff told us that a prosecution would have helped with the continuing management of SP's case because it would have

become part of his risk history. It would also have provided a reference point illustrating both for SP and for his carers the risks that he presented when he was unwell, so it would have been useful tool for encouraging future engagement and compliance. A successful prosecution would also have opened up the possibility of SP becoming subject to a restriction order under section 41 of the MHA.

10.24 It is not within our remit to determine whether or not the decision not to prosecute SP was justified, nor can we say what the outcome of any attempt to prosecute SP might have been. However, we agree with the views expressed to us about the benefits a prosecution that might have brought and we find that the CPS's decision not to prosecute was at the least a missed opportunity in the management of SP's condition.

10.25 Chris Stanger told us that when he was told of the CPS's decision not to prosecute SP, he did not have any official means by which to query that decision, or to find out about the reasons for it. He told us he was now forming relationships with the Wandsworth and Kingston CPS which would allow him to make inquiries about matters in those boroughs but that he has no such informal relationship with the CPS representatives in other boroughs covered by the trust. We believe it was regrettable and undermining of staff confidence in the support available to them from the judicial system that they were unable to learn why SP was not prosecuted.

10.26 Since SP came under the care and treatment of the EIS, the NHS SMS, the CPS and the Association of Chief Police Officers have drawn up a Memorandum of Understanding (MoU) on a national basis aimed at promoting more effective working relationships between NHS organisations, the CPS and the police. We are pleased to note the following provision in the MoU between the NHS SMS and the CPS:

> *"10.1 When requested, because a private prosecution or civil action may be brought, the CPS will provide detailed explanations as to its review decisions in particular cases. Such requests should be made via the relevant NHS SMS Liaison Officer.*
> *10.2 Where there is disagreement on the CPS decision to charge, caution or not to prosecute, or on the level of charge, concerns should be raised with the NHS SMS Liaison Officer. The Liaison Officer will then seek an explanation from the investigating officers, who may contact the Crown Prosecutor."*

10.27 In March 2007 the trust in consultation with the CPS introduced a local prosecution protocol under which the trust's criminal justice adviser is to be informed of all incidents that have been reported to the police. Under the protocol the criminal justice adviser is also now primarily responsible for ensuring that trust staff produce witness statements and are supported so as to ensure the progress of cases reported to the police. The criminal justice adviser is also given primary responsibility in the trust for monitoring the local prosecution protocol in terms of which prosecutions are successful, the reasons why cases are not successfully pursued and the learning points and recommendations arising.

10.28 In light of experience in SP's case, we welcome these moves towards a greater understanding and closer working between the trust and the CPS and the police. We believe there is a need to ensure that local arrangements to implement the national agreements set out in the Memorandum of Understanding are effective and kept under review.

Recommendation

R13 The trust should enter into a local joint working protocol with the police as envisaged by the recent Memorandum of Understanding (MoU) between the Association of Chief Police Officers and the NHS Security Management Service (NHS SMS).

10.29 Chris Stanger told us there were more than 250 assaults each year in the trust of which about 40 to 50 are reported to the police. This creates a large workload for the trust staff responsible for advising on and pursuing prosecutions. Mark Clenaghan told us the trust had recently appointed an NHS SMS Adviser to work on these matters alongside the trust's criminal justice adviser.

Recommendation

R14 The trust should keep under review the question of the resources needed to meet its changing and increasing responsibilities in progressing criminal prosecutions.

10.30 The EIS staff made plain to us they felt personally let down by the fact that SP was not prosecuted for the attack on Sanjaya Warnatilake. As Julia Heathcote, occupational therapist with the EIS, put it:

"I think it was a combination of probably feeling unsupported by senior management and also frustrated that the CPS hadn't considered it serious enough, because from our perspective it was very serious."

10.31 Staff also complained to us that the only support they received in respect of the attack was from colleagues in the EIS team and that they were not offered any support by the trust's senior management. Sanjaya Warnatilake, the victim of the attack, told us:

"With Neil [Hickman] *throughout management supervision sessions, he offered support frequently. Apart from that and from the immediate team* […] *I didn't get any senior staff support."*

10.32 Given the unusual severity of the attack on Sanjaya Warnatilake, the distress it caused him, and the anxiety it engendered within the EIS team, it is unfortunate that senior management offered no support. Clearly, staff morale and attitudes to work can be undermined if they do not feel that they have backing and support.

Recommendation

R15 The trust should review its processes and procedures for alerting senior managers to serious incidents which have significant potential for undermining staff morale and whether they offer adequate support for staff and adequately explain the trust's response to such incidents.

Accommodation issues

The care offered to SP under the supported housing scheme

10.33 At the beginning of February 2004 SP moved into Links Road, a property belonging to Sharon Lartey, under Merton Borough Council's supported housing scheme. Links Road continued to be his home until the fatal attack on Matthew Carter. For most of the time that SP lived at Links Road, he shared accommodation with two other clients of Merton Borough Council's supported housing scheme.

10.34 Under the terms of Merton Borough Council's licence agreement and individual service contract for adult placements, Sharon Lartey, as the "carer", granted SP a licence

to occupy a bedroom at Links Road at a rent of £115 per week and agreed to provide counselling and care services to SP in return for a further payment of £140.70 per week. Most of the money owing to Sharon Lartey was paid to her directly by Merton Borough Council (hereafter referred to as "Merton").

10.35 Under the individual service contract, a carer such as Sharon Lartey was required to provide certain practical care services, including cleaning and the provision and cleaning of bed linen. It was also part of the arrangement that the carer would fulfill a counselling and emotional support role. Bernadette Nicholas, Merton's housing support team manager, told us this might take the form of talking to clients, trying to motivate them to undertake activities and help with daily needs such as shopping, cooking and budgeting. Bernadette Nicholas told us there was a clear expectation on Merton's part that "*any carer would go in and see individual clients on a daily basis, at least twice",* although the timing of such visits was a matter of negotiation between the client and the carer. Merton's schedule of the sums due to Sharon Lartey for her care of SP specified that she was to be paid for 21 hours of care service at £6.70 per hour.

10.36 Sharon Lartey told us at interview that she went to Links Road almost every day but did not necessarily see SP every time because he was often out or asleep or might stay in his room and talk to her from behind the door. Sharon Lartey also said she did not go to Links Road at weekends and on the occasions she could not visit, her husband would go instead.

10.37 We showed Sharon Larty a draft of this section of the report and she wrote to us on 15 February 2008. Her letter says :

> *"My husband and myself were duly trained by the Housing Support in various areas of supporting clients who have underlying mental health needs. The Housing Support Team were fully aware that my husband and myself provided this support required, taking turns to ensure ongoing monitoring visits as agreed under the contract were taking place."*

The suggestion that Mr Lartey had received training on how to support clients with mental health needs directly contradicts what Sharon Lartey told us in her interview. And Bernadette Nicholas, Merton's housing support team manager, told us that Merton had no

record of Mr Lartey completing any training for carers under the supported housing scheme.

10.38 Bernadette Nicholas has also told us that Sharon Lartey and her husband made an application to become carers on the basis that Sharon Lartey was the "lead carer", and Mr Lartey was "*assisting with the more practical aspects of supportive accommodation at [Links Road] when [Sharon Lartey] was absent … The Housing Support Team were not aware that Mr Lartey had at any time become the main carer either on a permanent or a frequent basis*."

10.39 LP told us she visited Links Road to see SP at least twice a week and spoke to him by telephone regularly, asking if he had seen Sharon Lartey. It was her impression that Sharon Lartey was rarely at the property. Neil Hickman met Sharon Lartey when SP's move to Links Road was first arranged and at a housing review meeting a couple of months later, but otherwise he did not encounter Sharon Lartey on any of times he went to meet with SP at Links Road.

10.40 From about early November 2005 until 2006, Nigel Bates was employed by Merton as a housing support officer with responsibility for supporting and managing a number of carers under the supported housing scheme, including Sharon Lartey. He told us that notwithstanding the formal agreement between Merton and carers about the hours of care they would provide, the hourly pay was so poor that there was no real expectation that the agreed hours would in fact be provided. Talking of Sharon Lartey and Links Road, he said: "[…] *there was no way we would have expected her to see every one in that house* [Links Road] *daily, or made contact."*

10.41 We asked Nigel Bates about whether Sharon Lartey was required to keep a diary of her attendance at Links Road. He told us: "*We didn't have a set diary* […] *to gauge what was happening with adult placement carers, because there had been the anomaly of the hours and the hours didn't match how many hours were being put in, which was more the way it was set up as opposed to the standards of the carers. That was just a fault in the whole system as opposed to laziness on the carers' parts or trying to defraud the Council or anything".* We were dismayed by Nigel Bates's apparent willingness to excuse and indulge the failure of Sharon Lartey and other carers' to fulfill their contractual obligations.

10.42 Bernadette Nicholas was responsible for managing the housing support officers. She disputed Nigel Bates's view of the expectations Merton had of carers under the supported housing scheme. She said "*My expectations from the carers and my officers' expectation should be that you are putting in the hours you are contracted to do".* She went on to say that this expectation was made plain to housing support officers at team meetings. She also made plain that she expected carers to keep records of their contacts with service users and that housing support officers were to monitor those records at monthly meetings with carers.

10.43 Nigel Bates confirmed that he was expected to monitor the work of carers by seeing them monthly and speaking with them on a weekly basis. When asked about his contact with Sharon Lartey he told us: "*probably not every week, I probably didn't contact her every week, and I would have seen her most months, it might have been".*

10.44 We find that Sharon Lartey's attendance at Links Road and her contact with SP was much less regular than was expected or necessary to ensure that his progress was adequately monitored. We also find that Sharon Lartey inappropriately allowed her husband, who had not attended training for a carer under the supported housing scheme, to undertake her duty to visit Links Road on a frequent basis. For these reasons we criticise Sharon Lartey's performance as SP's carer under the supported housing scheme. We are also concerned about the weaknesses that the evidence revealed in the arrangements by which Sharon Lartey was managed and held to account by Nigel Bates.

Recommendation

R16 Merton Borough Council should review its practice and procedure for ensuring that carers under the supported housing scheme provide the services expected of them.

The role of the carer under the supported housing scheme

10.45 It is clear that Neil Hickman had limited contact with Sharon Lartey. He told us that, after the initial meetings to arrange SP's move to Links Road, he never again saw Sharon Lartey when he visited Links Road and she never phoned him directly. Neil Hickman told us that when he first referred SP to Merton supported housing department he provided them with a copy of SP's CPA as well as an extensive referral form. He also told us that there was discussion about the CPA when he met with Sharon Lartey and staff from

the supported housing team at the initial meetings to arrange SP's move to Links Road. However, there was never a one-to-one discussion between Neil Hickman or anyone else from the EIS and Sharon Lartey to consider SP's mental health issues and how she might have been able to help with his treatment. Sharon Lartey was not in any way involved in the CPA review that took place on 8 August 2005.

10.46 We cannot say that Sharon Lartey would necessarily have been able to make a significant contribution to SP's care and treatment if she had been given a greater understanding of SP's mental health issues. However, given the limited nature of SP's engagement with the EIS and the difficulties they therefore had in monitoring SP's mental state, we believe that it might have been helpful if Sharon Lartey could have been enabled to provide a better informed and more reliable line of communication between the EIS and SP.

10.47 Mark Clenaghan told us the trust's Merton service and Merton Borough Council were undertaking a joint review of the supported housing arrangements. He said: "*We want to move to a system of more directly supporting the service user within the supported housing framework. With* [Merton] *we are reviewing the housing support team and one of the outcomes from that is that some of the housing workers will be redeployed directly to our community health teams to provide support within that".* We welcome this review of the supported housing arrangements.

Recommendation

R17 Merton Borough Council and the trust should consider how carers under the supported housing scheme can best be supported and managed to enable them to understand and make a reliable contribution to the care and treatment of service users in supported accommodation.

Liaison between the EIS and the Housing Support Team

10.48 Neil Hickman first wrote to Merton's housing support team to refer SP for accommodation under the supported housing scheme on 27 September 2004. He enclosed a copy of SP's current CPA plan, dated 24 September 2004. The section headed relapse and risk management plan said it was not possible to complete a detailed risk history because SP's notes had not been forwarded to the EIS from Jupiter ward. The plan

referred to an alleged incident of criminal damage before SP's recent admission to hospital and to the fact that there had been several incidents of control and restraint during the admission. It also stated that there was no evidence of "*any current risks of aggression, self harm or self neglect".* The CPA was updated on 17 December 2004 to include a reference to *"3 x descriptions of assaults on other patients during admission on John Meyer ward".* For reasons Neil Hickman could not explain, no mention was made when the CPA was updated of the alleged incident on 4 July 2004 of SP restraining a pastor at his church, although that incident was detailed in SP's inpatient records and Neil Hickman was aware of it.

10.49 Neil Hickman told us he believed he took the updated version of the CPA to one of the meetings he and SP had with staff of the housing support team and Sharon Lartey before SP moved into Links Road. He also said he would have discussed the risk assessment at those meetings. He said however that he did not have time alone with Sharon Lartey to discuss SP's risk assessment or risk history, and that any conversations on the subject were conducted in SP's presence. This would have made the discussion, "*more complicated and possibly more circumspect".* Sharon Lartey, on the other hand, was adamant that she was never told of any incidents of violence or assault by SP and that she was never shown a CPA that mentioned violent behaviour by SP. Her recollection about whether she saw the 17 December 2004 version of the CPA appears to be supported by the fact that Bernadette Nicholas did not have a copy of that version of the CPA on the housing support team files.

10.50 According to Sharon Lartey, when SP was detained in hospital for a second time from 20 April 2005, Neil Hickman told her only that he was in hospital because he had a relapse. Her evidence was that she was not told of the assault on Sanjaya Warnatilake. Neil Hickman, however, told us that he remembered a *"much fuller discussion about the circumstances of the return from Jamaica, the admission and the assault".*

10.51 Bernadette Nicholas also gave evidence that she was not told of the assault on Sanjaya Warnatilake. She told us that she would have expected Neil Hickman to telephone her directly about the matter. She said that it would probably have made her reconsider whether Links Road was suitable accommodation for SP.

10.52 We asked Neil Hickman about his failure to tell Bernadette Nicholas of the attack on Sanjaya Warnatilake. He explained that he forwarded Merton housing support team a copy of the CPA including updates made on 1 July, 8 August and 4 September 2005, under

cover of a letter to Bernadette Nicholas dated 31 October 2005. That version of the CPA made reference to the attack on Sanjaya Warnatilake and stated that in the event of relapse, SP would present a significant risk to others. However, the letter to Bernadette Nicholas dated 31 October 2005 was sent six months after the attack along with other enclosures, with a view to seeking alternative independent accommodation for SP. It did not draw attention to significant additions to SP's risk history. Bernadette Nicholas told us that in any event the letter arrived while she was on holiday and was filed along with its enclosures without being passed on to Nigel Bates or Sharon Lartey.

10.53 Neither Sharon Lartey nor the Merton housing support team were made aware of the CPA review on 8 August 2005. Neil Hickman explained that this was because the EIS team had undertaken the CPA at short notice, having seized an opportunity to meet with SP after a number of earlier planned meetings had not taken place.

10.54 We find that Sharon Lartey was not adequately briefed about SP's risk history and risk assessment when she agreed he would move into Links Road or at any time thereafter. We believe that even if Neil Hickman had shown Sharon Lartey a copy of the 17 December 2004 version of the CPA and discussed it with her, those discussions would have been inhibited by the fact that SP was present. There is a conflict of evidence about what Neil Hickman told Sharon Lartey about the assault on Sanjaya Warnatilake. We note however that Neil Hickman, who was usually good at record-keeping made no note of having told Sharon Lartey about the attack. In any event, even if he did tell her of the "*circumstances of the return from Jamaica, the admission and the assault",* we are not satisfied that this amounted to an adequately straightforward explanation of the event or of the fact that SP was considered a significant risk to himself and others when unwell.

10.55 We believe that Sharon Lartey, as the owner of Links Road and SP's carer under the supported housing scheme had the right to know about his risk history because it was relevant to her role as a carer and potentially had a bearing on her own safety and that of the other occupants of Links Road. The failure of Neil Hickman to be explicit about those matters potentially put at risk Sharon Lartey and the other occupants of Links Road, and denied Sharon Lartey the right to form a view about whether she wished to accept those risks. For the same reasons, we believe that Neil Hickman should have spoken directly and explicitly to Merton Housing Support about SP's risk history and risk assessment before SP's return to Links Road after the second episode of inpatient treatment.

10.56 We are not satisfied that the Merton housing support team was adequately informed of SP's risk history. There is no evidence that they were provided with a copy of the 17 December 2004 version of the CPA, even if it was discussed at meetings at Links Road. So far as being informed of the attack on Sanjaya Warnatilake is concerned, we do not think that it was adequate to rely on the fact that an updated CPA was sent under cover of the letter dated 31 October 2005. That letter was some six months after the event in question and four months after SP returned to live at Links Road following his discharge from hospital. It did not draw attention to the fact that the CPA contained significant new information relating to SP's risk assessment.

Recommendations

R18 The EIS should review its practice and procedure about informing local authority housing departments and carers under their supported housing schemes of the risk histories and risk assessments of service users and of significant revisions to the CPAs of service users.

R19 Merton Borough Council's housing support team should review its procedures for identifying and acting upon important information and documentation received by it and its arrangements for dealing with correspondence during staff absences.

11. Progress made on the implementation of the recommendations made by the internal investigation

11.1 The independent investigation terms of reference state that there should be a consideration of the actions of the trust in response to the death of Matthew Carter and there should be a review of any previous recommendations and the progress made in their implementation.

11.2 After the killing of Matthew Carter the trust carried out an internal investigation to review the history of its contact with SP. A report was completed which made recommendations for improvements to services. The report of the internal investigation team was submitted to the trust board on 6 June 2006.

11.3 The internal investigation made 16 recommendations and these, along with the internal report, were accepted by the trust board in June 2006. The recommendations are listed at appendix G. The trust developed an action plan to implement the recommendations. The action plan identifies senior trust staff ("leads") to take the recommendations forward. There have been three reviews of the progress on implementing the recommendations (January 2007, May 2007 and July 2007). A further review took place in February 2008

11.4 Ten of the 16 recommendations were trust-wide (R1, R3, R4, R5, R6, R7, R11, R12, R15 and R16). The remaining six were aimed specifically at the EIS (R2, R8, R9, R10, R13 and R14). The trust rejected recommendation seven.

11.5 The July 2007 review of the progress on implementing the action plan, which appears at appendix G, states that seven of the recommendations have been fully implemented, eight partially. A wider review of trust adult mental health services is underway. The review is taking into account the provision of the EIS service, the allocation of ward beds to certain teams and longer service opening hours. The review is due for completion in April 2008. The trust expects this will address the outstanding recommendations.

12. Postscript

12.1 Our terms of reference were to investigate the care and treatment of SP and, arising from that, to make "clear, sustainable and targeted recommendations". We understand that we were to undertake our investigation by reference to the legislative framework within which the services that dealt with SP had to operate. We did not think it would be expedient or timely for us to consider at length, or to seek to add our own recommendations to, the debate that has resulted in the passing of the MHA 2007. This act, which received royal assent in July 2007 and which will come into force in November 2008, makes provision, among other matters, for community treatment orders.

12.2 We suggest that if the mental health services that treated SP had had an explicit power to compel him to comply with treatment, the course of events in his care and treatment might have been different. The tragic death of Matthew Carter might have been avoided. It remains to be seen whether under the provisions of the new legislation, services dealing with patients like SP can and do manage their care so as to minimise the risks they pose, and prevent deaths such as that of Matthew Carter.

APPENDICES

Appendix A - List of abbreviations

ASW	Approved social worker
AWOL	Absent without official leave
CMHT	Community mental health team
CPA	Care programme approach
CPN	Community psychiatric nurse
CPS	Crown Prosecution Service
DH	Department of Health
DI	Detective inspector
GP	General practitioner
EIS	Early intervention service
ETHOS	Early treatment and home-based outreach service
LEO	Lambeth early onset
MHA	Mental Health Act 1983
MoU	Memorandum of Understanding
PICU	Psychiatric intensive care unit
PIG	Policy implementation guide
PCT	Primary care trust
RCA	Root cause analysis
SpR	Specialist registrar
NHS SMS	National health service security management service

Appendix B - List of witnesses

Witness	Role	Date interviewed
Dr Doreen Attard	Formerly senior house officer to Dr Dewsnap	Monday 11 June 2007
Dr Ashwin Balabhadra	Formerly senior house officer to Dr Dewsnap	Monday 18 June 2007
Nigel Bates	Formerly Merton housing manager	Monday 26 March 2007
Detective Inspector Andy Booth	Investigating police officer	Thursday 5 July 2007
DC	Matthew Carter's brother	Friday 12 October 2007
JC	Matthew Carter's mother	Friday 12 October 2007
Dr Trevor Chan	Formerly senior house officer with EIS	Friday 9 March 2007
Dr Brock Chisholm	Formerly clinical psychologist with EIS	Tuesday 13 March 2007
Mark Clenaghan	Service director: Merton	Friday 13 July 2007
Dr Paul Dewsnap	Consultant psychiatrist: East Mitcham CMHT / Jupiter ward	Monday 5 March 2007 Wednesday 13 June 2007
Julia Heathcote	EIS occupational therapist	Monday 12 March 2007
PC Alex Henderson	Metropolitan police constable	Tuesday 11 March 2008
Neil Hickman	Care coordinator / team manager of EIS / approved social worker	Friday 11 May 2007 Thursday 8 March 2007
Dr Ferdinand Jonsson	Formerly specialist registrar with EIS	Wednesday 13 June 2007
Felix Kadzombe	Formerly John Meyer ward primary nurse	Thursday 26 April
Dr Krishnan	Formerly senior house officer with EIS	Friday 9 March 2007
Rachel Langley	EIS occupational therapist	Monday 12 March 2007
Sharon Lartey	Carer	Wednesday 25 April 2007
Karen McNeil	EIS vocational worker	Tuesday 13 March 2007
Dr Parimala Moodley	Formerly consultant psychiatrist (John Meyer ward)	Monday 18 June 2007
Bernadette Nicholas	Housing support team manager / Sharon Lartey's manager	Wednesday 25 April 2007

Dr Felicity Nicholson	Forensic medical officer (Croydon)	Wednesday 28 March 2007
Dr Aileen O'Brien	Formerly specialist registrar to Dr Dewsnap	Tuesday 5 June 2007
Dr James Ovens	Formerly senior house officer to Dr Dewsnap	Monday 11 June 2007
LP	SP's mother	Wednesday 28 March 2007 Thursday 10 May 2007
SP	Perpetrator	Thursday 19 April 2007
Dr Ian Petch	Consultant clinical psychologist	Monday 12 March 2007
Jenny Scudamore	MHA office manager	Friday 13 July 2007
Prof Swaran Singh	Consultant psychiatrist	Thursday 26 April Monday 11 June 2007 Friday 20 July 2007
Chris Stanger	Trust criminal justice advisor	Monday 26 March 2007
Sanjaya Warnatilake	EIS community psychiatric nurse	Tuesday 13 March 2007

Appendix C - Documents reviewed

Clinical records

CPA records (Sept 04 - Aug 05)
FME (Croydon) records
GP notes
Notes from admissions (June 04, July 04, April 05)
Ward records (June 04 – September 06 and April 05 – June 05)

Internal investigation documentation

Internal investigation report
Internal investigation transcripts
SP internal inquiry action plan

Correspondence and other documentation

240 Links Road license agreement and miscellaneous records
Borough ethnic compositions
Correspondence / documents April 04 – Jan 06
Correspondence including: letter from solicitor (04/01/07), letter from GP Mina Patel (13/02/07)
EIS ethnic data (staff)
EIS message book
Letters from Neil Hickman
LP's diary of events
Note of interview with David Grafton LEO 25/05/07
Sentencing remarks
Sharon Lartey diary entries (2006)

Policies and procedures

CMHT operational policy

- CMHT GP alignment
- CMI action plan April 2003 – April 2005
- Core induction checklist
- Cover assessment and cover care planning documentation (to be obtained)
- Discharge from SEC.117
- Eligibility criteria
- Individual CMHT information
- Job description team leader
- Policy on copying correspondence to clients
- Supervision in the adult CMHT
- Transfer of care policy

Community zoning
Department of Health policy implementation guidelines
EIS comparison with mental health policy implementation guide
ETHOS operational policy (2007-2008)
ETHOS progress notes May 04 – February 06
ETHOS team meeting minutes (November 2001-November 2004)
ETHOS: draft review operational policy
ETHOS: operational policy
Guidance for managers on dealing with critical incident reporting
Guidance to approved social workers on nearest relative
Guidance to ASWs on nearest relative objectives to section 3 MNA
Healthcare Commission documents (including 2003/2004 report on trust performance of
South West London and St George's Mental Health NHS Trust
Home treatment and crisis resolution team operational policy
Jupiter ward admission rates May 2005
LB Merton license agreement
LB Merton service agreement

LB Merton service contract
London EIS outcome measures handbook
MAPPA policy (March 04)
Mental Health Act activity
Merton management supervision framework guidance notes
MHA commission annual reports (Sept 05 – Sept 06 and Oct 04 –Oct 05)
MHA papers section (June 04, July 04, April 05)
Missing person and AWOL policy
Monthly status report - action plan for critical incident enquiry with the EIT Jan 07
MoU between Crown Prosecution Service and NHS Security
Policy on the Care Programme Approach, care management, and risk assessment and management February 2001
Policy on the CPA, care management and risk assessment and management
Record keeping policy
Referral criteria and process
Risk assessment policy and guidance
SWL&StG's health and safety policy and procedure (2006)
Trust's prosecution protocol
Trust's training schedule

Relevant articles and academic papers

Franklin, Donna *et al* (2000) "Consultant psychiatrists' experiences of using supervising discharge: results of a national survey" *Psychiatric Bulletin* 24:412-415
Gabriel, Deborah (2007) "Psychiatry professor under fire again for denouncing institutional racism in mental health services" *Black Britain* 10 April 07
Power *et al* (2007) "Early Intervention in the Real World"
The Sainsbury Centre for Mental Health (2003) "A Window of Opportunity: a practical guide for developing early intervention in psychosis services"
Singh, Swaran Singh and Tom Burns (2006) "Race and Mental Health: there is more to race than racism" *BMJ* 333: 648-651

Appendix D – Timeline highlighting SP's care and treatment

Date/time					
	Date not known	**Jul-03**	**Apr-04**	**23-Apr-04**	**28-Apr-04**
Event					
	SP was arrested as a juvenile for fighting.	LP (SP's mother) noticed a deterioration in SP's mental state after this date	SP was seen by a private doctor in response to sleeping problems. He was diagnosed as having "mild schizophrenia".	SP registered with Wideway Medical Practice and saw GP Dr Patel	Dr Patel made a referral to consultant psychiatrist, Dr Dewsnap, at East Mitcham community mental health team (CMHT).

Date/time					
	7-May-04	**14-May-04**	**20-May-04**	**24-May-04**	**25-May-04**
Event					
	A letter was sent to SP from East Mitcham CMHT asking him to telephone to arrange an appointment. The letter was copied to Dr Patel.	SP did not telephone. Second letter sent to SP encouraging him to make appointment.	SP arrived late (by one hour) for his appointment. Dr Ovens saw SP for 2/3 minutes. SP was reported to be hearing voices and using cannabis. LP suspected use of crack cocaine. Diagnosed as having acute psychotic illness. Decision made to refer to the early intervention service (EIS).	The EIS made a telephone call to SP to give him a first assessment appointment (26 April 2004).	LP telephoned the EIS. She was unhappy that SP had been contacted and stated that she did not want him admitted and that he had been more agitated since the telephone call made on 24 May 2004.

Date/time					
	27-May-04	**6-Jun-04**	**7-Jun-04**	**7-Jun-04**	**10-Jun-04**
Event					
	LP telephoned Dr Dewsnap regarding SP's failure to attend a police station in response to charges of criminal damage.	An out-of-hours Mental Health Act (MHA) assessment was attempted at SP's grandmother's house. The assessment was cancelled due to an inability to obtain police attendance.	LP went to see GP Dr Jones and told him of the failed MHA assessment the night before. Dr Jones contacted a duty approved social worker and arranged assessment. SP was admitted to John Meyer Ward (JMW) under section 4 MHA.	At 5.45pm - SP placed in seclusion due to agitated behaviour.	Section 4 MHA was converted to a section 2 MHA

Date/time					
	11-Jun-04	**12-Jun-04**	**14-Jun-04**	**15-Jun-04**	**17-Jun-04**
Event					
	SP made several attempts to jump over JMW fence.	SP was reviewed by consultant psychiatrist Dr Moodley. Later that day SP absconded from JMW. He was felt to be a risk to self and others. The police suspected that SP might be with LP but not responding to messages. SP's father telephoned to say that SP was with his grandmother. His father advised that LP would conceal SP's whereabouts because she was reluctant to entrust mental health services with SP's care.	SP's father rang JMW to report that SP was with his grandmother. The information was passed to police.	Ward staff spoke with LP who advised that she did not know where SP was.	SP's father rang JMW to advise that he suspected that SP was staying at LP's address. A visit was carried out to LP's address by an ASW - there was no response. The ASW then visited SP's grandmother's address but SP could not be located.

Date/time					
	18-Jun-04	**19-Jun-04**	**22-Jun-04**	**4-Jul-04**	**5-Jul-04**
Event					
	A psychiatric report was completed by Dr Moodley	LP contacted JMW and asked if she could collect SP's property - she was told this would not be possible without SP's authorisation.	Wandsworth police telephoned JMW to advise that SP was with LP. Dr Ovens called LP who said she knew where SP was refused to disclose this information to him. LP advised that she would discuss matters with SP and phone JMW the next day.	While still absent SP attended church with his mother. After a disturbance SP was brought back to JMW by the police. He was placed in seclusion. Physical examination carried out.	SP was placed on section 5(2) MHA after section 2 MHA expired. Later that day he was placed on section 3 MHA.

Date/time					
	6-Jul-04	**10-Jul-04**	**11-Jul-04**	**12-Jul-04**	**13-Jul-04**
Event					
	SP was aggressive towards staff and placed in seclusion.	SP tried to grab a staff member's keys.	SP punched a window.	SP found a set of keys and absconded for a few hours from the ward. LP advised police who returned him to JMW.	SP was closely observed due to high risk of absconding

Date/time					
	15-Jul-04	20-Jul-04	22-Jul-04	24-Jul-04	26-Jul-04
Event					
	SP obtained a set of staff keys. Staff persuaded him to return them.	SP absconded from the ward for one hour. He was found by a home owner in his back garden. The police were called who returned SP to JMW.	SP intervened during the restraint of another patient.	SP assaulted two patients and attempted to grab a staff member's keys.	SP had an altercation with another patient. He was restrained and placed in seclusion

Date/time					
	28-Jul-04	3-Aug-04	10-Aug-04	12-Aug-04	13-Aug-04
Event					
	SP's observation levels were decreased.	SP was allowed in the ward garden under supervision	SP was transferred from JMW to Jupiter Ward.	SP refused medication despite the previous agreement that he would accept same.	A ward round was held with Dr Dewsnap: depot anti-psychotic medication prescribed. SP again refused medication. He was restrained and given rapid tranquilisation and depot injection. Transferred back to JMW.

Date/time					
	19-Aug-04	24-Aug-04	27-Aug-04	31-Aug-04	1-Sep-04
Event					
	SP was transferred back to Jupiter ward.	SP was recorded as being more settled: attending gym and observing boundaries. He was permitted two hours leave from ward.	An EIS member of staff attended ward round. Arranged a formal EIS assessment and attendance at the section 117 meeting in two weeks time. Dr Ovens spent time discussing medication with SP who was found to be "softening" to the idea of continuing to take medication. Allowed eight hours leave in every 24.	SP took overnight leave at LP's home.	SP returned to the ward as planned and accepted the depot anti psychotic injection as prescribed. He left the ward to go on leave to return on 3 September 2004.

Date/time					
	3-Sep-04	6-Sep-04	10-Sep-04	13-Sep-04	16-Sep-04
Event					
	The ward round identified that SP was well enough to be discharged but needed a review by the EIS first. SP returned from leave but left again until 6 September 2004.	SP returned to the ward and was assessed by two EIS staff (Dr Chan and Julia Heathcote). The service was explained to SP and he was given a leaflet. SP said his experience was due to taking his religious beliefs "too far". SP did not see medication as having a role in his recovery and felt that if given the choice he would stop taking medication. SP couldn't see the link between drug taking and his mental health problems. It was concluded that SP would be a suitable patient for the EIS.	A section 117 MHA meeting was held on Jupiter ward. SP, LP and Neil Hickman (EIS) attended the meeting. SP was recorded as questioning the need for medication and reluctantly agreeing to be seen by the EIS. It was agreed that EIS would provide follow-up care and continue attempts to persuade SP to accept depot anti psychotic injection. SP was discharged to LP's address from Jupiter ward.	Discussed at the EIS team meeting. A visit to SP was planned for 16 September 2004.	A home visit was carried out by SpR Dr Sasha Francis and community psychiatric nurse (CPN) Martin Keen. SP refused to continue to take antipsychotic medication. He agreed to maintain contact with EIS.

Date/time					
	24-Sep-04	**8-Oct-04**	**15-Oct-04**	**22-Oct-04**	**27-Oct-04**
Event					
	At the EIS team meeting Neil Hickman was allocated as SP's care coordinator and senior house officer (SHO) Dr Chan as second care coordinator. Later that day Dr Chan and Neil Hickman carried out a home visit to SP. A care programme approach (CPA) assessment was undertaken. It was agreed that the EIS would monitor SP weekly, that Neil Hickman would assist SP to apply for income support and take SP to see supported accommodation. The EIS vocational worker would consider SP's educational and employment options. Neil Hickman compiled a CPA record and Dr Chan prepared a relapse and risk management plan.	SP was seen in the presence of LP by Dr Chan.	Neil Hickman visited SP. Found to be "v positive" and "symptom free" and "generally making v good progress".	Neil Hickman visited SP. No psychotic symptoms were identified but he found SP to be "a little less communicative".	Neil Hickman and Vocational Worker Karen McNeil visited SP who "responded well to the vocational input". SP was recorded as being "symptom free".

Date/time					
	5-Nov-04	**10-Nov-04**	**16-Nov-04**	**17-Nov-04**	**26-Nov-04**
Event					
	Neil Hickman accompanied SP and LP to view supported accommodation. Although SP was recorded as being symptom free LP said that he had used cannabis again because of boredom.	Neil Hickman visited SP (LP was also present). Early warning signs of relapse were discussed.	Neil Hickman rang SP who confirmed that he wanted to pursue the supported accommodation.	Neil Hickman visited SP. He was found to be a "little negative in presentation". A Carer's Assessment form was given to LP at this meeting.	Dr Chan visited SP. He noted a lack of motivation. He reinforced the need for SP to take anti-psychotic medication and to avoid taking illicit drugs.

Date/time					
	3-Dec-04	**8-Dec-04**	**9-Dec-04**	**13-Dec-04**	**17-Dec-04**
Event					
	Neil Hickman visited SP (LP was also present). Neil Hickman noted that SP was symptom free but that he was sleeping for long periods and not achieving the practical goals that had been set.	LP telephoned Neil Hickman to check the progress made with SP's housing. She expressed her concern regarding SP's lack of motivation. A home visit was undertaken but there was no reply. A further home visit was planned for the following day.	There is no evidence that a visit was undertaken on this day.	Dr Patel advised the independent investigation panel that SP "left the GP practice" on this date.	A CPA review was due to take place but LP rang to advise that SP was refusing to see the EIS. Neil Hickman sent an email to Dr Dewsnap alerting him to SP's potential early warning signs.

Date/time					
	20-Dec-04	**21-Dec-04**	**22-Dec-04**	**10-Jan-05**	**13-Jan-05**
Event					
	SP's case was discussed in the EIS team meeting. It was agreed that Neil Hickman would write to SP. The letter invited SP to telephone Neil Hickman to discuss the best way for the EIS to maintain contact with him. The CPA and risk assessment were updated (date on form identified as 17 December 2004)	Neil Hickman telephoned LP who reported that SP was staying in bed all day. She wanted SP to move out as soon as possible and she also added that she did not like being called by the EIS.	Neil Hickman wrote to SP to arrange a home visit on 13 January 2005.	LP telephoned Neil Hickman. She reported that he "was much better over Christmas and New Year". Neil Hickman then telephoned SP and described him as "quiet but amenable".	Neil Hickman took SP to see the supported accommodation.

Date/time					
	17-Jan-05	**25-Jan-05**	**5-Feb-05**	**15-Feb-05**	**4-Mar-05**
Event					
	SP telephoned Neil Hickman to ask for details of the housing team.	Placement meeting was held between Neil Hickman, SP, Sharon Lartey the carer/owner of the supported accommodation and housing support team worker. Neil Hickman recorded that prompt nomination for independent accommodation would be needed.	SP moved into the supported accommodation during this week.	Neil Hickman visited SP at the supported accommodation but he was not at home.	Neil Hickman visited SP. He recorded that SP "presented as entirely symptom free" and that he had "settled into the property". Neil Hickman planned that he would discuss job search with Karen McNeil and that he would undertake a further review on 11 March 2005.

Date/time					
	11-Mar-05	**18-Mar-05**	**1-Apr-05**	**15-Apr-05**	**18-Apr-05**
Event					
	Neil Hickman reviewed SP with the housing support worker. He was found to be "very positive". Neil Hickman also recorded that SP had "settled in well" and that he was "stable and amenable".	A home visit was undertaken by Neil Hickman. SP was not at home. Neil Hickman left a note stating that he would telephone SP the following week.	Neil Hickman visited SP at home. He was found to be symptom free. Neil Hickman recorded that a CPA review was planned for 13 April 2005 and that he would telephone the housing department and that he would enquire about funds for a holiday grant.	LP telephoned Neil Hickman and told him that SP was in Jamaica. LP telephoned Neil Hickman later that day and advised that she had been told by relations that SP was unwell. It was agreed that Neil Hickman would telephone LP on Monday 18 April 2005 for an update.	Neil Hickman telephoned LP who advised that she had been told that SP was agitated and verbally hostile.

Date/time					
	20-Apr-05	**21-Apr-05**	**22-Apr-05**	**24-Apr-05**	**26-Apr-05**
Event					
	SP returned from Jamaica. LP telephoned Neil Hickman and asked him to visit urgently. Neil Hickman and CPN Sanjaya Warnatilake went to LP's house. They found SP to be acutely psychotic. They withdrew from the scene but SP assaulted Sanjaya Warnitalake. The police were called and SP was placed on section 4 MHA and admitted to JMW. He was violent on admission and required seclusion. He was diagnosed as having an acute psychotic episode and a relapse of paranoid schizophrenia.	SP assaulted a member of staff and was placed in seclusion.	SP slapped another patient and later kick boxed the same patient. He was placed in seclusion and given emergency tranquilisation. SP was placed on a section 3 MHA.	SP attempted to climb over the JMW garden wall but was prevented from doing so by staff.	At ward round it was planned that SP would be given oral medication but if this was refused then he would be given an intra-muscular injection.

Date/time					
	28-Apr-05	**30-Apr-05**	**1-May-05**	**2-May-05**	**3-May-05**
Event					
	SP resisted taking his medication. He assaulted a nurse and was placed in seclusion and given emergency tranquilisation.	A test dose of depot anti-psychotic injection was administered to SP.	SP became angry and agitated when he saw another patient being restrained. He was placed in seclusion.	SP attempted to climb the JMW wall. Staff prevented him from doing so.	SP assaulted another patient. Neil Hickman visited SP however he refused to have contact with Neil.

Date/time					
	6-May-05	**19-May-05**	**20-May-05**	**24-May-05**	**27-May-05**
Event					
	Ward review: SP noted to be "calm and appropriate at interview". He expressed some insight and advised that the "disturbing thoughts are less frequent now". Later he assaulted another patient.	SP was transferred to Jupiter Ward. The EIS Consultant Psychiatrist Dr Singh reviewed SP and noted that there had been an improvement since admission. He reinforced the need for SP not to take illicit drugs and to comply with treatment.	At Dr Dewsap's ward round it was agreed that a section 117 MHA planning meeting would be held on 27 May 2005.	At a ward psychology group SP said that the relapse in his mental illness was due to the pressures he experienced while in Jamaica. He advised that he now had insight and did not need medication.	The trust MHA office gave notice to Dr Dewsnap that SP had applied to the MHA Tribunal to be discharged and that a tribunal hearing had been convened for 27 June 2005. A MHA section 117 meeting was held. SP, LP and the EIS clinical psychologist Dr Chisholm were in attendance (Neil Hickman was on holiday). SP's mental state was noted to be stable. SP was placed on leave.

Date/time					
	31-May-05	**1-Jun-05**	**3-Jun-05**	**6-Jun-05**	**10-Jun-05**
Event					
	SP did not return from leave as planned.	SP returned from leave. Permitted further leave until 3 June 2005.	SP returned from leave. Given depot anti-psychotic injection and then discharged.	The EIS clinical psychologist Dr Chisholm and SHO Dr Ajay Krishnan visited SP. He was found to be "co-operative" and "calm" but also talked about God talking to him and feeling that his thoughts were being read.	CPN Amy Hon attempted to contact SP but he was not available. She contacted LP to advise her that SP should attend Jupiter ward to meet her on 16 June 2005 for his depot anti psychotic injection.

Date/time					
	16-Jun-05	**17-Jun-05**	**20-Jun-05**	**27-Jun-05**	**28-Jun-05**
Event					
	SP did not attend Jupiter Ward to meet Amy Hon as planned. Amy Hon telephoned SP but he was not available. She then telephoned LP who told her that SP had cancelled the appointment and that he had told her he did not want any more injections or to continue with medication. LP advised that SP had a new mobile telephone number but LP was unwilling to give this number for fear it would jeopardise her relationship with SP.	Amy Hon advised Neil Hickman that SP had not attended for depot anti-psychotic injection.	Neil Hickman telephoned LP who told him that SP was doing "v. well" and "looking for work". Neil Hickman planned to visit SP on 27 June 2005.	SP was not present when Neil Hickman visited.	SP telephoned Neil Hickman. A home visit was arranged for 30 June 2005.

Date/time					
	30-Jun-05	**1-Jul-08**	**3-Jul-05**	**7-Jul-05**	**21-Jul-05**
Event					
	Home visit carried out by Neil Hickman who noted "a concerning lack of recognition of the severity of the last relapse and assault" and that "he does not need medication". Neil Hickman wrote that a review was planned to take place on 7 July 2005, that a forensic referral would be discussed and that housing options would be reviewed.	Neil Hickman updated the risk assessment documentation of SP's CPA documentation.	SP was discussed at the EIS team meeting with reference to risk.	Planned home visit did not take place because of EIS commitments.	Planned home visit did not take place because of EIS commitments.

Date/time					
	22-Jul-05	**4-Aug-05**	**8-Aug-05**	**22-Aug-05**	**5-Sep-05**
Event					
	Home visit carried out but SP was not available. LP advised that he was at a job interview.	Neil Hickman telephoned LP who stated that SP was "v. well" and that he had started work.	A CPA meeting was held with SP. Dr Singh and Neil Hickman were present. Dr Singh recorded that there was a "significant risk of relapse but patient unwilling to engage".	Home visit carried out by Neil Hickman. SP was leaving the house and so contact was brief. Neil Hickman recorded SP "appears well and maintains he is nearly 100%" but that it was "difficult to see how we can contribute to any relapse prevention at present".	Home visit by Neil Hickman but SP was not at home. Neil Hickman sent a letter to SP stating that he would visit again on 21 September 2005.

Date/time					
	21-Sep-05	**12-Oct-08**	**13-Oct-05**	**24-Oct-05**	**26-Oct-05**
Event					
	SP was not at home when Neil Hickman visited him. Neil Hickman recorded that "it appears [SP] is disengaging". Neil Hickman recorded that he contacted the housing support team to arrange a review.	Neil Hickman received a telephone call from LP who passed the phone to SP. A home visit was planned for 13 October 2005.	Neil Hickman visited SP as arranged. He recorded that SP had returned to full-time education and this was the reason for SP not engaging. It was agreed that SP would meet with Neil Hickman on 25 October 2005 during one of his weekly visits to use the Springfield Hospital gym.	Neil Hickman telephoned LP in response to her message to him. She advised him that SP needed a medical certificate.	SP did not attend the appointment at Springfield Hospital. Neil Hickman tried to telephone him but his telephone was switched off.

Date/time					
	31-Oct-05	**2-Nov-05**	**3-Nov-05**	**11-Nov-05**	**21-Nov-05**
Event					
	Neil Hickman wrote to Bernadette Nicholas of the housing support team. Neil Hickman put forward SP as a candidate for low support housing under the housing department mental health quota.	SP telephoned Neil Hickman in reply to Neil Hickman's earlier message. Neil Hickman noted that SP "sounded fine".	Neil Hickman wrote to Wideway Medical Centre to establish whether SP was still registered with the surgery. The medical centre later advised that SP had left the practice in December 2004.	Neil Hickman noted that he received several telephone calls from SP. Neil Hickman noted that SP "seems to be stable at present".	The EIS team reviewed SP's case. The record of the meeting consisted of: maintaining contact with SP; considering referral back to CMHT and the possibility that SP could not be discharged because he was resident in supported accommodation.

Date/time					
	25-Nov-05	**8-Dec-05**	**3-Jan-06**	**13-Jan-06**	**23-Jan-06**
Event					
	LP telephoned Neil Hickman. She reported that SP was very well and achieving good results at university.	Neil Hickman carried out a home visit to SP. He recorded that SP appeared well.	LP telephoned the EIS and spoke to CPN Amy Hon. LP reported that there were problems with the electrics in SP's accommodation. This was reported to Sharon Lartey.	Neil Hickman made telephone calls to the housing support team and to LP regarding the maintenance of SP's accommodation.	SP telephoned Neil Hickman and reported her concerns that SP was showing early signs of relapse. Neil Hickman planned to telephone SP on 25 January, to liaise with the housing support team and to discuss SP in the EIS team meeting.

Date/time					
	24-Jan-06	**25-Jan-06**	**25-Jan-06**	**25-Jan-06**	**25-Jan-06**
Event					
	Neil Hickman telephoned and left messages for the housing support team and the owner of SP's accommodation.	Nigel Bates of the housing support team returned Neil Hickman's call. He said that he had no concerns about SP. He advised Neil Hickman that Sharon Lartey intended to close the accommodation and that SP would be issued with notice to quit.	Neil Hickman received a telephone call from Sharon Lartey who advised that she had issued a notice to quit. She felt that SP was fine when she saw him on the previous weekend however Neil Hickman advised her of the concerns expressed by LP.	Neil Hickman rang LP. She advised that she hadn't seen SP since the weekend and that she would speak to SP's brother about him visiting SP.	LP rang Neil Hickman. She advised that she had spoken to SP and also that she suspected that he was screening his telephone calls. Neil Hickman noted that LP would telephone him if she had any further concerns.

Date/time				
	26-Jan-06	**31-Jan-06**	**3-Feb-06**	**8-Feb-06**
Event				
	Neil Hickman discussed SP with the EIS team. He recorded the following concerns: SP not contactable; that there were early warning signs reported by LP; there were concerns about the risk that SP might pose to mental health staff when unwell and that LP was opposed to SP's admission to hospital. Neil Hickman noted that the plan would be to maintain liaison with relevant people; to continue to try to speak with SP; that there should be no impromptu visits at present; that the crisis service should be alerted and that EIS staff should consult either consultant psychiatrist Dr Singh or Neil Hickman before any visit was carried out.	Neil Hickman telephoned SP. Neil Hickman recorded that SP sounded 'absolutely fine' and that there were 'clearly no grounds to consider any formal assessment'.	Neil Hickman telephoned LP. She reported that she felt SP had settled having rested for a week. Neil Hickman recorded that he would visit SP on 8 February 2006	SP was stopped by police while driving a car in Croydon. He was arrested and charged with a motoring offence. He was reported to be agitated and upset at the police station . He was examined by a forensic medical examiner in the presence of LP. LP helped to calm SP down. It was concluded that he was not psychotic.

Date/time				
	9-Feb-06	**9-Feb-06**	**9-Feb-06**	**15-Feb-06**
Event				
	LP telephoned Neil Hickman and informed him of what had happened the previous day. Neil Hickman recorded that LP maintained that SP had the early signs of relapse and that he was distracted and talking to himself. Neil Hickman also recorded LP's opposition to SP's admission to hospital. LP requested a prescription to enable SP's brother to try to persuade him to take medicine.	Neil Hickman obtained a prescription and delivered it to LP.	Neil Hickman tried to telephone SP but it was not possible for the call to be connected. Neil Hickman also sent SP a text message asking him to make contact.	LP telephoned Neil Hickman. She described SP as stable but with early warning signs. She said that SP had reacted angrily when she tried to talk to him the day before about restarting medication. She said that he had not responded to her calls since this time. LP stated that SP continued to attend university and play football. Neil Hickman recorded that he would continue to try to speak to SP on the telephone and that he would speak to the EIS specialist registrar Dr Jonsson. Neil Hickman also recorded that that there was no clear evidence that a Mental Health Act assessment was justified.

Date/time			
	15-Feb-06	**16-Feb-06**	**19-Feb-06**
Event			
	Neil Hickman telephoned SP. The recording in the notes was made on 21 February 2006 after the events of the night of 18/19 February 2006. Neil Hickman recorded that SP sounded calm and rational but evasive about arranging contact with the EIS. SP stated that he did not want Neil Hickman to support him at the forthcoming court hearing although it was agreed that Neil Hickman would contact SP immediately after the hearing.	The recording in the notes was made on 21 February 2006 after the events of the night of 18/19 February 2006. An EIS team discussion was held during which it was agreed that attempts would be made to try to persuade SP to see Dr Jonsson and Neil Hickman on 22 February 2006	Matthew Carter was attacked and killed by SP.

Appendix E - Medication timeline

Date	Source of Information	Type of medication prescribed	Comments
09 Jun 2004	Prescription chart / progress notes	PRN Lorazepam 2mg (oral)	First inpatient episode: admitted to hospital 7 June 2004. Absent from hospital 12 June 2004
04 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Readmission to hospital 4 July 2004
05 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
06 Jul 2004	Prescription chart / progress notes	PRN Lorazepam 2mg (i/m)	
06 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
07 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
08 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
09 Jul 2004	Prescription chart / progress notes	Olanzapine 5mg (oral)	
10 Jul 2004	Prescription chart / progress notes	Olanzapine 5mg (oral)	
11 Jul 2004	Prescription chart / progress notes	Olanzapine 5mg (oral)	
12 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
13 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
14 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
15 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
16 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
17 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
18 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
19 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
20 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
21 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
22 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
23 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
24 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
25 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
26 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	Refused
26 Jul 2004	Prescription chart / progress notes	PRN Lorazepam 2mg (i/m)	
26 Jul 2004	Prescription chart / progress notes	PRN Haloperidol 10mg (i/m)	
27 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	

Date	Source of Information	Type of medication prescribed	Comments
28 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
29 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
30 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
31 Jul 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
01 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
02 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
03 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
04 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
05 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
06 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
07 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
08 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
09 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
10 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
13 Aug 2004	Prescription chart / progress notes	PRN Lorazepam 2mg (i/m)	
13 Aug 2004	Prescription chart / progress notes	PRN Haloperidol 5mg (i/m)	
13 Aug 2004	Prescription chart / progress notes	Zuclopenthixol decanoate 100mg (i/m)	
13 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
14 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
15 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
16 Aug 2004	Prescription chart / progress notes	Olanzapine 10mg (oral)	
18 Aug 2004	Prescription chart / progress notes	Zuclopenthixol decanoate 300mg (i/m) x 2 weekly	
01 Sep 2004	Prescription chart / progress notes	Zuclopenthixol decanoate 300mg (i/m) x 2 weekly	Discharged from hospital 10 September 2004
16 Sep 2004	Prescription chart / progress notes	Zuclopenthixol decanoate 300mg (i/m) x 2 weekly	Offered by EIS. Refused
20 Apr 2005	Prescription chart / progress notes	PRN Olanzapine 10mg (i/ml)	9.20pm Second inpatient episode
20 Apr 2005	Prescription chart / progress notes	PRN Lorazepam 2mg (i/m)	9.20pm
20 Apr 2005	Prescription chart / progress notes	PRN Haloperidol 5mg (i/m)	9.45pm
21 Apr 2005	Prescription chart / progress notes	Olanzapine 20mg	Refused
22 Apr 2005	Prescription chart / progress notes	Olanzapine 20mg	Refused

Date	Source of Information	Type of medication prescribed	Comments
22 Apr 2005	Prescription chart / progress notes	PRN Olanzapine 10mg (i/m)	9.20pm
22 Apr 2005	Prescription chart / progress notes	PRN Haloperidol 10mg i/m	9.20pm
22 Apr 2005	Prescription chart / progress notes	PRN Lorazepam 2mg (i/m)	9.20am
22 Apr 2005	Prescription chart / progress notes	PRN Lorazepam 2mg (i/m)	9.20pm
23 Apr 2005	Prescription chart / progress notes	Olanzapine 10mg (i/m)	
24 Apr 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
25 Apr 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
26 Apr 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
27 Apr 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
28 Apr 2005	Prescription chart / progress notes	PRN Lorazepam 2mg (oral)	
28 Apr 2005	Prescription chart / progress notes	Olanzapine 10mg (i/m)	
29 Apr 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
30 Apr 2005	Prescription chart / progress notes	Zuclopenthixol decanoate 100mg (i/m)	
01 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
02 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
03 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
04 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
05 May 2005	Prescription chart / progress notes	Zuclopenthixol decanoate 200mg (i/m)	
05 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
06 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
07 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
08 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
09 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
10 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
11 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
12 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
13 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
14 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
15 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
16 May 2005	Prescription chart / progress notes	Olanzapine 20mg (oral)	
17 May 2005	Prescription chart / progress notes	Olanzepine 10mg (oral)	Olanzapine 20mg reduced to 10mg on this date

Date	Source of Information	Type of medication prescribed	Comments
18 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
19 May 2005	Prescription chart / progress notes	Zuclopenthixol decanoate 200mg (i/m)	
19 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
20 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
21 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
22 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
23 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
24 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
25 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
26 May 2005	Prescription chart / progress notes	Olanzapine 10mg (oral)	
27 May 2005	Progress notes		Oral medication discontinued on 27 May 2005
02 Jun 2005	Prescription chart / progress notes	Zuclopenthixol decanoate 200mg (i/m)	Discharged from hospital 3 June 2005
16 Jun 2005	Prescription chart / progress notes	Zuclopenthixol decanoate 200mg (i/m)	Offered by EIS. Refused

Appendix F - Mental health policy implementation guide: section 5

5. EARLY INTERVENTION IN PSYCHOSIS

5.1 Who is the service for?

- People aged between 14 and 35 with a first presentation of psychotic symptoms
- People aged 14 to 35 during the first three years of psychotic illness

5.2 What is the service intended to achieve?

Psychosis is a debilitating illness with far-reaching implications for the individual and his/her family. It can affect all aspects of life – education and employment, relationships and social functioning, physical and mental wellbeing. Without support and adequate care, psychosis can place a heavy burden on carers, family and society at large.

The mean age of onset of psychotic symptoms is 22 with the vast majority of first episodes occurring between the ages of 14 and 35. The onset of this disease is therefore often during a critical period in a person's development.

At present it can take up to two years after the first signs of illness for an individual and
his/her family to begin to receive help and treatment. Lack of awareness, ambiguous early symptoms and stigma all contribute to the delay in appropriate help being offered and taken up.

Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal harm. One in ten people with psychosis commits suicide - two thirds of these deaths occur within the first five years of illness.

Intervening early in the course of the disease can prevent initial problems and improve long term outcomes. If treatment is given early in the course of the illness and services are in place to ensure long-term concordance (co-operation with treatment), the prospect for recovery is improved.

An early intervention service should be able to:

- reduce the stigma associated with psychosis and improve professional and lay
- awareness of the symptoms of psychosis and the need for early assessment.
- reduce the length of time young people remain undiagnosed and untreated
- develop meaningful engagement, provide evidence-based interventions and promote recovery during the early phase of illness
- increase stability in the lives of service users, facilitate development and provide opportunities for personal fulfilment
- provide a user centred service i.e. a seamless service available for those from age 14 to 35 that effectively integrates child, adolescent and adult mental health services and works in partnership with primary care, education, social services, youth and other services
- at the end of the treatment period, ensure that the care is transferred thoughtfully and effectively

Evidence indicates that the following principles of care are important:

- Culture, age and gender sensitive
- Family orientated
- Meaningful and sustained engagement based on assertive outreach principles
- Treatment provided in the least restrictive and stigmatising setting
- Separate, age appropriate facilities for young people
- Emphasis on normal social roles and service user's development needs, particularly involvement in education and achieving employment
- Emphasis on managing symptoms rather than the diagnosis.
- A typical early intervention service will aim to meet the needs of a million total population. The service will comprise 3 or 4 teams and appropriate respite facilities. By April 2004 each early intervention service will have established its first team. The overall service will be established during the lifespan of the NSF through the initial investment and service restructuring/reinvestment. The exact configuration of the 50 services will be established on a regional basis.

5.3 What does the service do?

The service has a number of key components. Each must be in place if the service is to operate successfully.

Table 5a

Key components	Key elements	Comments
GENERAL		
Raising awareness of psychotic illness	• Active involvement in community-based programmes to reduce stigma associated with psychotic illness • Symptom awareness programmes for primary care, educational institutions, social services and other relevant agencies	• See service specification for Mental Health Promotion Framework (section 7 of this guide) for information on effective programmes • Awareness programme needs to emphasise the often ambiguous and subtle ways in which psychotic illness can develop
Focus on symptoms	• All professionals need to understand the many and varied ways in which psychosis can develop and the spectrum of 'normal' mood and behavioural changes that can occur during adolescence and early adulthood • Professionals and agencies working at the first point of contact must feel free to refer young people for an expert assessment based on suspicion rather than a certainty of psychosis • Treatment needs to focus on management of symptoms and sufficient time needs to be allowed for symptoms to stabilise before a diagnosis is made	• Diagnosis can be difficult in the early phases of a psychotic illness. The services should be able to adopt a 'watch and wait' brief when the diagnosis is unclear

Age, culture and gender sensitive service	• Effective links with youth and young person's services should be established • 24 hour access to translation services should be available • Single sex accommodation and gender sensitive services should be provided (See section 8 for guidance on developing culturally competent services)	• Onset of symptoms usually occurs in adolescence or early adulthood. Services need to reflect this. • The high prevalence of diagnosed psychosis in certain groups emphasises the importance of culturally competent services • Specialist services that comply with the Children Act are needed for service users who are 14 to 18 years old
ASSESSMENT		
Early detection	• Training programmes and written guidance for GPs and other key agencies are needed on the importance of early detection and how to refer people with potential early psychosis • Regular audit of effectiveness of referral pathways and training programmes	• Pathways of care must be explicit and understood by all involved • Access to assessment should be easy and rapid

Assessment	•Service user centred, multidisciplinary assessment co-ordinated by care coordinator •Sufficient time should be allowed to develop a relationship and let symptoms stabilise •Physical Health Assessment where appropriate	Comprehensive assessment to include as a minimum: • Psychiatric history • Mental state examination • Risk - including suicide risk • Social functioning and resource assessment • Psychological assessment • Occupational assessment • Family/support assessment • Service user's aspirations and understanding • Contribution from people important to the service user
Production of comprehensive care plan	•Initial care plan produced within a week of assessment •Initial care plan comprehensively reviewed at three months •Care plan updated at least six monthly	• Care plan flexible enough to adapt to changes in the level and type of care required
INTERVENTIONS		
Early and sustained engagement	•Allocation of dedicated community-based care co-ordinator to each service user •Assessment should take place in the service user's home or other low stigma setting •Sustained engagement using an assertive outreach approach so that no service users are 'lost to follow up'. •Failure to engage in treatment should not lead to case closure.	• Lack of clear diagnosis should not lead to case closure. Instead an active 'watching brief' should be adopted if there is a suspicion of psychotic illness but no firm diagnosis. • See Assertive Outreach Service Specification (section 4 of this guide) for more information on the assertive outreach approach • Focusing on the strengths and interests of the service user and the benefits that contact with the service can bring can help improve engagement and concordance (co-operation) with care
		• Local evidence-based prescribing and therapy protocols should be

Medication	•Use of **low** dose or atypical neuroleptics first line and consideration of mood stabilisers and antidepressants if appropriate •Service user involved in decision making and monitoring effects •Care designed to improve concordance •Standard side effect monitoring tools to be used regularly by staff and service user	developed and used • Choice of medication dependant on clinical condition • Specialist support from CAMHS expertise needed when prescribing for under 16 year-olds • Avoidance of and careful attention to side effects are important to ensure effective treatment and long term engagement with services

Psychological therapies	•Use of cognitive behavioural therapy as appropriate •Psycho-education •Information provided to service user about local recovery or service user groups	• Cognitive behavioural therapy can be of considerable benefit to service users • Promotion of coping skills is vital
Family/carers/ Significant others involvement and support	•Family/carers/significant others should be involved in assessment and treatment process as early as possible •Provision of psycho-education, family therapy and support •At least monthly contact with family/carers/significant others •Connexions workers	• Engagement of family/friends improves assessment, and the long term outcomes of the service user, and can alleviate stress within the family. • Care must be taken to engage and support **all** those important to the service user. This is particularly important if the service user has left home
Addressing basics of daily living	Care plan should address all aspects of daily living	• Unstable living and financial circumstances are known vulnerability factors for relapse. • However, early reliance on disability allowance can hamper rehabilitation and chances of finding valued employment. Every effort must be made to provide an effective pathway to valued education and occupation

Providing pathway to valued education and occupation	•Vocational assessment (if required) should take place within 3 months of referral •An education or training plan/pathway to valued employment should be produced within 3 months	• Formal links with key agencies and schemes such as local careers advisory services, ConneXions, New Deal, Training and Enterprise Agency, further education colleges, voluntary organisations etc. must be established. • Early referral is vital. The longer an individual remains out of work/education in the early phase, the harder it becomes to gain employment/participate in education later on.
Treating co-morbidity	Regular assessment of common co-morbidity's particularly: • Substance misuse • Depression/suicidal thoughts • Anxiety disorders	• Early intervention team should have core skills to assess and deal with common co-morbidities. • Specialist help for any of these conditions should also be available. Care co-ordinator should co-ordinate provision of care as appropriate. If referral is necessary, early intervention team should continue to have overall responsibility for the service user.

Relapse prevention plan	•Individualised early warning signs plan developed and on file •Relapse prevention plan agreed with service user and involve family/carers	• Changes in thought, feelings and behaviours precede the onset of relapse but there is considerable variation between service users. Development of individualised plans can be effective in reducing the severity of relapse.
Crisis plan	•Service user/family/carers know when and how to call for help •Intensive support in the community provided by the team during the crisis •If acute care is thought to be required, joint assessment should take place between early intervention team, crisis team and/or acute care team so that the least restrictive / stigmatising setting for care is arranged	• Avoidance of restrictive / stigmatising care wherever possible • As much treatment provided in the community/service user's home as possible • Links with crisis team to ensure 24 hour crisis team available

Inpatient and respite care	•Avoidance of hospitalisation if possible and provision of alternatives to hospital care e.g. community hostels, cluster homes, day care •If hospitalisation is needed • Separate age, gender and culture appropriate accommodation should be provided • Regular, formal joint (inpatient and early intervention staff) review to ensure service user is transferred to the lowest stigma/restrictive environment as soon as clinically possible • Early intervention team to be actively involved in discharge planning	• Avoidance of trauma and stigma associated with hospitalisation is important to reduce harm and ensure long term engagement • Service user/family/carers involved in decision making and discharge planning as much as possible • Primary care and other services to be involved in discharge planning as appropriate and kept informed of discharge plans
Regular review	•Regular team review of effectiveness of care •Second and third line pharmaceutical and range of psychological treatments considered where necessary	• Local evidence-based prescribing and therapy protocols should be developed and used • Avoidance of and careful attention to side effects are important in ensuring effective treatment and long term engagement with services • Service user actively involved in decision making and side effect monitoring

Discharge	The following discharge possibilities could be considered: •If stable and well - discharge to primary care with yearly joint consultant/primary care review •If unstable and fulfilling criteria for assertive outreach, refer to the Assertive Outreach Team •If many negative symptoms and unwell, refer for rehabilitation and ongoing care •If well but concerns about ability of primary care to care for service user - follow up as an outpatient •If service user moves homebefore three years, the Early Intervention Team should continue care until care package established in new area	• Usually a service user will require care from the Early Intervention Team for three years. • There should however be flexibility regarding the 'three years' with early discharge arranged for stable service users and later discharge possible if engagement and stabilisation were problematical early in the course of illness • Continuity of care is vital. Early intervention team should not disengage with the service user until adequate contact with other services has been established

Links with crisis resolution/home treatment team

For users aged 14 or over, the crisis resolution/home treatment team can provide crisis
care out of hours – see crisis resolution/home treatment service specification for more
details (section 3 of this guide).

Local arrangements have to be made between the crisis resolution/home treatment team, the early intervention team and child and adolescent mental health services (CAMHS) to ensure service users who are under 16 years old have adequate and rapid access to an out of hours crisis service.

As one of the principles of early intervention services is the maintenance and reestablishment of the integration of users with age appropriate mainstream community services, there need to be a wide range of close links fostered. This will include close ties with primary care, education, youth agencies, leisure providers and a variety of other services across the voluntary and statutory sectors.

5.4 Management of Service and operational procedures

Joint commissioning

A joint commissioning approach involving PCGs/PCTs, HAs and social services should be
adopted with commissioners being advised by the advisory group (see under formation of service).

Model of service delivery

Early intervention services are best provided by a discrete, specialist team that has:

- Staff members whose sole (or main) responsibility is the management of people in the early phase of psychotic illness
- An adequate skill mix within the team to provide all the interventions listed above
- Strong links with other mental health services and a good general knowledge of local resources.
- Clarified medical responsibility for patients. This would normally be integrated within the team and maximally supportive of the team intervention.

Formation of service

Year 1 (2001-2002)

- Set up a project management team (PMT) to include as a minimum adult mental health services (health and social care) and child and adolescent mental health services (health and social care)
- The employment of a project manager to oversee the formation of the early intervention service should be considered [moved up and team altered to service]
- Set up an advisory group that includes a broad range of stakeholders (e.g. young service users, their carers, youth agencies, education, criminal justice, drug and alcohol, leisure, primary care)
- Develop an implementation plan that includes
    A. the overall long-term plan to establish the early intervention service over the lifespan of the NSF
    B. the detailed plan to establish the first team between April 2002 and March 2004
- The PMT should set up an audit of pathways of care, should map current service provision and establish the number of people aged 14-35 with possible psychosis presenting to mental health services for the first time. Information from this audit should then be used to develop an implementation plan and be reported in the comprehensive review of services (see Chapter 8).

Years 2 and 3 (2002-2004)

- The first team should be set up, recruited, trained
- There should be ongoing development of the overall service including ongoing population-based audit of how the needs of young people with first episode psychosis are being met.

Caseload

Ideally each Early Intervention Service should manage 150 new cases per year and have a total caseload of approximately 450. It is envisaged that each Early Intervention Service will cater for a population of around 1 million people. An understanding of local epidemiology is needed as the size of population covered will depend on a number of different factors including:

- Geography of the area
- Health and Social Service boundaries
- Demography and epidemiology

Teamwork is vital for success. Dividing the service into a number of teams (three or four), each managing a caseload of 30 to 50 new cases per year and 120 to 150 in total, optimises the benefits of working within a team framework. Each service should therefore consist of a number of teams.

Staffing

The table below gives details of suggested staffing levels and skill mix for a team with a caseload of 120 to 150.

Table 5b	
Care co-ordinators Key skills: • High energy level • Team player • Ability creatively to engage service users • Understanding of needs of service users, including specific needs related to cultural background/age/gender etc • Able to co-ordinate care and provide broad range of interventions • Works well with young people	Total 10 wte care co-ordinators with service user to care co-ordinator ratio maximum 15 to 1 Team leader must have an active caseload Appropriate mix of psychiatric nurses, ASWs, OTs, psychologists needed to ensure that all the interventions listed can be provided within the team
Psychiatrists – adult mental health • Active members of the team • Dedicated sessions	0.5 wte adult consultant psychiatrist 1.0 wte non career grade psychiatrists
Psychiatrists – CAMHS • Active members of the team • Dedicated sessions	0.1 wte CAMHS consultant
Specialist skills - adult • These skills should be available within the team either by employing a fully qualified practitioner or by training other team members • External supervision, support and training needed for 'non specialists' providing these interventions	• OT/OT skills • Psychologist/psychology skills • ASW/strong links to social services and ability to undertake thorough assessment and activate services as needed
Specialist skills – CAMHS	0.2 wte clinical psychologist with special interest in CAMHS
Support workers • People with health, social care or appropriate life experience or personal experience of mental health problems/treatment	• Number of support workers to be determined by the team • Support workers to reflect the demography of the local population
Programme support	• 1 wte administrative assistant IT, audit and evaluation support may also be needed

Hours of operation

- Core working hours should be 8am to 8pm, 7 days a week
- Out of hours (8pm to 8am) - advice should be available from staff at the community respite facility or alternative (either by telephone or by visiting the unit) or from an on-call member of the Early Intervention Team
- Note there is no provision for home visits out of hours. Service users should be referred to crisis resolution/home treatment team/out of hours CAMHS service if home visit is required (see above).

Referrals

Early intervention is a specialist service. The service should take direct referrals from CMHTs, CAMHS, primary care, crisis resolution/home treatment team, forensic services,
assertive outreach, other mental health services, acute medical services (including A+E).

Provision of alternative residential care

Each service requires easy access to community respite care appropriate to each age group:

- Respite beds for adults over 22 years of age (separated from other mental health facilities)
- Young person's beds (adults aged 16 to 22)
- Regional unit adolescent beds

Risk assessment and policy on violence

- Each team should have a written policy outlining the level of risk the team is able to manage
- Operational policy should explicitly address staff safety

Staff training should include:

- Principles of the service
- Training in all key components listed above
- Team building, colleague support and working within a team framework
- Medication – storage, administration, legal issues, concordance training and side effect management, prescribing to under 16 year olds
- Use of Mental Health Act and alternatives to hospital treatment
- Understanding of the Children Act
- Benefits to service user and family/carers of this service
- Suicide awareness and prevention techniques

Service user information

Service users and their family should be provided with the following information:

- Description of the service, key elements and what to expect
- Name and contact details of care co-ordinator and other relevant members of the team
- Contact details for out of hours advice/intervention
- Information about assertive outreach approach and benefits of maintaining regular contact
- Ongoing care plan and information about medication
- Relapse prevention and crisis plan
- How to express views on the service

5.5 Evidence for Further Reference

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Appendix G - Recommendations made by the internal investigation

1. The Trust should ensure that Good Practice Guidelines are developed so that Adult Mental Health Teams can benchmark their practice and performance against them, and have a mechanism to help them work appropriately when dealing with difficult situations. Such a good practice guideline would cover issues such as how mental health services should engage with service users who are reluctant to engage with services, and advice on what to do when attempts to engage do not succeed.
2. The Operational Policy of the ETHOS EIS should be reviewed (it was due in April 2006) to see whether it is still appropriate in the light of this report.
3. The Trust should review its procedure regarding the prosecution of service users in the event of incidents against staff, and the relationship with the police. A formal meeting between the Trust, the police and the CPS could be useful to clarify issues, and to agree a formal protocol based on the 11 June 2001 letter quoted above.
4. It would also be useful if the role of the Trust Criminal Justice Advisor could be extended to 'progress chase' any cases where the Trust is seeking a prosecution to ensure that the right process is followed in a timely manner, and that all those involved are informed of progress. The development of closer liaison with the Legal Protection Unit could also be included with the role.
5. Guidance should be issued to practitioners faced with a situation in which a section 3 assessment would appear to be indicated according to the Code of Practice but the nearest relative objects. This guidance should specifically address those circumstances in which (a) there is judged to be an immediate and serious risk, either to the patient of to others, and (b) applying to the county court for displacement of the nearest relative may involve an unacceptable delay. (To be considered with Recommendation 1 regarding the development of Good Practice Guidance).
6. The Trust should make sure that when a member of staff is assaulted, or suffers any other traumatic event in the course of their work, that staff member is offered appropriate help and support (which is Trust policy) but that other members of the team and/or the whole team have the opportunity for a facilitated debrief to clarify their thoughts and feelings about the incident.

7. The Trust should make sure that when a service user faces prosecution, including for an assault on a member of staff, and circumstances allow it, consideration is given to providing that service user with the opportunity for a facilitated debrief to clarify their thoughts and feelings about the incident/prosecution. This may be with the staff member assaulted and/or other members of staff depending upon the individual circumstances of the situation, depending too on the wishes and feelings of the staff member assaulted.
8. The EIS should examine the role of the MDT meetings, and look towards the purpose of the 'acute list' being to stimulate discussion, challenge and suggest alternative strategies for the handling of cases where there are blockages or difficulties in securing full engagement by service users. The function of the Thursday meeting needs to be reviewed.
9. The Trust should issue guidance to the effect that where a service user has been assessed as being in the 'Red Zone' for a period of six months the case should be considered for peer reviewed by other clinicians within the Trust to provide suggestions for alternative interventions (The Oxford Model). This could link to recommendation 1 and the issuing of Good Practice Guidelines.
10. Where a service user is failing or refusing to engage with the EIS it should consider a change in the care coordinator. This is not to imply criticism of the existing member of staff fulfilling the role, but is an open and honest attempt to see if the service user might respond in a different way to a different member of staff and a different approach.
11. The Trust should include in Practice Guidance notes that the needs of carers should be taken into account. In many situations there is often a need for people in a caring role to be assertively approached and for the member of staff to stress the need for those caring to become fully involved in their own right. Consideration be given regarding how best the carer can be supported, and not to assume that it has to be via the same member of staff working with the service user.
12. The Trust should examine its provision of support to the carer of the service user in cases where they commit serious crimes, and discuss with the police and other relevant agencies how support might best be given. The appropriate role for each agency should be agreed, together with a mutual

understanding on how they can most usefully work together to meet the specific needs of both victim, victim's family, service user and carer.

13. The Trust should review the working of the EIS with a view to reducing its isolation by ensuring that is has its own inpatient beds co-located with the team thus allowing the continuity of Responsible Medical Officer status, and a wider staff base with a shared ideology and set of working principles.
14. The Trust should review the Operational Policy of the ETHOS EIS to see whether its hours of operation should be increased to comply with the Department of Health Policy Implementation Guidance. The possibility of the EIS having a member of staff available for phone contact 24 hours a day should be explored in line with the same Department of Health Guidance. This should be done in conjunction with Recommendation 13 about it having its own beds.
15. The Trust should take steps to ensure that inpatient case notes any recorded incidents are reviewed monthly and collated with a summary, and filed in a separate section of the file for ease of reference.
16. The Trust should review the position of professional supervision within the community teams, including the EIS, and in order to ensure that such supervision takes place, make it mandatory.

Appendix H - SP internal inquiry action plan

Last Updated: **February 2008**
July 2007
May 2007
January 2007

Recommendation 1 **SP**	**Action**	**Progress to date**	**Lead**	**Expected Completion date**
The Trust should ensure that Good Practice Guidelines are developed so that Adult Mental Health Teams can benchmark their practice and performance against them, and have a mechanism to help them work appropriately when dealing with difficult situations. Such a good practice guideline would cover issues such as how mental health services should engage with service users who are reluctant to engage with services, and advice on what to do when attempts to engage do not succeed.	Development of DNA policy incorporating guidance on management of 'difficult to engage' patients.	DNA and 'difficult to engage' patients guidance incorporated within revised CPA policy.	Mark Potter	Completed.
	Review risk management training	Stage 1 risk management training undertaken for all Trust staff. The new mandatory Patient safety and clinical risk level one training has been rolled out across trust services for all clinical staff. This is being undertaken by a (secondee position) risk management trainer.	Maresa Ness	Completed
		Stage 2 risk management training to be rolled out from Oct'07.	Maresa Ness	Ongoing

		Level 2 clinical risk training was launched in December 07 and is available to all community and inpatient clinical staff. All of the above is incorporated in the clinical risk and vulnerability policy ratified in September 2007.		
Recommendation 2 **SP**				
The Operational Policy of the ETHOS EIS should be reviewed (it was due in April 2006) to see whether it is still appropriate in the light of this report.	EIS Policy to be reviewed within context of wider reviews of adult service models in Wandsworth, Merton & Sutton	Operational policy review undertaken and implemented. EIS Operational policies for separate S&M and W EIS services being developed.	Mark Clenaghan Mark Clenaghan Stuart Thomson	Completed April '08
Recommendation 3 **SP**				
The Trust should review its procedure regarding the prosecution of service users in the event of incidents against staff, and the relationship with the police. A formal meeting between the Trust, the police and the CPS could be useful to clarify issues, and to agree	Protocol to be developed.	Protocol developed, agreed and launched	Mark Clenaghan	Completed

a formal protocol based on the 11 June 2001 letter quoted above				
Recommendation 4 **SP**				
It would also be useful if the role of the Trust Criminal Justice Advisor could be extended to 'progress chase' any cases where the Trust is seeking a prosecution to ensure that the right process is followed in a timely manner, and that all those involved are informed of progress. The development of closer liaison with the Legal Protection Unit could also be included with the role	CJA role to be reviewed	CJA role to 'progress chase' confirmed within protocol.	Kim Goddard	Completed.
Recommendation 5 **SP**				
Guidance should be issued to practitioners faced with a situation in which a Section 3 assessment would appear to be indicated according to the Code of Practice but the nearest relative objects. This guidance should specifically address those circumstances in which (a) there is judged to be an immediate and serious risk, either to the patient of to others, and (b) applying to the county court for displacement of the nearest relative may involve an unacceptable delay. (To be considered with Recommendation 1	Policy to be developed	Policy developed, ratified and implemented	Kim Goddard	Completed

regarding the development of Good Practice Guidance)				
Recommendation 6 **SP**				
The Trust should make sure that when a member of staff is assaulted, or suffers any other traumatic event in the course of their work, that staff member is offered appropriate help and support (which is Trust policy) but that other members of the team and/or the whole team have the opportunity for a facilitated debrief to clarify their thoughts and feelings about the incident	This is normal practice and reflected in Trust Critical Incident Policy (TWC 10) – App.4 'Support and Information Following Incidents'.	Completed	Service Directors	Completed.
Recommendation 7 **SP**				
The Trust should make sure that when a service user faces prosecution, including for an assault on a member of staff, and circumstances allow it, consideration is given to providing that service user with the opportunity for a facilitated debrief to clarify their thoughts and feelings about the incident/prosecution. This may be with the staff member assaulted and/or other members of staff depending upon the individual circumstances of the situation,	This recommendation is not accepted in that such a facilitated de-brief would contaminate any evidence for such a prosecution.			

depending too on the wishes and feelings of the staff member assaulted				
Recommendation 8 **SP**				
The EIS should examine the role of the MDT meetings, and look towards the purpose of the 'acute list' being to stimulate discussion, challenge and suggest alternative strategies for the handling of cases where there are blockages or difficulties in securing full engagement by service users. The function of the Thursday meeting needs to be reviewed	Implement Zoning in EIS Zoning to be implemented in all Trust services.	Zoning implemented in EIS (Operational Policy paras.14.2 and 16.5) Zoning project managing training and implementation across all Trust services.	Mark Clenaghan Maresa Ness	Completed. April'08
Recommendation 9 **SP**				
The Trust should issue guidance to the effect that where a service user has been assessed as being in the 'Red Zone' for a period of six months the case should be considered for peer reviewed by other clinicians within the Trust to provide suggestions for alternative interventions (The Oxford Model). This could link to recommendation 1 and the issuing of Good Practice Guidelines	Oxford model for peer review of difficult cases to be introduced	Oxford model introduced in Nov.06 as part of Merton governance process. Peer review process of reviewing critical incidents introduced for senior Trust clinical and managerial staff	Geraldine Fitzpatrick Maresa Ness	Ongoing. Completed.

Recommendation 10 **SP**				
Where a service user is failing or refusing to engage with the EIS it should consider a change in the care coordinator. This Is not to imply criticism of the existing member of staff fulfilling the role, but is an open and honest attempt to see if the service user might respond in a different way to a different member of staff and a different approach	Change of care coordinator to be considered as an option within care delivery in EIS.	This has been introduced within clinical review meetings within EIS, and reflected in operational policy (Para.11.2).	Mark Clenaghan	Completed.
Recommendation 11 **SP**				
The Trust should include in Practice Guidance notes that the needs of carers should be taken into account. In many situations there is often a need for people in a caring role to be assertively approached and for the member of staff to stress the need for those caring to become fully involved in their own right. Consideration be given regarding how best the carer can be supported, and not to assume that it has to be via the same member of staff working with the service user	Current procedures of assessing care need and supporting/involving carers to be reviewed.	Carer needs to be determined through carer assessment process. Close working relationships with carers and carer representatives in each borough.	Service Directors Service Directors	Ongoing Ongoing

Recommendation 12 **SP**				
The Trust should examine its provision of support to the carer of the service user in cases where they commit serious crimes, and discuss with the police and other relevant agencies how support might best be given. The appropriate role for each agency should be agreed, together with a mutual understanding on how they can most usefully work together to meet the specific needs of both victim, victim's family, service user and carer	Support for carer of service users who have committed serious crimes to be progressed through Memorandum of Understanding.	Memorandum of understanding discussed and agreed in all Police Liaison meetings in 5 boroughs.	Service Directors	Completed
Recommendation 13 **SP**				
The Trust should review the working of the EIS with a view to reducing its isolation by ensuring that is has its own inpatient beds co-located with the team thus allowing the continuity of Responsible Medical Officer status, and a wider staff base with a shared ideology and set of working principles	EIS to have direct access to in-patient beds on one ward to ensure in-patient/community continuity of care.	Staged process agreed - Disaggregate S&M and W EIS into two separate teams. - Review models and capacity for EIS in-patient beds within wider review of Trust beds	Mark Clenaghan Maresa Ness	April'08 Sept'08

Recommendation 14 **SP**				
The Trust should review the Operational Policy of the ETHOS EIS to see whether its hours of operation should be increased to comply with the Department of Health Policy Implementation Guidance. The possibility of the EIS having a member of staff available for phone contact 24 hours a day should be explored in line with the same Department of Health Guidance. This should be done in conjunction with Recommendation 13 about it having its own beds	EIS Operational policy to be reviewed within context of adult community service reviews in Wandsworth, Merton and Sutton.	EIS policy reviewed and extended hours now incorporated within this for S&M EIS. 24 hour access to EIS is not currently affordable in S&M – EIS clients to be supported as required by C&HTT.	Mark Clenaghan	Apr' 08
Recommendation 15 **SP**				
The Trust should take steps to ensure that inpatient case notes any recorded incidents are reviewed monthly and collated with a summary, and filed in a separate section of the file for ease of reference	Review within care records policy.	NHS Litigation Authority have advised against separate filing in case records. All incidents will continue to be reported through Trust reporting system, and common themes considered at Improving Clinical Practice Committee.	Kim Goddard	Achieved.

Recommendation 16 **SP**				
The Trust should review the position of professional supervision within the community teams, including the EIS, and in order to ensure that such supervision takes place, make it mandatory	All community staff to have regular management and clinical supervision.	Management supervision being implemented within KSF project. Professional supervision procedures in place (Op. policy paras. 16.1 and 16.4)	Service Directors Kim Goddard Mary Morley Chris Gilleard	Ongoing Achieved

Mark Clenaghan,
Merton Service Director
February 2008.