



**REPORT OF THE INDEPENDENT  
INQUIRY INTO THE CARE AND  
TREATMENT OF  
STEPHEN SOANS-WADE**

Commissioned by North East London Strategic Health Authority and published by its  
successor organisation NHS London

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## **Glossary**

CCTV	Closed Circuit Television
CDT	Community Drugs Team (Tower Hamlets)
CAMHS	Child and Adolescent Mental Health Service
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CRS	Care Records System
CSCI	Commission for Social Care Inspection
DDU	Drug Dependency Unit
DH	Department of Health
HMP	Her Majesty's Prison
LIT	Local Implementation Team
PAF	Performance Assessment Framework
PCT	Primary Care Trust
PRN	(Taking medication) as required
RAP	Referral Assessment and Packages of Care
SHO	Senior House Officer (doctor in training)
SSI	Social Services Inspectorate

## **Acknowledgements**

This is the third Independent Inquiry involving the East London and The City Mental Health NHS Trust which I have been invited to chair. As on the two earlier occasions, I have been helped enormously in my task by the co-operation of witnesses and by the diligence and expertise of others involved in the Inquiry process. I am grateful to them all and particularly wish to mention the following.

I should like to begin by expressing my sincere thanks to the witnesses who came to give evidence to the Independent Inquiry into the Care and Treatment of Stephen Soans-Wade and for the frank and very helpful information and opinions they provided. I had no power to require the attendance of any witness and I am therefore grateful to each witness for giving up time to prepare for the interviews and then subsequently attending them. With their help and co-operation, the Inquiry Panel has sought to conduct a comprehensive review of the care provided to Stephen Soans-Wade by the relevant psychiatric and social services, especially in the months leading up to the tragic death of Christophe Duclos. We have also been guided and assisted by many of the witnesses in our investigation of the present service provision in East London for those patients who present with dual diagnoses of both mental health and substance misuse problems and for those patients who have personality disorders, and in our understanding of the service providers' current aspirations, wishes and intentions for improving those health and social care services.

I also add my thanks to the governor and staff at HMP Frankland for their support in making it possible for us to visit Stephen Soans-Wade.

The Inquiry has been managed by Dulara Khatun. The running of an Inquiry requires a significant amount of administration and organisation and, in particular, it is by no means easy to schedule the attendance of witnesses on days which are convenient to both them and the Inquiry Panel. Nonetheless, Dulara has devoted a lot of time and work to managing the Inquiry and has done so at all times cheerfully and with patience and politeness. I thank her for all of her work.

Having heard the evidence, the Inquiry Panel has reached a number of conclusions which appear in this report. As a result of those conclusions, we have formulated recommendations which we hope will lead to the improved provision of mental health services in East London whilst acknowledging the considerable constraints within which those services operate. Completing this task has required the comprehensive and extensive knowledge and expertise of my fellow Panel members, Dr Andrew Johns and Mr Hari Sewell, and I record my gratitude to them for their significant assistance and advice. I have benefited greatly from hearing their views and assessments of the services both in terms of those which were available to Stephen Soans-Wade at the relevant time and those which are currently provided. This report reflects the findings and recommendations of all of the Panel members.

Clare Price

June 2006

## Summary

### HSG (94) 27

1. On 13<sup>th</sup> September 2002, Stephen Soans-Wade pushed Christophe Duclos into the path of an oncoming underground train causing him to sustain severe injuries which sadly resulted in his death on 16<sup>th</sup> September 2002. Before this event and particularly in the period immediately preceding it, Stephen Soans-Wade had been a patient under the care of East London and The City Mental Health NHS Trust, and it was therefore decided that there should be an independent investigation into the care and treatment he had received from that NHS Trust. This Independent Inquiry was accordingly established pursuant to the Department of Health *Guidance on Discharge of Mentally Disordered People and their Continuing Care in the Community* (HSG(94)27). The Inquiry's terms of reference required it to identify the health and social care services used by Stephen Soans-Wade and to examine all the circumstances surrounding his care and treatment. The Inquiry was also obliged to prepare an independent report including such recommendations as may be appropriate and useful to the services involved and their commissioners and to present it to the Chief Executive of North East London Strategic Health Authority, the Director of Social Services in the London Borough of Tower Hamlets and the Tower Hamlets Primary Care Trust. The commissioners and East London and The City Mental Health NHS Trust have prepared a joint Action Plan which is published together with this report.
2. Stephen Soans-Wade has been diagnosed as suffering from a severe personality disorder (primarily a dissocial personality disorder but also other related personality disorders), drug and alcohol dependence and as having suffered at times paranoid symptoms which have reached psychotic intensity.
3. Stephen was born in Darlington, County Durham on 7<sup>th</sup> July 1967. He has a history of drug and alcohol abuse from his teenage years. He appears to have taken an overdose in 1990. In November 1992, he was admitted initially on an informal basis to Kingsway Hospital, Derby suffering from what was thought to be agitated or manic depression. During this admission, he was considered to

be a potential danger to himself and he became subject to compulsory detention under section 5(2) Mental Health Act 1982 for a period of two days when he expressed a wish to self-discharge.

4. In April 1993, Stephen was admitted to Winterton Hospital, Sedgefield on an informal basis having been found in a car with a hose attached to the exhaust pipe and a suicide note.
5. By 1997, Stephen had moved to live in London. In June 1997, he registered at the Great Chapel Street Medical Centre, London, at which time his presenting problems were recorded as “substance misuse and depression”. He saw Dr Alice Parshall, a Consultant Psychiatrist, on eleven occasions between July 1997 and September 1998. In November 1998, he was banned from the Medical Centre for life having threatened to kill a doctor who was working there.
6. In March 2000, Stephen approached Tower Hamlets Community Drugs Team for help with his drug problem. Following this, he was referred to the Drug Dependency Unit run by the East London and The City Mental Health NHS Trust and he saw Dr Robert Cohen, a Consultant Addiction Psychiatrist, between November 2001 and August 2002. In September 2001, he was admitted to Lansbury Ward, St Clement’s Hospital, London complaining of depression and anxiety.
7. On 1<sup>st</sup> August 2002, Dr Cohen referred Stephen to the Accident & Emergency Department at the Royal London Hospital believing that he was experiencing a deterioration of his psychotic illness and would benefit from admission. Stephen was not, however, admitted and subsequently spent the night sleeping in the park. On 2<sup>nd</sup> August 2002, he went to see Dr Robson, a General Practitioner, and told him repeatedly that he would harm himself or somebody else and wanted to be “sectioned”. Dr Robson referred Stephen again to A&E where Dr Read, a Consultant Psychiatrist, arranged for his admission on an informal basis, being of the view that his psychotic symptoms were probably worsening, thereby leading to an increased risk of self neglect or harm to himself or others.



8. Stephen remained on Monro Ward at St Clement's Hospital until 22<sup>nd</sup> August 2002. On 23<sup>rd</sup> August 2002, he returned to the ward demanding to be admitted again. His request was refused and he later went to the A&E department at the Royal London Hospital although left without being assessed. Later that day, he was taken back to A&E by the police, although they were called to remove him when he threw a table or chair across the room and threatened an assault after being told that he would not be re-admitted.
9. On 25<sup>th</sup> August 2002, Stephen attended the A&E department at King's College Hospital, London requesting admission to prevent self-harm. He was not admitted, but advised to go to the Drug Dependency Unit for a prescription for Methadone.
10. On 26<sup>th</sup> August 2002, Stephen went back to the A&E department at the Royal London Hospital. Whilst he was there, he threatened to kidnap or assault a Dr Robson.
11. On 27<sup>th</sup> August 2002, he went to see Dr Boomla, a General Practitioner. He said that he was agitated and upset and did not feel safe in the community. Dr Boomla referred him again to A&E for reassessment. Whilst there, Stephen was recorded as saying that:

"I feel like I'm going to do something"

"I'm going to push somebody under a bus or a train unless I get help. I'm not safe."

Because of these threats, Stephen was re-admitted to Monro Ward for a crisis admission which lasted until 5<sup>th</sup> September 2002. Following discharge, he took an overdose of Paracetamol tablets and was admitted once again to Monro Ward on the basis that he was a suicide risk and expressing ideas of harming others. This admission lasted until 9<sup>th</sup> September 2002.

12. On 13<sup>th</sup> September 2002, he was taken by the police to St Clement's Hospital at 08.10 hours. However, he did not wait to be seen and went to Mile End Underground Station shortly after 16.00 hours where he remained and was

behaving in an agitated manner until he pushed Christophe Duclos from the platform about an hour later.

13. Stephen Soans-Wade pleaded not guilty to the murder of Christophe Duclos but guilty to his manslaughter at the Central Criminal Court. This plea was not accepted by the Crown Prosecution Service and he was subsequently convicted of murder. On 24<sup>th</sup> February 2004, His Honour Judge Stephens QC sentenced him to life imprisonment.
14. Stephen had, therefore, had intermittent contact with mental health services since the early 1990s. However, the focus of this Independent Inquiry has been largely centred on events in 2002 when his condition deteriorated and his presentation became more chaotic and complex. By 2002, psychiatric care had been provided mainly in a community setting for a very considerable period of time. It should have been possible to provide Stephen with effective and co-ordinated care planning based on fully researched, well-informed assessments and intended to provide him with support and treatment when he needed it. Unfortunately, the Inquiry Panel has formed the view that the lack of a cohesive and collaborative system of service provision resulted in a failure fully to identify and act upon Stephen's mental health and social care needs. Whilst we accept that there have been significant improvements and that there are many dedicated and hardworking staff trying to provide sustained care for patients often in difficult and challenging circumstances, there is still more work to be done to ensure that adequate services are provided to those patients who present with personality disorders and dual diagnoses and to those who potentially represent a considerable risk to themselves or others.
15. We believe that the providers of psychiatric help and assistance from whom we heard already acknowledge and accept the problems we have identified and the changes which still need to be made. We hope that consideration of the conclusions and implementation of the recommendations of this Inquiry will enable them to progress that work yet further, as swiftly and efficiently as possible. Throughout this report, the Inquiry Panel's findings and opinions are highlighted in bold type. Our recommendations as to the steps and measures

which could and should be taken to improve and strengthen the psychiatric and social care services for those patients in East London and The City of London with severe mental health problems and/or a clinically significant personality disorder and problematic substance misuse are set out in chapter 8. In summary, the Inquiry Panel recommends as follows:-

- The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and the Tower Hamlets Primary Care Trust should review their strategy and operational policy for the provision of services to patients with a dual diagnosis, i.e. a substance misuse problem co-morbid with mental illness or a clinically significant personality disorder. The Trust needs to define and develop a coherent and integrated approach to services for people with dual diagnoses in conjunction with the London Borough of Tower Hamlets and all other relevant commissioners of services.
- East London and The City Mental Health NHS Trust should give consideration to the development of a specialist personality disorder team to provide training, consultation and support to staff working both within the Trust and in external agencies.
- The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and the Tower Hamlets Primary Care Trust should conduct a comprehensive review of the adequacy of day services they make available to patients with multiple morbidities as part of their care package. That review should assess the services available on a trust-wide basis from both statutory and non-statutory agencies.
- The reporting mechanisms between the London Borough of Tower Hamlets and East London and The City Mental Health NHS Trust should be improved. The London Borough of Tower Hamlets should monitor the Trust's progress and achievements in the delivery of mental health and substance misuse services which have been delegated to it pursuant to the National Health Service and Social Care Act 1999.

- East London and The City Mental Health NHS Trust, in partnership with the London Borough of Tower Hamlets and Tower Hamlets Primary Care Trust, should review its performance management systems to satisfy itself that those systems are sufficiently robust to ensure compliance with the Care Programme Approach and its requirements. Key areas of weakness that continue to need constant monitoring are assessments of patients (including risk assessments), care planning, the provision of full and timely discharge summaries and record-keeping.

## Alphabetical List of Witnesses

Name	
Dr Kambiz Boomla	General Practitioner, Chrisp Street Health Centre, London E14
Dr Andrew Biggs	Consultant Psychiatrist, North East London Mental Health NHS Trust
Dr Robert Cohen	Consultant Addiction Psychiatrist
Dr Robert Dolan	Medical Director, East London and The City Mental Health NHS Trust
Sheila Foley	Chief Executive, East London and The City Mental Health NHS Trust
John Goldup	Head of Adult Services, Tower Hamlets Social Services
Sharon Hawley	Service Manager, Specialist Addiction Service
Lynne Hunt	Director of Nursing and Quality, East London and The City Mental Health NHS Trust
Marc Micoud	Christophe Duclos' cousin
Stephen Soans-Wade	Subject of the Independent Inquiry
Tracy Upex	Community Mental Health Team Sector Manager, East London and The City Mental Health NHS Trust
John Wilkins	Director of Child Mental Health Services, Modernisation and Specialist Services, East London and The City Mental Health NHS Trust

## Chapter 1 Introduction

1. On 13<sup>th</sup> September 2002, Stephen Henry Soans-Wade pushed Christophe Duclos from a platform at Mile End underground station causing him to fall under a tube train. Sadly, Christophe Duclos suffered extremely severe injuries including the traumatic amputation of his left arm and multiple fractures. He was taken to the Royal London Hospital where he died at 06.00 hours on 16<sup>th</sup> September 2002. Subsequently Stephen Soans-Wade pleaded not guilty to the murder of Christophe Duclos but guilty to his manslaughter at the Central Criminal Court. This plea was not accepted by the Crown Prosecution Service and, following a trial, he was convicted of murder. On 24<sup>th</sup> February 2004, His Honour Judge Stephens QC sentenced him to life imprisonment.
2. Prior to the homicide, Stephen Soans-Wade had been living in London since about 1997. He had been provided with mental health services by East London and The City Mental Health NHS Trust (which is referred to throughout this report as “the Trust”) since 2000. The Trust is a specialist mental health trust offering a wide range of services and it rightly recognized that it needed to investigate the nature, scope and quality of the services it had made available to Stephen Soans-Wade in the light of the tragic killing of Christophe Duclos.

### The Internal Inquiry

3. Following the incident, the Trust, therefore, quickly established an Internal Inquiry which had two Consultant Psychiatrists and the Acting Director of Services on its review team. They conducted a thorough examination of Stephen’s contact with psychiatric services and summarised his risk history, both in terms of self-harm and the risk he had posed to others. They concluded that, in terms of diagnosis, Stephen has multiple morbidities which include the following:-
  - a psychotic disorder which could be argued to meet the criteria for schizophrenia,

- mental and behavioural disorders due to multiple drug use and the use of other psychoactive substances,
  - a personality disorder,
  - dis-social personality disorder,
  - emotionally unstable personality disorder, both impulsive and borderline type.
4. The review team observed that the provision of effective, appropriate and acceptable mental health care for somebody with such a range of diagnoses, which are also complicated by threatening behaviour, is a challenging and complex matter. They were of the opinion that, although a number of committed and hardworking professionals were involved in Stephen's care, there was a failure to provide an integrated and coherent package of care for him. This is a view which was expressed by a number of the witnesses who gave evidence to this Inquiry, and is one which we have also formed and with which we agree. In summary, the Internal Inquiry recommended the following:-
- There should be formal links put in place between the Community Mental Health Teams (CMHTs) and the in-patient team (which was then based at St Clement's Hospital, although this is soon to close).
  - Upon admission to hospital (or as soon as possible after discharge) there should be a full agency CPA meeting with contingency and crisis planning evident.
  - Discharge plans and the means by which they are to be carried into effect, and by whom, should be clear.
  - Consultants in addiction psychiatry should have direct admitting rights in consultation with the catchment area consultant.

- The Accident & Emergency department liaison service action plan should provide adequate cover with minimal single handed shifts which, where necessary, should include arrangements for the staff to consult with colleagues.
- There should be a move towards a single health record including medical and nursing notes and the notes of allied health professionals.
- A set of standards for note keeping should be formulated and agreed, and there should be a random audit to ensure compliance.
- Tower Hamlets' Acute Care Forum should seek to ensure senior clinical staff of all disciplines including psychologists, social workers and occupational therapists have input into the care of inpatients.
- All nursing staff should have access to clinical supervision from senior experienced staff.
- Consideration should be given to developing a training course for in-patient staff. It was recommended that their skills should include medication management, dealing with dual diagnosis and symptom managing. Staff should be helped to gain the skills and confidence necessary to manage patients with co-morbid personality disorders.

5. Thereafter, the members of this Inquiry Panel were invited to conduct an independent investigation into this matter. We were given the following terms of reference.

1. The Inquiry has been set up in accordance with the Department of Health Guidance HSG (94) 27: *Guidance on Discharge of Mentally Disordered People and their Continuing Care in the Community*, in order to inquire into



the care and treatment of Stephen Soans-Wade following his conviction for the murder of a stranger at Mile End tube station in September 2002.

2. The Inquiry will:

2.1. Identify the health and social care services used by SSW

2.2. Examine all the circumstances surrounding SSW's care and treatment

2.3. Make recommendations to the North East London Strategic Health Authority, designed to reduce the likelihood of such an event recurring.

3. The Inquiry will particularly look at:

3.1. The quality and scope of his health and social care

3.2. The appropriateness and quality of any risk assessment, care plan, treatment or supervision provided, having particular regard to:

3.2.1. His past history

3.2.2. His psychiatric diagnosis

3.2.3. His history of alcohol and substance misuse

3.2.4. His assessed health and social care needs

3.2.5. Carers' assessment and carers' needs

4. The extent to which his care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health (including the Care Programme Approach HC (90)23/LASSL (90)11 and the Discharge Guidance HSG (94)27 and local operational policies.

5. The extent to which his care and treatment plans:

5.1. Reflected an assessment of risk

5.2. Were effectively drawn up, communicated within and beyond mental health services, and monitored

5.3. Were complied with by SSW.

6. The Inquiry will examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care of SSW or in the provision of services to him, in particular whether all relevant information was effectively passed between the agencies involved and other relevant agencies, and whether such information as was communicated was acted upon adequately.
7. The Inquiry will examine the adequacy of the communication and collaboration between the statutory agencies and any family or informal carers of SSW.
8. Consideration of the management of risk should consider with equivalent attention the risk to himself and the risk to others represented by SSW, and whether his treatment and care were proportionate.

### **Inquiry Procedure**

1. The Inquiry will be held in private.
2. The findings of the Inquiry and any recommendations and ensuing action plans will be made public.
3. The evidence which is submitted to the Inquiry orally or in writing will not be made public by the Inquiry, except as is disclosed within the body of the Inquiry's final report.
4. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:
  - 4.1. of the terms of reference, the membership, and the procedures adopted by the Inquiry

- 4.2. of the areas and matters to be covered with them
- 4.3. requesting them to provide written statements to form the basis of their evidence to the Inquiry
- 4.4. that when they give oral evidence they may raise any other matter they wish, and which they feel might be relevant to the Inquiry
- 4.5. that they may bring with them a friend or relative, member of a trades union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness
- 4.6. that it is the witness who will be asked questions and who will be expected to answer
- 4.7. that panel members cannot be cross examined
- 4.8. that their evidence will be recorded and a copy sent to them afterwards for them to sign and amend if necessary.

5. Witnesses of fact will be asked to confirm their evidence is true.
6. It is not a principal objective of the Inquiry to seek to blame individuals, although if serious negligence or incompetence are uncovered the Inquiry should make such findings known and give the individuals concerned the opportunity to respond. Any points of potential criticism will therefore be put to a witness of fact, whether orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.
7. The commissioners reserve the right to refer individual practitioners to the relevant professional bodies where negligence or incompetence are identified.
8. Written representation may be invited from voluntary or other organisations and other interested parties as to present arrangements for persons in similar circumstances as the present Inquiry and as to any recommendations they may have for the future. These witnesses may be asked to give oral evidence about their views and recommendations.

9. Anyone else who feels they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.
10. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on those findings.
11. The Inquiry will prepare an independent report including such recommendations as may be appropriate and useful to the services involved and their commissioners, and presenting it to the Chief Executive of North East London Strategic Health Authority and the Director of Social Services in the London Borough of Tower Hamlets and other key agencies involved.
12. The commissioners will invite relevant agencies to respond to the Inquiry Report through a joint Action Plan which will be published alongside the Inquiry Report.

### **The Conduct of the Independent Inquiry**

6. It will be apparent from the above that the terms of reference set out in part the procedure which was to be adopted by the Inquiry Panel. We began by obtaining Stephen Soans-Wade's consent to the release to us of documents relating to his care and treatment and also to his subsequent conviction at the Central Criminal Court for use during the course of the Inquiry and the preparation of this report. These documents included his medical records and nursing notes which are extensive and run to a considerable number of pages because Stephen has had a significant amount of contact with psychiatric services since the early 1990s. There was also a small number of documents held by Tower Hamlets Social Services. Stephen agreed that this report should include his name when published.
7. Before we heard any evidence, we also requested copies of the relevant Trust policies which were in existence in 2002 and which are in use now. In addition,

we considered current guidance on the issues with which we are concerned, for example the Department of Health's Mental Health Policy Implementation Guide *Dual Diagnosis Good Practice Guide, Personality Disorder: No Longer a Diagnosis of Exclusion* ((NIMHE: 23<sup>rd</sup> January 2003) and the North East London Strategic Health Authority's *Review of Sexual Health and Substance Misuse Services* (April 2004).

8. Using the above documents and with the assistance of the joint commissioners of this report, we listed the witnesses who we considered were likely to be able to give relevant evidence to the Inquiry. At an early stage, each member of the Inquiry Panel separately formed the view that the history of Stephen's care and of decisions made about his care which are material to this Inquiry could be ascertained to a significant degree from the documents with which we had been provided. Furthermore, throughout, we have placed considerable importance and emphasis on the need for us to look to the future and to address the question of how the provision of mental health services for those people with dual diagnoses and resulting complex needs can be met and, where necessary, improved. To this end, we were keen to avoid interviewing a proliferation of witnesses whose evidence would be limited in its scope and who may have already given evidence to the Internal Inquiry. Thus, where we have needed to establish facts which were not apparent from the written records or have wished to expand upon the information available to us in those records, we decided to invite largely only the senior clinicians involved in Stephen's care to give evidence about those facts and otherwise relied on the relevant notes in an attempt to ensure the evidence heard was germane and proportionate to the issues we were asked to consider.
9. On 2<sup>nd</sup> August 2004, the Inquiry Panel held a meeting which was attended by the joint commissioners at which we outlined our plans for the progress of the Inquiry.
10. The Inquiry Panel heard the evidence on 29<sup>th</sup> and 30<sup>th</sup> June 2005 and on 9<sup>th</sup> September 2005 at Quadrant Chambers, London. Two members of the Panel

went to HMP Frankland on 16<sup>th</sup> November 2005 to speak to Stephen Soans-Wade.

11. Having heard all of the evidence, a draft report was prepared. That draft was provided on a strictly confidential basis to the commissioners of the Independent Inquiry and other key agencies, and they were invited to make such responses as they considered appropriate. Some amendments were made to the report as a result of the helpful responses which we received and for which we were grateful.
  
12. The conclusions we have reached and the opinions we express in this report are based on the evidence we have heard and read in the course of the Inquiry and on the responses we received to the draft report. This report concludes with our recommendations which are based upon the evidence we have heard and which we hope will lead to a more integrated and cohesive system of health and social care in East London than that which existed in 2002.

## Chapter 2 Christophe Duclos

1. Even though such homicides are rare, the killing by a stranger of a person simply going about his day-to-day affairs is shocking. Such killings strike fear and apprehension into members of the public when they contemplate the ease with which their apparently secure existence can be invaded by wholly unexpected and random events.
2. Christophe Duclos was a complete stranger to Stephen Soans-Wade and, at the start of the Inquiry, we were very aware that that we also knew little about him. The police had gathered some information about him in witness statements which were available to us, but we were keen to know some more about the man who died in such a terrible manner. We also wanted to know whether his family had any concerns or questions which they wished to raise with the Inquiry Panel. His cousin, Marc Micoud, therefore kindly agreed to talk to us. Marc Micoud was a calm, dignified and very pleasant witness and we wish to record our gratitude to him for coming to talk to the Independent Inquiry. If the need for improvements to the provision of mental health services in East London and The City is recognized and acted upon as a result of Christophe's death, then we hope that some good has come from a dreadful incident.
3. Christophe Duclos was born on 8<sup>th</sup> March 1965 in Marignier, France. He was one of three children, having a brother and sister who both live in France. Christophe Duclos himself lived there until he was about twenty-five years old when he moved to England. He worked as a security guard but he wanted to make as much of his life as possible. Marc Micoud described him as having "huge aspirations" and said that he did unexpected things. By way of example, he explained that it was a surprise when his cousin decided to move to London, but said that was the way he lived and that he probably found he had greater opportunities in London. He said that it was entirely possible that, one day, he would have simply decided to move on again to live in a different country and to experience a different way of life. Christophe went to college to improve his English and to gain information technology skills. He wanted to learn more

languages and to find a career which involved speaking foreign languages. He had many hobbies including rugby, films and music. He was also interested in photography and had been taking photographs at functions and exhibitions as a hobby. He would have liked to turn this into a commercial enterprise. He was quite a private person, but obviously talented, and he had made a number of friends in London.

4. Marc Micoud told us that Christophe Duclos' family were very grateful to the police who had supported them and been very kind and compassionate to them when they came to London following the incident. Neither Christophe's brother nor sister speak English and they were grateful for the assistance they had received.
5. However, he explained that they felt somewhat removed from the Inquiry process because they and other family members are all in France and consider it to be a matter for the relevant British authorities to address. They are, however, concerned as to how such a terrible event could have occurred and wonder what, if anything, could be done to try to prevent a similar tragedy in the future. They also, understandably, are interested to know what was done about the threats of violence made by Stephen Soans-Wade in the period leading up to Christophe Duclos's death about which more is said later in this report. Marc Micoud said that he felt that there may be a gap in service provision for those people whose mental health needs are managed satisfactorily in the community for most of the time, but who suffer a period or periods of significant deterioration in their mental health and then have more complex needs. That is a view which, in our opinion, has considerable validity.
6. Tragic and high profile killings by people with mental health problems have been used to suggest that the community care model for mental health services has failed. In fact, the proportion of homicides committed by people with mental illness has fallen since the 1960s by about 3% a year (Gunn & Taylor 1999). There is little to suggest the trends in homicide figures over time bear any relationship to mental illness or changes in its treatment. These researchers conclude:-



“whilst most mental health services may offer adequate assessment and treatment to people with major mental illness, there is a reluctance and probably even inability on the part of most services to provide for people with problems of substance misuse or personality disorder”.<sup>1</sup>

7. As described in this report, the Inquiry found that the care received by Stephen Soans-Wade was inadequate in a number of respects. It is possible that had he received better co-ordinated care, with a key-worker as a point of contact who was able to act on his behalf and to identify which of his acute needs could be appropriately met, and which could not be met, then he would have felt less disregarded, less impulsive, and less dangerous. Nonetheless, it is our view that even such an “ideal” package of care may well not have prevented this impulsive and tragic act of homicide.

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<sup>1</sup> Ref: Gunn J & Taylor P (1999) **Homicides by people with mental illness: myth and reality** British Journal of Psychiatry, 174, 9-14.

## **Chapter 3 Stephen Soans-Wade's Early Contact with Mental Health Services**

1. An abridged chronology setting out in tabular form the key events in Stephen's contact with mental health services appears as an appendix to this report.
2. Two members of the Inquiry Panel visited Stephen Soans-Wade in HMP Frankland on 16<sup>th</sup> November 2005 to learn his views of the care and treatment he received. Many of the questions he was asked were inevitably of a personal nature, and we appreciated his willingness to answer fully and openly all of the questions put to him and to co-operate with the Inquiry and the preparation of this report.
3. Stephen was born in Darlington, County Durham on 7<sup>th</sup> July 1967. He is one of five children born to an Asian mother and white father. Stephen claims that he saw his father being violent towards his mother on many occasions and has said that he would often try to protect her from the violence. His parents divorced when he was young. He alleges that he was subjected to sexual abuse when he was seven years old, although we understand this was denied by the alleged abuser. As far as we know, no criminal proceedings resulted. He attended St John's Comprehensive School gaining about 5 CSEs and appears subsequently to have undertaken Youth Training Schemes with a carpet company and an engineering company.
4. Stephen has a history of significant drug and alcohol abuse. By the age of 17, he has said that he was drinking 4-5 pints of alcohol three times a week. He then began to take cannabis when he was about nineteen, took LSD and continued to drink alcohol 2-3 times per week. During his twenties, his cannabis and LSD use continued, his alcohol consumption appears to have increased and he started to take amphetamines. By the early 1990s, he had started using heroin as well.

5. Stephen's forensic history is not set out clearly in his medical records and we have not seen a list of his previous convictions. However, he appears to have convictions for burglary, theft and being drunk and disorderly. He served two sentences of imprisonment in 1996 and 1997 following convictions for offences of criminal damage and assault.

### **Kingsway Hospital, Derby**

6. In 1990, Stephen seems to have taken an overdose of vodka and some medication, although subsequently said that he did not particularly want to die. At about the same time, he moved to live in Derby and, on 20<sup>th</sup> November 1992, Dr Bronks (a Consultant Psychiatrist) made a domiciliary consultation visit to him following a referral by his GP. This was Stephen's first contact with psychiatric services. He was with somebody who was not his girlfriend but who was herself under psychiatric care. He was described as "tense, agitated and restless" and also appeared depressed. He described his emotions to Dr Bronks as "all mixed up" and expressed the feeling that he was a bad person. Although Stephen was described by his friend as "normally a nice, cheerful person", she said he had become increasingly depressed and tearful over the past four or five weeks. He was described as becoming increasingly tense, suspicious and hostile as the interview progressed, and Dr Bronks decided that he should be admitted to hospital for further assessment including a more extended interview with Stephen's friend and also, if possible, a member of his family. On the evidence available, Dr Bronks felt unable to reach a firm diagnosis. Dr Bronks formed the opinion that his condition seemed most in keeping with an agitated depressive illness, but felt unable to exclude the possibility either that his condition was drug-induced or that he was suffering from early schizophrenia.
7. Stephen was admitted informally to Kingsway Hospital, Derby on 20<sup>th</sup> November 1992. Upon admission, the impression of him that was recorded was:-

"25 yr old, single, lives alone, has limited friends, feeling unwell for about 1/12 [1 month], presented today being depressed, tearful, tense and agitated, tearful, paranoid ideas, no real suicidal intent but has thought of suicide in the past 1/12. Has very poor concentration. Also has been abusing illegal drugs. Has been taking cannabis until yesterday.

? Agitated Depression.

? Manic Depression.

Discussed with Dr Bronks. Difficult to say exactly what is going on at present but to treat his agitation which is more prominent at present."

8. Stephen was prescribed Chlorpromazine 100mg four times daily and Temazepam 10mg at night.
9. On the following morning, he was described as "feeling low", feeling guilty that he felt like killing himself and finding it difficult to trust anybody. The impression was that he was very depressed and he was to be observed and was prescribed Diazepam on a PRN (as required) basis. Within an hour, he was expressing a desire to discharge himself and was very agitated and refusing his medication. He was considered to be a potential danger to himself. His status as a patient was accordingly re-graded so that he was subject to compulsory detention under section 5(2) Mental Health Act 1982. At 17.46 hours, a note was made in his records that he had passed his right hand through three windows sustaining a small cut on the front of his wrist.
10. On 23<sup>rd</sup> November 1992, Stephen was interviewed with his mother and one of his brothers. The note of this interview includes the following:-

"He says that he has been low recently and has had feelings of guilt for things he has done in the past. He has been using drugs (LSD, amphetamines and cannabis) regularly during his three years in Derby.... Today he says he feels better and although still low says that he is more settled. ...

Imp: 25 yr old man, unemployed with a history of drug abuse and with recent onset of low mood and agitation with feelings of hopelessness and guilt.

Δ [diagnosis] depressive illness.

Plan – change Haloperidol to Amitriptyline. For review by Dr Bronks tomorrow.

His mother and brother Joe have travelled down from Durham ...They wish to take him home to Durham on Discharge where he will stay with Joe and Joe's wife. Joe thinks that if he gets a Job things will be better.... They both say that his premorbid state was one of a happy go lucky, confident man who was pleasant to know. He does not appear to have been low previously."

11. On 24<sup>th</sup> November 1992, Dr Bronks reviewed Stephen's condition and re-graded his admission status to an informal one. He was diagnosed as having had an amphetamine psychosis and discharged to live with his brother. His prescribed Chlorpromazine was reduced to 50mg three times a day.

### **Winterton Hospital, Sedgfield**

12. On 27<sup>th</sup> April 1993, Stephen was admitted to Winterton Hospital on an informal basis following an emergency domiciliary visit. He had been living with his brother since his discharge from Kingsway Hospital, although he reported that he had stopped all of his medication as soon as he was discharged. On admission to Winterton Hospital, he was recorded as saying he had thought about hanging himself two months previously. His brother reported to a Dr Seukeran that Stephen had been fine over the previous four weeks. However, his brother said that he had woken on the morning of 27<sup>th</sup> April 1993 to find Stephen missing. He went in search of him and found him in a car with a hose attached to the exhaust pipe and a suicide note.
13. Stephen explained that he had been depressed for several years and he was admitted for constant observation and review. He remained in hospital under 11<sup>th</sup> May 1993 when it was concluded that he was not depressed and there was no evidence of psychosis. His diagnosis was of an antisocial personality disorder. Although he described periods of depression, these were not considered severe enough to classify him as having a major affective disorder. No psychiatric follow-up was arranged.

14. In about August 1993, Stephen was referred by his GP to Ronald Siddle, a Cognitive Behavioural Therapist employed by SW Durham Mental Health NHS Trust for urgent help with low mood. He was seen on two occasions and then declined to attend any further appointments. The assessment was therefore incomplete. Mr Siddle recorded that Stephen had scored 25 on the Beck Depression Inventory, a score associated with depression at a moderate to severe level with occasional thoughts of suicide and mild feelings of hopelessness for the future. Stephen said that he believed the onset of his difficulties had been some three to four years earlier when he began to abuse drugs seriously. Mr Siddle considered that there were, however, indicators of a more longstanding personality disorder rather than depression, listing Stephen's revelation early in his first interview of his sexual abuse, history of drug abuse, suicidal behaviour and ambivalence to therapy. He considered a referral for cognitive therapy was appropriate. Although he discharged Stephen from his list because of his reluctance to attend for therapy, he expressed a willingness to see him again with a view to longer term intervention aimed at dealing with his underlying beliefs rather than any crisis. Stephen does not, however, appear to have followed up this offer.
  
15. By 1997, Stephen had moved to live in London. His last full-time job was as a care assistant in 1996. He went to London initially with the intention of evading a warrant which had been issued for his arrest in Derby, but then returned to Derby. When he went back to London, he lived in a hostel in Aldgate, but was asked to leave after a fight with one of the other hostel residents. He then moved to bed and breakfast accommodation before being allocated council accommodation.

### **Great Chapel Street Medical Centre**

16. Stephen had no further contact with mental health services until 23<sup>rd</sup> June 1997 when he registered at the Great Chapel Street Medical Centre. His presenting problems were recorded as "substance misuse and depression". He said that he felt under stress all of the time, that alcohol gave him a "short fuse" and he was very angry and drank to give himself confidence. He was using heroin and

crack cocaine and told the Inquiry Panel that he also took valium at times. Stephen was prescribed two doses of Thioridazine 50mg and referred for psychiatric assessment.

17. Stephen then saw Dr Alice Parshall, Consultant Psychiatrist, on eleven occasions between 22<sup>nd</sup> July 1997 and 7<sup>th</sup> September 1998. At their first interview, he told her that he was not sleeping well and that he felt “paranoid” and that people might be talking about him. He said he had worked in health care but complained about his work colleagues. He told her he had spent two months in prison and had a court case pending. Dr Parshall’s recorded impression at that first interview was of a:-

“vulnerable personality for developmental reasons. Probable intermittent psychosis since “bad trip” in 1992 with attempts at self-medication and exacerbation with other substances, ↑ [increased] with additional psychostressors of this year.”

18. On 6<sup>th</sup> August 1997, he reported that he had had a bad week and had thrown a chair from a window a few days earlier. On 2<sup>nd</sup> September 1997, Dr Parshall recorded that Stephen had been arrested for “disturbance of peace”, having broken a glass door during an argument about the price of a meal. He had been made homeless ten days earlier. Dr Parshall’s opinion was that he needed focussed anger management.
19. Stephen did not then see Dr Parshall until 5<sup>th</sup> January 1998 when he told her that he had spent three months in a bail hostel in Derby having been arrested for failing to attend Court. He appears to have been prescribed Prothiaden for the preceding two months, but told Dr Parshall that, with hindsight, he thought that Thioridazine was more helpful, particularly for his nocturnal symptoms. She prescribed Thioridazine 50mg up to three times daily and Carbamazepine 200mg at night.
20. On 20<sup>th</sup> January 1998, Stephen told Dr Parshall that he had been drinking and using heroin and crack cocaine since he last saw her. He was feeling “pretty unsociable to people”, but said that he had not actually hurt anyone but would

“rather” hurt himself. He told her that he had injected some heroin and thought that he might overdose and “be done with it”. However, he continued by saying that he would not do it again because he had been sick. He acknowledged that he was on a “dangerous path” and said that he wished to return to prescribed medication.

21. On 9<sup>th</sup> March 1998, Stephen told Dr Parshall that he had gone back to drinking beer and up to four to five bottles of wine a day. He had “nearly” been in trouble having been involved in a fight the week before when he had feared that he had nearly killed somebody. He said that he had dragged the person to the floor and stamped on his head, but not used a weapon. He felt that he was unable to stop trying to please people until they “push their luck and he explodes”. Dr Parshall decided to try to re-start Stephen on Carbamazepine and prescribed 200mg per day. She was also of the view that Stephen needed help with his assertion, anger management and alcohol use. He was to be referred to somebody for assistance with those matters according to Dr Parshall’s notes, although we have seen nothing which suggests that he did in fact undergo such therapy.
22. On 23<sup>rd</sup> March 1998, Stephen said that he had only been taking his Carbamazepine when he was not drinking, but did want to try to become established on it. As a result, Dr Parshall prescribed 200mg per day again. On 7<sup>th</sup> April 1998, she recorded that he had been “relatively committed” to his Carbamazepine and was drinking relatively little alcohol. However, he was experiencing disturbed sleep and problems with breathing, feeling unable to relax. He had “explosiveness” and felt other people were stealing his air space. He discussed his fear of spontaneous combustion with her. Dr Parshall increased the Carbamazepine prescription to 400mg and prescribed Fluanxol to try to address the anxiety symptoms.
23. On 7<sup>th</sup> May 1998, Dr Parshall recorded that Stephen no longer required to see her. However, on 7<sup>th</sup> September 1998, he returned to Great Chapel Street Medical Centre saying he had sustained a head injury which had been sutured and was then noted to be healing well. He also saw Dr Parshall and



apologised for not returning to see her, but explained that he had been worried about the results of blood tests which had been done on 7<sup>th</sup> April 1998. He described himself as “muddling along all right” at Aldgate Hostel which is in Dock Street, London E1, until the preceding week when he had been evicted because he had tried to push a man off a balcony. He said that he was drunk at the time and would not have got into the fight had he been sober. He had gone to live with a friend. Stephen told Dr Parshall that he had been on the run from the police since December 1997 and wanted to surrender to them to sort out the matter. However, he said he had had no help with his mental health problems the last time he was in contact with the police and said he did not think he could cope.

24. On 10<sup>th</sup> November 1998, Stephen attended the Great Chapel Street Medical Centre, having cut his right thumb on glass. He apparently asked for some minor surgery to tidy up the wound and was advised to have an x-ray first. According to the record of this attendance, he then became:

“v. [very] pushy wanting brain scan

“swearing

“threatening to get violent”

25. Stephen was noted to smell of alcohol. He was asked to leave the medical centre but refused to do so. He was advised that the police would be called and then left. A decision was made that he should be banned from the medical centre if he caused more trouble. He appears to have returned and gone to the x-ray department and security had to be called. He made threats to kill a Dr Reid who was working there and the medical centre imposed a one year ban. Notwithstanding this, he returned and the police were called to deal with him. He threatened to wait outside for Dr Reid with the intention of doing him some harm. Following these threats, Stephen was banned from the medical centre for life.
26. Stephen told the Inquiry Panel that he did not think he did anything useful with his life whilst living in London. He recognised that he “ended up in the drug

culture” and had no real friends to whom he could turn for help. He had very limited contact with his family.

## Chapter 4 Treatment between March 2000 and July 2002

1. In about March 2000, Stephen Soans-Wade approached the Tower Hamlets Community Drugs Team (which is also known as Addaction) for help with his drug use. The Tower Hamlets CDT is a non-statutory, community based drug service offering advice, information, counselling support and care to people who are using drugs. It operates a contract system between the Team, the patient and his/her prescribing doctor, thereby providing the GP with support and access to a specialist drugs agency. Stephen's drug use was assessed and the CDT suggested that he should be started on a drug treatment programme using oral Methadone on a daily basis. He then attended appointments regularly with his CDT keyworker and GP, receiving his Methadone prescription from his GP. His notes record attendance at the CDT throughout the following nine months, although they show attendance after that at his GP for prescriptions. Urine screens indicate that he supplemented his Methadone treatment with heroin.
2. Tower Hamlets CDT also referred Stephen to the Trust's Drug Dependency Unit ("DDU") at St Clement's Hospital where he was seen a by Dr Justin Reid for the first time on 14<sup>th</sup> April 2000. Dr Reid considered that Stephen suffered a well contained and mild form of schizophrenia, but noted that he refused to accept anti-psychotic medication and also refused to consider entering the DDU Methadone programme. Dr Reid discharged him, but considered that, if he were re-referred, he should be viewed as a priority in view of "mental health issues + need to engage". On 2<sup>nd</sup> June 2000, Dr Reid wrote to the CDT saying that Stephen was suffering from a mild form of schizophrenia compounded by poly substance abuse. He categorically refused any assistance from the DDU and Dr Reid reported that he had kept the case open for a full month, but as he had had no contact from Stephen, he had closed it
3. By letter dated 19<sup>th</sup> September 2000, his then GP (Dr Jennie Read on behalf of Dr Vanda Playford, his registered GP at the Gill Street Health Centre, London

E14) referred Stephen to the psychiatric services at St Clement's Hospital, 2a Bow Road, London E3 saying that he:-

"recently has expressed a feeling of great anxiety. For some time, he has spoken about anxiety in relation to his physical health: for example he has feared a difficulty in his breathing, he has also feared that sweating at night may represent a sinister underlying illness and there have been concerns about the seriousness of his haemorrhoids. To date, this anxiety has been contained. ... However, more recently, the anxiety has become less specific and yet, more severe. Thus, he recently spoke about feeling so anxious that he was going to call the Out of Hours Doctor and he has now moved to living with a friend so that he is not on his own.

"... has spoken about having "experiences". He associates this with a particularly bad trip that necessitated him to be hospitalised at number of years ago (sic). He feels that he never really quite got over the experiences that he had on this trip. ...

"In talking to Stephen, I found it extremely difficult to unravel whether the experiences that he describes are consistent (sic) with a form of schizophrenia. According to the CDT Helper, he attended the DDU at Clements and the nurse at that interview formed the interpretation that he had mild schizophrenia. I am not altogether convinced by this. ... In addition, I feel that Stephen warrants an assessment with regards to his current management and it is possible that he may benefit from cognitive therapy rather than pharmaceutical manipulation."

4. On 15<sup>th</sup> November 2000, Dr Andrew Cobb (Consultant Psychiatrist) saw Stephen in his outpatients clinic. Dr Cobb found no evidence of mental illness during the appointment, but considered that Stephen's drug use was a problem, recording expenditure then of about £40.00 per week on heroin together with his prescribed Methadone. Dr Cobb informed Stephen's GP that he did not intend to see him again, although he would do so should his circumstances change, provided he were living within Dr Cobb's catchment area. On 1<sup>st</sup> December 2000, Dr Cobb also wrote to Sue Brewer (a Drugs Care Manager) in the following terms:-

"This man is not mentally ill, is well able to organise his life, augments his prescribed Methadone, probably understates his drug use and is using his flat as a means of collecting post only.

"I do not intend to provide him with any service, although it is just possible that he may develop mental health needs which will require my colleagues' intervention at some point in the future."

5. In December 2000, Stephen applied to Clouds House, Wiltshire for help with his drug dependency, listing heroin as his primary drug of choice on the application form. The reason for his not going there is not apparent from his GP notes, but we were told that the London Borough of Tower Hamlets had agreed to fund his rehabilitation there but he chose not to take up this offer.

6. By letter dated 20<sup>th</sup> April 2001, Dr Playford tried to refer Stephen to the clinical psychology team at St Clement's Hospital explaining that he was:-

"complaining of depression and sometimes paranoid ideas that people have negative feelings towards him which provoke angry, hostile reactions in him. On a number of occasions he has found himself in rather potentially violent situations with Health Professionals and other people which he feels he could learn to avoid. ...

"He feels that he is failing in life and is unable to find motivation or complete anything. He lacks confidence. He is avoiding any social activity with other drug users and has applied for funding to attend Narcotics Anonymous. He would like to attend these meetings every evening and as soon as this is teed up, he hopes to discontinue with his Methadone.

"We have [had] a very long conversation today about all his problems and at the end of the interview, I felt that an assessment by yourself would be important as I wondered if he would benefit from cognitive behavioural therapy. He's keen to find a regular job and try and build his life up again."

7. On 26<sup>th</sup> April 2001, a Frances Sammut replied to Dr Playford's letter saying that the psychological therapy department could not take direct referrals from GPs.

8. In June 2001, Stephen registered with the Chrisp Street Health Centre, London E14, it having become apparent that he was not living within the Gill Street Health Centre catchment area and had probably not been doing so for a significant amount of time. He first saw Dr Kambiz Boomla on 11<sup>th</sup> June 2001, who recorded that Stephen was an injecting drug user who was being

prescribed 20ml of Methadone daily. Dr Boomla told the Inquiry Panel that, in the course of this first consultation, Stephen said that he did not consider his drug use to be his main problem but that that he was suffering from an anxiety state which had worsened over the past few years. Stephen explained that he regarded his heroin use as a means of keeping his anxieties/psychological/psychiatric symptoms under control. Dr Boomla also referred Stephen back to Tower Hamlets CDT intending to work in conjunction with the team, as was usual for the Chrisp Street Practice. On 6<sup>th</sup> July 2001, Ciara O’Gorman referred him to the DDU for a psychiatric assessment expressing the opinion that psychiatric help for the anxiety/depression he experienced would help him not to take heroin which he was using as an anti-depressant and would help with his anxiety attacks.

9. Dr Boomla also continued to see Stephen on a regular basis throughout July and August 2001 and recorded that he was using heroin and, occasionally, cocaine and cannabis. On 23<sup>rd</sup> August 2001, Stephen said that he was not taking his prescribed Methadone. During these consultations, Dr Boomla discussed Stephen’s anxiety and panic attacks and, given that the clinical psychology team at St Clement’s Hospital could not take a GP referral, decided to refer him to Sue Smith, a Clinical Psychologist based at the Chrisp Street Practice who was part of the Tower Hamlets Community and Primary Care Psychology and Counselling Service. The purpose behind this referral which was made by letter dated 6<sup>th</sup> September 2001 was for a psychological assessment of Stephen’s needs to be undertaken.
10. On 20<sup>th</sup> September 2001 at 04.36 hours, Stephen presented at the Royal London Hospital Accident & Emergency Department complaining of hallucinations and paranoia and that things were “closing in on him”. He had taken heroin the night before and reported symptoms of depression and anxiety over the preceding two months with suicidal impulses which he had not acted upon. He said that he wanted to be in a secure environment and felt that he could not trust himself. It was thought that his symptoms could be caused by his heroin use and that he should undergo a psychiatric assessment once the effect of the heroin had worn off.

11. Stephen was subsequently assessed by a Senior House Officer in psychiatry, a Dr Gill, whose note of the assessment included the following information:-

“... feeling paranoid ...

MSE [mental state examination] ... irritable and aggressive at times, feeling he may be physically violent, left department when OP [future outpatients appointment] offered, returned, tearful...

has had “suicidal thoughts” daily ... previous suicide attempts ... 1993 tried to gas himself in a car ... 1992 took some tablets 1989 120 anadin + bottle of vodka ...

Drugs ... 17 yrs Alcohol + cannabis 20 yrs – regular drink 6 pints lager a night 3-4 times a week 20 yrs cannabis progressed to speed + acid 1993 crack cocaine – 1995... IV use speed heroin

Forensic Hx [history] criminal damage; assault – 1996 5/12 [5 months] assaulted ambulance crew + police drunk + disorderly common assault – 1997 2/12 [2 months] – shouting. On remand various times ... shoplifting charge 1 yr ago....

Imp [impression] – 34 yr old male (with) longstanding paranoid delusions and pseudohallucinations recently getting worse in last few months. Concomitant drug use of heroin and cocaine – also on methadone. Would like admission to St Clements as feeling paranoid, unable to cope. ...

Explained would arrange urgent O.P. ... became very upset – said he was feeling aggressive – Duty Dr and nurse left room. ... Left department – returned 10 minutes later.... Says he will cut his wrists if not admitted.

Spoke (with) GP [i.e. Dr Boomla]

- methadone, heroin + cocaine addict
- discharged from St Johnson St 15/8/01 – CDU as not attending...
- ? schizophrenic type history prior to drug abuse ...
- Due to see Sue Smith clinical community psychologist for panic attacks and paranoid thoughts ...
- (GP) feels there are some risks and he isn't able to offer any further help ...

(P) [plan] – Informal admission to assess mental state further – currently suffering from persecutory delusions, delusions regarding health, feels he's going to die, depression, anxiety, thoughts of suicide – risk of self harm and aggressive behaviour.

Risks – male

- Unemployed
- Drug addiction
- (psychiatric) history
- 2 previous suicide attempts – one serious
- No social or family support.
- risk of self harm ...
- 5-10 mins – risk of aggression and violence.

Pt [patient] informed that may be short admission.”

### **Comment**

**It was clear from the oral evidence that the Inquiry heard that different parts of the mental health and substance misuse systems had no explicit knowledge of the distinct operational policies of other services. For example, some services assumed that the presence of psychiatrists in the Drug Dependency Unit meant that this service would provide psychiatric expertise for general mental health conditions. The DDU itself looked to adult mental health services for such expertise. The lack of clarity that was prevalent, and the assumptions that resulted, were compounded as a greater number of services became involved and Stephen’s presentations became more complex.**

### **Admission to Lansbury Ward: 20<sup>th</sup> to 25<sup>th</sup> September 2001**

12. Following this assessment, Stephen was admitted to Lansbury Ward at St Clement’s Hospital. He remained on Lansbury Ward until 25<sup>th</sup> September 2001, during which time he reported feeling anxious and depressed. He is, however, described in his medical notes as appearing calm and at ease, smiling, being co-operative and having good rapport and eye contact. It was decided that he had been abusing heroin and was continuing to do so whilst on the ward, was showing no evidence of mental illness and that there was no immediate risk of self-harm.



13. A risk assessment dated 20<sup>th</sup> September 2001 recorded two incidents of violence in 1996 which resulted in minor injuries to a police officer and an ambulance driver, a conviction for common assault in 1997, three suicide attempts and his history of alcohol and drug abuse.
  
14. Dr Boomla described this admission to the Inquiry Panel as the first of a number of emergency, unscheduled admissions to St Clement's Hospital. He was notified of the fact of both Stephen's admission and discharge and received an in-patient nursing discharge summary which informed Dr Boomla of the following plan for Stephen's care, but no details of any diagnosis made for him:-  
  
"- Discharged to home address.  
- No TTA's [to take away medication] given  
- To continue to get methadone from GP  
- CPA level standard  
- DDU to send appt [appointment]  
- O/P appt with Dr Cobb's team in 6/52 [6 weeks]"
  
15. There is a note in his GP records of a conversation between Dr Nadia Abdel Aal (a psychiatric SHO) and a Dr Emily Farrow on 3<sup>rd</sup> October 2001 to the effect that Stephen had declined drug rehabilitation saying that his paranoia was the cause of his drug abuse, and that the psychiatrists had detected no mental illness whilst he was on the ward. They were described as being unsure why he had come to the hospital in the first place, but thought that it might have been because he had friends on the ward. Following discharge, he was to have an appointment at the DDU, but no general psychiatry review according to the note.
  
16. On 15<sup>th</sup> October 2001, Stephen failed to attend an appointment with Dr Robert Cohen, Consultant Addiction Psychiatrist, although he appears to have telephoned subsequently to explain that he was unwell and to have asked for a further appointment. In the meantime, Dr Boomla continued to prescribe Methadone for him.

17. On 19<sup>th</sup> November 2001, Stephen had an appointment at the DDU with Dr Cohen for an assessment of his mental state and a psychiatric opinion in relation to his drug use. Stephen told Dr Cohen that he had a history of alcohol and drug use starting at the age of 17, and that he was then taking heroin one to two times a week, crack cocaine between one and five times a week, occasional cannabis, valium and “alcopops” together with 60mg of prescribed Methadone daily. He told him that he had had a number of strange mental experiences from 1993 onwards which followed the episode when he took speed and acid, which he had described as a “bad trip” to Dr Parshall when he was seeing her. He described being unable to sleep, having difficulty with his breathing and being fearful that other people were trying to harm him and told Dr Cohen that these feelings had continued. He had believed himself at times to be both the devil and Jesus. He made good eye contact and rapport initially in the interview, although he subsequently started to become drowsy which he attributed to having been awake for a large part of the night. He was not irritable or hostile.
18. Dr Cohen considered that his examination was incomplete and that he required corroborative information from the other hospitals which had treated Stephen. However, his diagnosis at that time was of a psychotic condition caused either by the illicit drugs he was taking, or an underlying illness, for example schizophrenia. Dr Cohen concluded that further investigation was needed before a definitive treatment plan could be instituted, but advised Stephen not to take illicit drugs which were likely to aggravate his symptoms. On 8<sup>th</sup> January 2002, he wrote to Dr Boomla setting out his findings and impression.
19. On 16<sup>th</sup> January 2002, Sue Smith saw Stephen who recorded, as others had done early on in his contacts with mental health services, his history of drug abuse and his complaints of sexual abuse as a child and of a violent relationship between his parents. She formed the view that his use of heroin might well be linked to the anxiety symptoms he suffered and advised him to remain in contact with Dr Cohen, believing that her continued involvement “would confuse any support he receives at the DDU”. Dr Boomla told the

Inquiry Panel that he had discussed Stephen's care and treatment with Sue Smith, and that she considered him to be exhibiting psychotic symptoms, and believed that his needs would be better served by a psychiatrist rather than a clinical psychologist.

20. On 25<sup>th</sup> February 2002, Stephen attended a second appointment with Dr Cohen, who was of the opinion that there was continuing psychosis which was possibly drug-induced. Dr Cohen decided that he needed a key worker, further work to ascertain whether the psychosis was drug-induced, and support with returning to college. He encouraged Stephen to start taking Olanzapine. Dr Cohen told the Inquiry Panel that he had further appointments with Stephen on 4<sup>th</sup> March 2002 and 13<sup>th</sup> May 2002 when Stephen's presentation and the resulting clinical picture were similar. He then failed to attend an appointment scheduled for 26<sup>th</sup> June 2002 and, when Dr Cohen next saw him on 1<sup>st</sup> August 2002, he said that Stephen was then quite distressed about his psychological experiences.
21. Dr Boomla's evidence about this period was in similar terms to that of Dr Cohen. He described Stephen continuing to come regularly to the Chrisp Street Health Centre for Methadone prescriptions, but not experiencing any deterioration in his mental health until 4<sup>th</sup> July 2002 when he said that he felt worse, was having difficulty breathing, getting pins and needles in his body and felt that parts of his body were asleep. Dr Boomla formed the view that his panic-disorder symptoms were worsening, and urged him to see Dr Cohen when Stephen told him that he had not attended his last appointment and was no longer taking Olanzapine.
22. Dr Boomla next saw Stephen on 18<sup>th</sup> July 2002 when he said that he had started to take his Olanzapine again, but was not feeling any better. He complained of episodes of chest pain and shortness of breath which were not caused by exertion but made him panic. On 19<sup>th</sup> July 2002, Dr Boomla wrote to Dr Cohen saying that Stephen's symptoms were getting worse and he had re-started him on Olanzapine. Dr Boomla explained that he had encouraged him to telephone to make an appointment with Dr Cohen, although Dr Cohen

in fact wrote to Stephen on 25<sup>th</sup> July 2002 offering him an appointment on 1<sup>st</sup> August 2002.

## Chapter 5 August and September 2002

### 1<sup>st</sup> August 2002

1. On 1<sup>st</sup> August 2002, Stephen attended the appointment with Dr Cohen who told the Inquiry Panel that Stephen was very distressed on this occasion. Dr Cohen said that Stephen was feeling tense and suicidal, and he gained the impression that he was using more drugs than he had done previously. During the appointment, he told Dr Cohen that he wanted to be admitted to hospital and was concerned that he would be refused treatment and might then leave and do “something stupid”. Dr Cohen’s assessment was that this was not a serious intention, but he formed the opinion that he was very distressed and required admission to hospital, although he considered that his management would be relatively straightforward. Dr Cohen did not himself have access to in-patient beds and was therefore unable to admit Stephen. Accordingly, he wrote to Dr Abdel Aal (who was then the duty psychiatric SHO at the Royal London Hospital) in the following terms:-

“ ... has a long history of drug abuse and chronic psychotic illness. It appears that the two are not directly related. ... has complained of psychotic symptoms, but has found it hard to establish on Olanzapine.

Today he has said that he has felt worse over the last 2 months, has taken more drugs (cocaine, heroin, and occasional cannabis, alcohol and benzodiazepines) and has heard voices, like an echo, of people (one female, one male, unknown) speaking to him directly saying that things will be alright. He feels that there is a conspiracy going on and he feels that people know what he is thinking. He feels that everyone else is indulging in telepathy, but they are not telling him about it. He says that he feels very anxious about his life.

He is prescribed methadone mixture 60mg daily by his GP.

Mental state examination today revealed an age-appropriate man, with short hair but one or two days’ growth. He sat anxiously in the chair but made good eye contact and rapport. Speech was normal in form, rate, rhythm and volume. ...

He said that he feels like kicking off and that he is only just able to “keep a lid on it”. He has auditory hallucinations ... and describes a beam of light ... (sounding like a visual hallucination). ... He said that he felt that he would be one of those people who were sent away by the doctor and then went and did something stupid. He asked me “to section” him – I said he was permitted to request a voluntary admission.

It appears that he is experiencing a deterioration of his psychotic illness and that he is only just containing his feeling from acting out. Although his drug use is probably aggravating his mental state, I feel he would benefit from an admission in which the drugs could leave his system and he could be establish (sic) on a regular neuroleptic....”

2. Stephen then went to the Royal London Hospital where he was assessed by Dr Rosie Davis (the on-call psychiatric SHO), whose assessment was considered by Dr Popescu (the on-call psychiatric Specialist Registrar). Dr Davis wrote a letter to Dr Cohen dated 1<sup>st</sup> August 2002 in which she explained that she had contacted St Clement’s Hospital and learned that there were no beds available. It was noted that Stephen had admitted that he would not tolerate waiting for an extra-contractual referral. In any event, Dr Davis was of the opinion that Stephen was not showing any acute psychotic symptoms, nor any signs of affective disorder. He denied any suicidal ideation and any feelings of aggression or ideas about homicide. For those reasons, it was decided that he should not be admitted (a view with which Dr Popescu appears to have agreed, it being recorded that Dr Popescu advised there appeared to be no acute changes in this patient to precipitate emergency admission). Stephen was prescribed 10mg Olanzapine and Diazepam to help him sleep, although may not have taken these. It appears that he agreed that anxiety management training would be helpful in the long term and also to make contact again with the CDT. He was advised to seek further help should he become suicidal or his condition deteriorate further.
3. Dr Cohen went on annual leave in early August 2002 and did not therefore see Stephen again. However, he received Dr Davis’s letter before he went on holiday and, since Stephen had not been admitted, decided that he would try to refer him to the relevant catchment area psychiatrist believing that he needed some input from a general psychiatrist.

4. Stephen subsequently telephoned the GP out-of-hours co-operative on 1<sup>st</sup> August 2002 from outside the Accident & Emergency Department complaining of anxiety, depression and opiate dependency. He said that he was feeling very anxious and could not go back to his flat. He was seen by Dr Suzie Burns, who had also discussed his case with the Accident & Emergency liaison psychiatry nurse. Dr Burns was told that Stephen had been fully assessed that evening and had been offered Olanzapine and Diazepam but declined them. He had been escorted from the Royal London Hospital by a security guard. Dr Burns explained to Stephen again the plan formulated by the on-call psychiatrists (i.e. no admission) and advised him to return to A&E to collect his medication. According to her record, Stephen was not happy with the advice and walked out.

5. On 2<sup>nd</sup> August 2002, Stephen went to the Chrisp Street Health Centre and saw Dr John Robson. He was anxious and told Dr Robson repeatedly that he would harm himself or someone else and wanted to be “sectioned”. Dr Robson recorded that:-

“He was easily upset and a bit threatening – but calmed down. Feels he’s going to hurt himself of (sic) someone else – said that “if he had to go down there and see them again he would stab them”.

6. Dr Robson spoke to a duty psychiatrist who said that he/she would reassess Stephen’s condition and he accordingly went back to the Accident & Emergency Department of the Royal London Hospital where he was assessed by a Consultant Psychiatrist, Dr Read. Dr Read’s note of that assessment includes the following:-

“Returned to A&E. Assessed yesterday after referral from Dr Cohen – psychotic symptoms and drug abuse.

[Complaining of] psychotic symptoms last 2 years.

Describes symptoms suggestive of delusional mood over last few weeks. Vague feelings of danger – conspiracy, maximal in his flat ... Slept in park.

No antipsychotics – Olanzapine didn't help. No methadone last few weeks, taking heroin. Willing to restart methadone.

Back to GP today – distressed by symptoms – fearful of ↑ [increasing] isolation leading to self harm or harm to others ...

[Impression] Dual diagnosis: opiate addict. Probable psychotic symptoms worsening leading to ↑ risk of self neglect or harm to self or others. Dr Cohen who knows him is concerned about deteriorating [mental state] and recommends admit.

For admit informally ... PRN antipsychotics only and methadone 15ml tds. He understands that the purpose of admission is to assess and treat psychotic illness and that he will be discharged eventually back to his accommodation.”

### **Admission to Monro Ward: 2<sup>nd</sup> to 22<sup>nd</sup> August 2002**

7. Following Dr Read's assessment, Stephen was admitted to Monro Ward, St Clement's Hospital at 19.10 hours on 2<sup>nd</sup> August 2002 under the care of Dr Andrew Biggs. Dr Biggs was then a Specialist Registrar employed by the Trust, but had also been acting as the locum Consultant Psychiatrist for Monro Ward since March 2002. He was using two special interest sessions to cover the ward. He has a good recollection of Stephen and, although his first contact with him was on this admission, he was already informally aware of him from other colleagues.

### **Comment**

**Monro Ward was a busy ward looking after patients with complex needs and demands. At this time, it did not have a permanent manager. Dr Biggs described the interaction in 2002 between Monro ward and the CMHT as “not very good” saying that it was difficult to get members of the CMHT to come to the ward and that there was no formal arrangement whereby ward referrals could be discussed with the CMHT. It appears that there was a different locum Consultant who was responsible for the CMHT at that time. In addition, Sharon Hawley (who was the DDU manager in 2002) described the interface between Monro Ward and the DDU as “in**



**general very bad” and the relationship between the CMHT and the DDU as “awful”.**

**It was clear to the Panel that there was a failure to engage between the various services which, if recognized by the Trust, was not being addressed at all. Day-to-day relationships were poor and there were no clear policies or corporate systems to compensate.**

**The following is not intended as a criticism of Dr Biggs. Nonetheless, in 2002, he was still training and thus had limited experience. He was able to devote only two sessions a week to the ward. Whilst the Panel appreciates that the Trust had encountered problems with recruitment to consultant psychiatric posts, Dr Biggs should not have been appointed to be in charge of the ward – it was unfair and inappropriate to expect him to take on this responsibility given the local demography, the fractured systems in the organization and the need for clear and experienced clinical leadership. This should have been obvious to the Trust at the time.**

8. Dr Biggs said that he stopped Stephen’s Olanzapine prescription on admission, in order to be able to observe and assess his psychological condition in the absence of anti-psychotic medication. He told the Inquiry Panel that Stephen showed no objective evidence of psychosis on the ward. He was calm, eating and sleeping well, not thought-disordered and displayed no aggressive or agitated behaviour. His observation of Stephen’s demeanour is supported by the nursing notes in which he is described, for example, as calm, settled, pleasant, not agitated and posing no management problem. There was only one incident of agitated behaviour which was thought by the ward staff to be related to drug use.
9. The medical notes record that Dr Biggs stopped the prescription of Olanzapine on 7<sup>th</sup> August 2002. On 14<sup>th</sup> August 2002, Dr Biggs recorded that Stephen did “not appear to have deteriorated since stopping Olanzapine” and his mental state was “stable”. Dr Biggs said that Stephen was asked whether the psychotic symptoms he had described in the community were still present, and

he said they were not, which Dr Biggs considered to be significant. On 14<sup>th</sup> August, it was accordingly decided that his psychotic symptoms appeared to be drug induced, his discharge should be discussed and that the drug liaison team would discuss rehabilitation on discharge. Again, on 20<sup>th</sup> August 2002, it was recorded that Stephen did not appear to be experiencing psychotic phenomena, and his past ones were attributed to possible drug use.

10. On 22<sup>nd</sup> August 2002, Dr Biggs recorded that Stephen's mental state was stable with no psychotic symptoms elicited. A urine test had, however, tested positive for various illicit drugs including opiates, cocaine and cannabis, and it was thought that he was taking unprescribed drugs when away from the ward. His psychotic symptoms had disappeared with no current anti-psychotic medication being taken and it was decided that, despite the history of psychotic features, this presentation was one of drug-induced psychosis. Dr Biggs concluded that Stephen did not seem to be benefiting from in-patient care. He was settled, happy and sociable during the day, although somewhat more agitated during the evening, which the clinical team considered to be related to illicit drug use whilst on leave from the ward. A decision was made to discharge him that day and to notify the DDU that this had happened.
11. Dr Biggs told the Inquiry Panel that he could find no evidence of mental illness whilst Stephen was on Monro Ward, and that the only problem seemed to be that he was continuing to misuse drugs. As a result, the intention was to transfer his care back to the DDU and no other mental health intervention was anticipated.

### **Comment**

**It was apparent from the evidence heard by the Panel that there was little integration between adult mental health services and the DDU in 2002. The DDU was regarded as a separate entity and was not using the Care Programme Approach ("CPA") at all. If the DDU had a client with a significant mental health problem, that client was referred to the adult mental health services, but there was little joint working between the services. At no time in Stephen's treatment and care was a joint**

**assessment meeting between the services held, either with or without Stephen being present. In our view, this fragmentation meant that patients were at risk of losing the benefit of a comprehensive assessment of their needs and the strength of different perspectives informing their treatment plans.**

12. Stephen left Monro Ward understanding that he was to have an outpatient appointment at the DDU but that the date of that appointment had not been fixed. He did not know how the Trust intended to communicate the date of the appointment to him, but assumed that he would receive a letter about it.
13. It is fair to record here that Stephen believes that he was helped considerably by being in the stable and settled environment that the ward provided. It is his belief that he was discharged, and subsequently denied the treatment he wanted, because he was thought to be dealing drugs on the ward, an allegation which he strenuously denies.

**Comment: (1) Risk assessment**

**The admission to Monro Ward provided an opportunity to assess and manage any risk Stephen then posed, but this was not done. The Inquiry Panel considers that the need for risk assessments is obvious and well-known, and that one should have been carried out in this instance.<sup>2</sup> In fact, in Stephen's case, much of the Trust's CPA documentation was incomplete or had not been filled in at all. For example, we found in his records:-**

- a) a risk communication document which reflected a history of violence, serious harm, suicide attempts and risk behaviours, but gave no team leader's outcome. This was undated and unsigned;**

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<sup>2</sup> The Trust's Care Programme Approach and Care Management Policy (March 2001) recognised that "Concern for safety and the assessment and management of risk are core components of the CPA. Assessing risk is an integral part of any assessment, care planning and review process, but there is no fail-safe method for predicting risk."

- b) a Needs Assessment which had been partially filled in, but notably contained no summary of the assessment and no initial action plan; and
- c) a blank risk checklist and risk assessment forms which appeared to have been filed in the records at the time of this first admission in 2002, but it was impossible to know whether our impression was right or not.

In the Inquiry Panel's view, it is essential that all documentation is properly completed. Risk assessments should be carried out, documented and shared with all relevant agencies or people in accordance with policy and good clinical practice. In modern mental health care, this should have been axiomatic by 2002. It is a point which has been emphasized by many Internal and Independent Inquiries. Yet still the problem arises time after time.

**Comment: (2) Joint Assessment**

Two Consultant Psychiatrists had expressed anxiety about Stephen's deteriorating mental state. In particular, Dr Read had emphasized that Dr Cohen, who had known Stephen since November 2001, was concerned about his worsening condition. In the Inquiry Panel's view, this admission provided a good opportunity to investigate, review and assess Stephen's mental health, but that opportunity was not taken up. There was a lot of information which would have been available to inform the course of Stephen's future care and treatment had there been a determined effort to collate that information. Some information which might have been relevant (e.g. his allegation that he had been sexually abused as a child) achieved no prominence at all. Specific thought should have been given to the different views that the DDU, Dr Boomla and the ward staff held about the validity of the symptoms that Stephen had described. These issues along with the history, which was well detailed in clinical notes, should have at least indicated that serious consideration needed to be given to a potential diagnosis of personality disorder. It is reasonable to expect that such a diagnosis would have led to a different care strategy.

**In April 2002, the Department of Health<sup>3</sup> had highlighted the need for joint working between mainstream mental health services and specialist drug services where both pathologies existed. It highlighted the need for the cohesive delivery of care within mental health services to avoid patients being shunted between services or dropping out of care completely. The health and social care system which Stephen Soans-Wade encountered in 2002 did not contain adequate provision for such collaborative working. To the contrary, the various components (i.e. primary care, Monro Ward, specialist drug services, Accident & Emergency Departments, the CMHT and social services) were all working in isolation to a significant extent.**

**In the Inquiry Panel's opinion, there should have been a joint meeting on the ward aimed at achieving effective pre-discharge planning. That assessment should have included consideration of Dr Cohen's and Dr Boomla's views, both of whom knew Stephen well and believed his symptoms to be worsening, as well as the views of the ward staff. The assessment (including risk assessment) should have looked at Stephen's previous medical records and should have involved a care co-ordinator and, if at all possible, a forensic consultant. His social care needs should also have been reviewed (e.g. using the input of a member of a housing advice team).**

**In fact, Stephen was discharged from the ward without any effective CPA planning having taken place at all. The absence of any joint assessment between the DDU and adult mental health services fundamentally weakened the care provided to Stephen and the potential benefit of two different perspectives within the same organization was not capitalized upon. The result was that Stephen left the ward with no adequate and integrated care planning having taken place. In practical terms, he had no support mechanism to help build upon, or as a minimum maintain, any**

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<sup>3</sup> Mental Health Policy Implementation Guide **Dual Diagnosis Good Practice Guide**

benefits that he would have gained from an inpatient stay. He did not even have a date fixed for his outpatient appointment at the DDU.

**Comment (3): discharge summary**

Sharon Hawley told us that it was not uncommon for the ward to discharge patients to the DDU without informing the DDU that this had been done, and without sending a discharge summary to the DDU. In Stephen's case, we could find no evidence that a discharge summary had been sent to the DDU, and Dr Boomla rightly complained that, as a GP, the information he received was often irrelevant or incomplete.

The failure to provide a discharge summary contravenes the principles of CPA, and further suggests that the adult mental health services did not regard the DDU and primary care as their equal partners in any attempt to co-ordinate care across various settings. In the Panel's view, effective communication and consultation between secondary and primary care should have been regarded as essential. The Panel felt that insufficient attention was given to the potential benefits of primary care taking a more leading role. Thus, the secondary care service was at risk of skipping elements of partnership and good clinical practice and, as a result, of undervaluing the role of primary care.

**23<sup>rd</sup> August 2002**

14. Having been discharged on 22<sup>nd</sup> August 2002, Stephen returned to Monro Ward at about 16.30 hours on the following day "demanding to be admitted" according to his medical notes. He told the Inquiry Panel that he felt that he could not cope outside hospital, that he could not look after himself and had nobody else either to look after him or to act as his advocate and seek treatment for him. He was not washing or feeding himself. He felt unable to communicate properly with people. He had people living in his flat who were using drugs and who he did not want to be there. However, he seems to have been unable to persuade them to leave. Stephen said that he realized that admission to hospital might not be the answer, but that he felt unable to

manage on his own and needed a “safety net” at that time. It was apparent from talking to him that he strongly believes that his needs were not adequately addressed and that he was let down at a time when he was asking for help.

15. A Senior House Officer, Dr McCubbin, was on Monro ward and he noted that Stephen was complaining of having spent all his money, and of having people staying at his flat that he did not like. He said that he had been using drugs since the day before. He was offered a referral to the Homeless Persons Unit, but would not accept that suggestion and became aggressive throwing a plant and some files around the office. Dr Biggs told the Inquiry that Dr McCubbin explained that the correct route for re-admission was via Accident & Emergency (not presentation at the ward itself), although Stephen threatened to harm himself in order to secure re-admission. He agreed to leave the ward, but became violent again as he was leaving (apparently trying to smash the glass in a door) and had to be restrained. The police were then called and Dr Biggs believes that Stephen was removed from Monro Ward.
  
16. In the evening of 23<sup>rd</sup> August 2002, Stephen went to the Royal London Hospital Accident & Emergency Department where he saw the duty psychiatric liaison Approved Social Worker and also a mental health liaison nurse. On one occasion (at 19.50 hours), he asked for Methadone or some Codeine, but was told that Methadone was not dispensed there. On another occasion, he requested a mental health assessment saying that he believed that he needed to return to hospital. At 20.20 hours, he was told that he needed to wait to be seen, although he subsequently left the department without doing so.
  
17. Stephen later contacted the police when he was apparently in some distress and saying that he might hurt someone. He was then taken back to the Accident & Emergency Department at 23.52 hours by the police using their powers to remove a person who appears to be suffering from mental disorder and to be in immediate need of care or control to a place of safety (in this case the A&E department): section 136 Mental Health Act 1983. He was seen by Dr Ince, the psychiatric SHO who was on call, and Robin Graham, an Approved Social Worker. Dr Ince was aware that Stephen had been to the department

earlier that evening and, also, that he had been discharged from Munro Ward, where there had been a decision that he was not mentally ill. Dr Ince's note of the consultation includes the following information:-

"Threatening to harm someone. Claims discharged without medication. In dept earlier today making various requests of staff. Left without treatment.

Previously asked to leave Munro Ward due to not found to be mentally ill. Dealing drugs on ward. ... Returned to ward this afternoon and became verbally abusive towards staff – escorted off the premises.

... Still feels suicidal. DENIES dealing drugs. ...

Mood – "pretty steady now. Thought I was going to explode. ...Does not know why he wanted to harm self or another. Not sure if he wants to harm self now. ...

Insight "I suffer from depression and anxiety". I need to be sectioned for my own safety and other people's safety....

"I don't think not being admitted would be a suitable outcome." ..."

18. Dr Ince recorded the impression that Stephen was "not psychotic", had "no clear suicidal plans" and displayed "little convincing evidence of mental illness". Mr Graham noted that "there was doubt about the validity of the symptoms he described". After a discussion with the psychiatric Specialist Registrar who was on call, Dr Ince informed Stephen that he would not be admitted. On hearing this, Stephen refused to accept any medication. He threatened to attack Dr Ince and Mr Graham and threw a table or chair at them, saying that he was determined to be "sectioned", and had to be restrained by security personnel. As a result of this behaviour, the police were called and he was arrested.

## **25<sup>th</sup> August 2002**

19. The next documented attendance at hospital was at 05.13 hours on 25<sup>th</sup> August 2002 when Stephen went to the King's College Hospital Accident & Emergency Department. At triage, he was recorded as being a patient with a longstanding



psychiatric history who said he was feeling suicidal and depressed. He was noted to have been in hospital, but it was said that he had been asked to leave because he was using non-prescribed drugs. He requested hospital admission to prevent self-harm saying that he would walk under a car. It was also noted that he had been arrested that night because he had assaulted a nurse at St Thomas's Hospital. Elsewhere, it is recorded that the incident happened at King's College Hospital. In any event, it appears that he was subsequently convicted of the offence and received a sentence of three months imprisonment.

20. A risk assessment was completed at King's College Hospital which we reproduce here:-

<u>SUICIDE</u>	Yes	No	Don't know	<u>VIOLENCE</u>	Yes	No	Don't know
Previous suicide attempts	√			Current			
Family history of suicide			√	Hostile or threatening behaviour	√		
Major mental illness		√		Violent thoughts or fantasies			√
Current intent to end life		√		Has problems controlling temper	√		
Current misuse of drugs/ alcohol	√			Possesses weapons with possible intent to use	√		
Feelings of hopelessness or lack of control	√			Has access to potential or threatened victim	√		
Recent disengagement or non-compliance		√		Drug or alcohol abuse	√		
Recent loss or threat of loss		√		Has symptoms which increase the risk of violence for this person	√		
High level of distress		√		Concern has been expressed by others about violence	√		
Physical illness or		√		Past history			

disability							
Lives alone (or will do after discharge)			√	Has a previous history of violence	√		
Social isolation		√		Has a history of disengagement from services	√		
Recent discharge from hospital	√			Witnessed or a victim of violence or emotional abuse in childhood			√
Concerns expressed by significant others		√					
Other individual factors (e.g. stressors, coping methods, relationships) <i>Poor coping skills.</i> <i>Threatening to self-harm if not admitted to hospital.</i>				Other individual factors (e.g. stressors, particular symptoms) <i>Hx (history) of polysubstance use.</i> <i>Hx of violence; assaulted PLN (psychiatric liaison nurse) in St Thomas yesterday</i> <i>Problems controlling temper</i>			
<u>Other risks to self (including from others)</u> Consider: self-neglect; accidental injury; physical health; deliberate self-harm; vulnerability to abuse or exploitation. <u>Please detail</u>				<u>Any other risks to other people</u> Consider: risk to child – intentional or unintentional; deliberate or accidental fire-setting; abuse or exploitation of others <u>Please detail</u>			
<u>Consider:</u> <ul style="list-style-type: none"> <li>• Nature and degree of risks identified: who is at risk? How likely is it to occur?</li> <li>• Relationship between risk and mental disorder, current social circumstances or other contextual factors.</li> <li>• Factors increasing the risk and protective factors that reduce risk. Previous helpful interventions.</li> <li>• Client's, carers' and others' views of risk.</li> <li>• Gaps in information.</li> </ul> <u>Violence:</u> <i>Hx of violence, assaulted PLN in St Thomas yesterday.</i> <i>Known to carry a knife.</i> <i>Polysubstance user.</i>							

→ *High risk of violence*

*DSH (deliberate self harm):*

*Hx of DSH/threats to self-harm;*

*Threatening to harm himself if not admitted to hospital. Behaviour demanding/intimidating on assessment.*

→ *moderate risk of DSH due to poor coping skills.*

*Plan :*

*(1) discharge*

*(2) Royal London/St Clemens (sic) aware*

*(3) security to escort pt out of dept.*

*(4) EC aware*

21. Stephen was seen at King's College Hospital Accident & Emergency Department at 9.20am by a Dr Muller-Pollard, when it was recorded that he was claiming that he could not cope and was "demanding to be put on section or admitted to a ward". He said that he could not deal with people and noise and that his anxiety was overwhelming. Dr Muller-Pollard also recorded the following information:-

"Whilst he is not suicidal at present when he gets anxious it makes him want to throw himself under a train or kill someone. If he does not get sectioned/admitted then he will either become violent or self harm."

22. The records make it clear that it was known at King's College Hospital A&E that Stephen had presented to hospitals on a number of occasions demanding admission. In a telephone call to somebody working at Monro Ward, it was confirmed that he had shown no evidence of psychiatric illness other than substance misuse and personality disorder whilst there. Under the heading "risk", it was noted that Stephen had complied with a search and had no weapon. It was decided that he was not suicidal at the time, but making threats to harm himself or others if his needs were not met. He was noted to have a history of violence, but not of following through his self harm threats. The clinical decision at King's College Hospital was that he should be discharged

and encouraged to self present to the DDU. He did not receive any medication there.

## **26<sup>th</sup> August 2002**

23. On 26<sup>th</sup> August 2002, Stephen went back to the Royal London Accident & Emergency Department, although there was little information about this attendance. It does, however, appear that, whilst there, he made threats against Dr Robson which were reported to the out-of-hours GP service. Dr Franco Taconnelli noted that Stephen was making “aggressive threats to his GP”, and warned the Chrisp Street Health Centre that this had happened. Dr Taconnelli recorded:-

“Patient has assaulted 2 people; was reviewed in Casualty by duty psychiatric SHO; threatened to kidnap/assault Dr Robson; but despite this has been released on bail??? The psychiatrist says not detainable and has called Thedoc to pass message onto GP practice; advised if he comes to Chrisp Street Practice to \*\*\*\*\* call police immediately\*\*\*\*\*”.

### **Comment**

**Although the threat was not made against him, Dr Boomla told the Inquiry Panel that he had a very good relationship with Stephen and was not personally worried about such threats. It was apparent from talking to Stephen that he similarly thought he had developed a positive relationship with Dr Boomla and Dr Boomla’s lack of concern for his own safety is understandable in that context.**

**Dr Dolan, however, observed to the Inquiry Panel that it should be considered serious where a service fails to respond when faced with reports of assaults by a patient, his threats to kidnap/assault a doctor and his reported anxiety that he will throw himself under a train or kill someone. The Inquiry Panel agrees with Dr Dolan’s observation.**

**Dr Biggs told us that he was not aware of Stephen’s various attendances at Accident & Emergency Departments, and we do not consider that he was fully**

aware of the different threats made by Stephen, nor of the risk assessment completed at King's College Hospital in which it was concluded that there was a high risk of violence. Indeed, we found no evidence that anybody was in a position to form a comprehensive overview of what was then happening. As a result, the various threats made by Stephen featured less significantly in the management of his mental health needs than they should have done. Stephen's threats and actions gave sufficient indication that his violent behaviour might escalate, but this was not recognized. The Panel recognizes the number of 'false positives' that arise in making assessments of risk. However, in Stephen's case there were multiple threats of violence and changes in behaviour.

#### **27<sup>th</sup> August 2002**

24. On 27<sup>th</sup> August 2002, Dr Khwaja (who is also a GP at the Chrisp Street Health Centre) discussed Stephen's attendance at the Accident & Emergency Department on the preceding day with the duty psychiatric SHO. Dr Kwhaja noted the threats made against Dr Robson and the impression of the Consultant Psychiatrist at St Clement's Hospital (presumably Dr Biggs) that Stephen did not have a psychiatric illness.
25. On the same day, Dr Boomla saw Stephen. Stephen was very agitated and distressed and told Dr Boomla that he did not feel safe in the community but needed to be in hospital again. Stephen said that nobody took him seriously each time he tried to get into hospital. Dr Boomla formed the view that Stephen was making threats to try to gain admission to hospital, but that he was doing so because he felt so anxious and tense that he did not feel safe on his own. Dr Boomla considered that he did need admission and advised him to return to the Accident & Emergency Department for re-assessment. He arrived at 11.55 hours where he was assessed by the on call psychiatric SHO, a Dr Noakes.
26. Stephen's presenting complaint was recorded as follows:-

"I just don't feel safe. I feel like I'm going to do something. I'm going to push somebody under a bus or a train unless I get help. I'm not safe."

Stephen claimed to have been thinking such thoughts since his discharge from Monro Ward. He told Dr Noakes that he had been doing well on Monro Ward and feeling better, but had been discharged for allegedly dealing and using drugs. He said that he had been feeling increasingly irritated since then and been trying to gain admission to hospital for the past week. Mental state examination revealed good eye contact, but psychomotor agitation. He expressed paranoid ideas saying that everyone was "out to get him", although he was no more specific about the conspiracy he perceived. He had frequent thoughts of suicide, but no plan or intent to carry it out. He told Dr Noakes that he would push somebody in front of a bus or train if he was not admitted.

27. Dr Noakes recorded the impression that Stephen was a "well known patient with drug problems, has been becoming [increasingly] violent. Claiming to be depressed and homicidal". Dr Noakes discussed Stephen's care with Dr Biggs who explained that he would not benefit from admission, was threatening but had no psychiatric illness. However, owing to Stephen's threats to cause harm to others, Dr Biggs agreed that he should have a crisis admission for a few days. This would be an informal admission with an agreed plan involving no leave from the ward and drug testing. Dr Biggs also considered that a forensic assessment was needed. He told the Inquiry Panel that Dr Noakes had been concerned about Stephen and was not comfortable with the idea of discharging him. Nonetheless, Dr Biggs explained that he considered Stephen's threats to harm somebody to have been made with the intention of coercing the Trust into agreeing to his admission. However, he stressed that he does not consider an acute psychiatric ward to be the appropriate place to treat patients with a personality disorder, but that he was trying to manage Stephen's condition within the constraints of the services available to him. It was also apparent that Dr Biggs did not know that Stephen had had the contact with hospitals set out above, which was rightly a matter of concern to him when we spoke to him.

## **Admission to Monro Ward: 27<sup>th</sup> August to 5<sup>th</sup> September 2002**

28. Stephen was therefore re-admitted to Monro Ward. Upon admission, Dr McCubbin noted in his records that:-

“We have explained that he has no leave at present, and have explained that any evidence of illicit drug use/dealing, alcohol use or aggression will result in his immediate discharge.

Plan:

- Short, crisis admission
- Social services review
- Dipstick urine
- Forensic assessment
- All involved → WR [ward round] incl[uding] DDU staff.”

29. On 30<sup>th</sup> August 2002, Stephen should have been at Court having been charged with assault following the incident on 25<sup>th</sup> August 2002.

30. Dr Biggs told the Inquiry Panel that, by the time of this admission, he thought that the diagnosis for Stephen was likely to be one of an emotionally unstable personality disorder, probably impulsive type, but also with substance abuse. He emphasized that there was again no evidence of any mental illness during the admission. Indeed, Stephen was described in his clinical records as being “calm and appropriate” and posing “no management problems”.

31. As a result, the decision was taken on 5<sup>th</sup> September 2002 that Stephen should be discharged from Monro Ward and he left that morning. He was described as showing “no evidence of acute psychiatric illness at present” and his mood was said to have been stable from the start of the admission. Dr Biggs explained that, although Stephen’s mental state remained stable, he had ongoing housing problems. He was therefore referred to the Housing Link Team (a specialist housing support agency for people with mental health problems which was based at St Clement’s Hospital) for accommodation advice, having been told that he could not expect to stay on the ward whilst his housing situation was sorted out, and that it was not reasonable to expect to be admitted for hospital for social reasons. He was also referred to the CMHT and Dr McCubbin

recorded that he “will hopefully be allocated a key worker”. In addition, it was noted that Stephen was “known to the DDU, and to Dr Cohen there”. Dr Biggs told the Inquiry Panel that “it was quite clear” that Stephen:

“needed to have someone in the community He needed someone to follow him up, assess him, find out what the situation was in the community, because it did appear, from the few reports that I had, to be different to the way he was presenting to us. So, we referred him to the Community Mental Health Team. But ... again, we were intending it very much to be sort of joint management with the Drug and Alcohol Service.”

32. Notwithstanding Dr Biggs’ assessment that Stephen needed some form of support in the community, he did not learn until much later that the CMHT had not accepted him as one of its caseload.

### **Comment**

**It is noticeable that Dr Biggs’ likely diagnosis of a personality disorder was not recorded in Stephen’s records. In our view, the care planning was affected adversely by the lack of clarity about the diagnosis. If diagnosed as suffering from a personality disorder, Stephen should have met the CMHT referral criteria<sup>4</sup>. However, it appears that the CMHT referral was refused, although the Inquiry Panel did not find any document recording the reason for the referral being refused and was unable to discover the reason for it. Whilst we consider that Dr Biggs correctly saw the need for Stephen to be referred to the CMHT, the system within which he was working lacked the cohesion which was necessary to address that need adequately.**

**We also record that Sharon Hawley told us that it was her perception that the CMHT often did not accept patients suffering from personality disorders or that, if, having been accepted by the CMHT, the patient failed to attend appointments or to engage with the service, the CMHT would discharge the patient. She said that the effect of this was that the DDU often found itself**

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<sup>4</sup> Cf East London and City Mental Health NHS Trust **Care Programme Approach and Care Management Policy** (March 2001)



**carrying on its work with the patient unsupported by any other part of the adult mental health service.**

33. At 16.12 hours on 5<sup>th</sup> September 2002, Stephen went to A&E having taken an overdose of 24 Paracetamol and having called an ambulance himself. It was noted that this was his sixth attendance at an Accident and Emergency Department since 2<sup>nd</sup> August 2002. He was described as feeling very angry at having been discharged from St Clement's Hospital that morning, and not being sure if he really wanted to kill himself. When talking to the Inquiry Panel, Stephen said that he had not been coping and had felt under stress and that there was a plot against him. He had been hearing voices which were instructing him to harm himself or somebody else, and thought that he might be dangerous to other people. He described to the Inquiry Panel feeling as though he were driving a stagecoach which was out of control and wanting somebody else to take hold of the reins for him and take control of his life. Again, he had felt alone and unsupported and believed that he needed to be admitted to hospital.

34. He was referred to the psychiatric liaison service and it was decided that there should be a further informal admission. The treatment plan included the following:-

- “- regular drug urine screens
- no leave for time being
- methadone 60mls/day
- Haloperidol 5mg im/po. PRN
- Procyclidine 5mg im/po. PRN
- Discussed with him that a lengthy hospital admission will not be beneficial for him and that he has to regain independence. ...

The admission is on grounds of his suicide risk and ideas of harming others. A regular antipsychotic and antidepressive medication should be consider (sic). Before discharge the possibility of day centre/community groups ... should be explored as he lacks any social support.”

## **Admission to Monro Ward: 5<sup>th</sup> September to 9<sup>th</sup> September 2002**

35. Stephen was therefore admitted again to Monro Ward. On 6<sup>th</sup> September 2002, his clinical notes include the following observations:-

“Once more, Stephen is now settled on the ward. Laughing and interacting with other patients and has a reactive affect. It would seem that Stephen has manipulated an admission due to his social situation.

Brixton police have a warrant for his arrest as he did not attend court last week.

Plan:

No leave

Discharge if violent/aggressive

Await word from police.”

36. On 9<sup>th</sup> September 2002, Dr Boomla recorded that Stephen had been discharged from St Clement’s Hospital and had spent the weekend in police custody. He had been supplied with Methadone which had run out and Dr Boomla arranged a prescription for the next two weeks, which Stephen collected. He also advised Stephen to contact Dr Cohen to make an appointment.
37. At 8.10 hours on 13<sup>th</sup> September 2002, Stephen was driven to St. Clement’s Hospital by the police. They had gone to him because he had been threatening to commit suicide or harm himself. One of the police officers involved recorded that Stephen was complaining about voices in his head which would make him do “bad things”. At St. Clement’s, the police were advised to take him to the A&E Department of the Royal London Hospital because access to the ward was via A&E. They then drove him to the Royal London Hospital and left him there. According to Dr Biggs, Dr Kent (a specialist registrar in psychiatry) telephoned him and asked for information about Stephen before she spoke to him. However, Dr Biggs said that he did not in fact wait to be seen.
38. At about 4.10pm on 13<sup>th</sup> September 2002, Stephen went to Mile End Underground Station and walked to the Eastbound Central Line platform. The

CCTV film seized from the station showed that he was behaving in an agitated manner and was seen repeatedly standing up and sitting down on a bench, walking in between the pillars of the platform and biting his fingernails. At 5.09pm, he was seen to push Christophe Duclos into the path of an oncoming underground train. Christophe Duclos was severely injured and was taken by ambulance to the Royal London Hospital. Upon admission, he was found to have sustained traumatic amputation of his left arm, multiple rib fractures and an underlying lung injury, fracture and dislocation of the left hip and a fracture of the left knee and ankle. His condition deteriorated whilst he was in the Intensive Care Unit and he died on 16<sup>th</sup> September 2002.

39. Stephen was arrested at Mile End Underground Station and taken to Bethnal Green police station. He was initially held on remand at HMP Belmarsh but, in February 2003, was transferred to Rampton Hospital.

## Chapter 6 Stephen Soans-Wade – diagnoses, presentation and needs

### Diagnoses

1. Following the homicide, Stephen Soans-Wade received extensive psychiatric assessment including placement at Rampton hospital. There is a striking concordance between the diagnostic views in the psychiatric reports made at the time of his trial.
2. Professor Nigel Eastman reporting for solicitors (in a report dated 20<sup>th</sup> August 2003) concluded “the defendant suffers from a lifelong personality disorder, longstanding substance dependence, and at the time of the offence, was suffering from a severe exacerbation of the symptoms of personality disorder, probably sufficient to amount to an additional diagnosis of psychosis”. This view is supported by Dr Pauline Souflas (in a report dated 22<sup>nd</sup> August 2003) who assessed Mr Soans-Wade at Rampton hospital. She found that at the time of the index offence, he was in a state of turmoil and distress, as well as feeling detached and unreal. He observed that he did not have a mental illness such as schizophrenia, and his reports of voices were of those that can occur with substance misuse and personality disorder. It was concluded that he suffers from a personality disorder, but he was not susceptible to treatment and did not therefore meet criteria for detention under the category of Psychopathic disorder.
3. Similarly, Dr Joseph (in a report dated 11<sup>th</sup> September 2003) found that he suffered from “a severe personality disorder...the primary diagnosis is dissocial personality disorder, also referred to as antisocial or psychopathic personality disorder...in addition he shows traits of other related personality disorders...In addition he also suffers from drug and alcohol abuse” although he was not drug or alcohol dependent. “The defendant has also suffered at times with paranoid symptoms which have reached psychotic intensity”. These paranoid symptoms

were thought to be drug induced. His complaints of voices telling him to e.g. shoplift probably did not represent a true auditory hallucination, but an internal expression of his own thoughts and feelings. Dr Joseph concluded that the defendant had a long history of making threats to achieve what he wanted and this was not a new situation in the month prior to the alleged offence. The episodes of aggression shown by the defendant were not related to any psychotic symptoms.

4. Looking back, the medical records suggest that various clinicians had made a tentative, but accurate formulation, that his main problem was a severe personality disorder quite early in Stephen Soans-Wade's psychiatric history.
5. Although his earliest presentations to the psychiatric services in Derby in 1992 suggested an agitated depression, within a short time the diagnosis was given as amphetamine psychosis (see Dr Bronks's assessment of 24<sup>th</sup> November 1992). After his next admission in April 1993, it was concluded that he was not depressed and there was no evidence of a psychosis – his diagnosis was of an antisocial personality disorder. This was essentially the view of Mr Siddle, a cognitive behavioural therapist who concluded that there were indicators more of a longstanding personality disorder rather than depression in August 1993.
6. In 1997, Stephen Soans-Wade moved to London. In his contacts with the Great Chapel Street Medical Centre from June 1997 until September 1998, he is recorded to have shown a vulnerable personality with probable intermittent psychosis (Dr Alice Parshall – 22<sup>nd</sup> July 1997). This period was terminated by his chaotic misuse of drugs and alcohol and his threats to others. From March 2000, he was variously assessed by the Tower Hamlets CDT, the DDU and adult psychiatric services. He was initially described as having a mild form of schizophrenia (Dr Reid 14<sup>th</sup> April 2000), but his GP expressed doubts and referred him for assessment from a general psychiatrist. Dr Cobb (15<sup>th</sup> November 2000) found no evidence of mental illness but that the main problem was opiate misuse. Following further acute presentations to psychiatric services, the next major diagnostic assessment was that of Dr Cohen who was concerned that he showed a psychotic illness either due to drug misuse, or

possibly due to underlying schizophrenia (assessment letter of 8<sup>th</sup> January 2002). On inpatient assessment in August 2002, Dr Biggs found no evidence of mental illness and the diagnosis is given as a drug-induced psychosis. In a further admission 27<sup>th</sup> August to 5<sup>th</sup> September 2002, it was found that Stephen Soans-Wade showed no evidence of acute psychiatric illness. Dr Biggs told the Inquiry Panel that at that time he thought the diagnosis was of an emotionally unstable personality disorder with substance abuse.

7. It would appear that when Stephen Soans-Wade was acutely disturbed, clinicians found him to be psychotic and attributed this to drug misuse or possible major mental illness. These assumptions are highly reasonable in an acute presentation. The inpatient admissions at least made it probable that he did not have a major psychotic illness, but the reasonable conjecture that he had a severe personality disorder was apparently not expressed as a clear diagnosis, nor did it appear to inform the treatment plan.

### **Presentation and needs**

8. Stephen Soans-Wade presented to a range of medical services in a chaotic, impulsive, needy and at times threatening state. He misused a range of drugs which made his mental state more unstable. He would in general settle rapidly on an inpatient psychiatric ward, only to become anxious and threatening at the point of discharge.
9. It would appear that in many of his interactions with psychiatric services, his needs were perceived as synonymous with ensuring that he did not have a treatable serious mental illness such as schizophrenia. The inpatient services, in particular, appear not to have regarded it as their task to address his impulsive and chaotic behaviour with the result that he made nearly impossible and escalating demands upon services.
10. In the care that he received over the year prior to the index offence, it has not been possible for the Inquiry to identify a single individual or team with the lead responsibility for co-ordinating and delivering care. This is not to suggest that all

of the requests made by Stephen Soans-Wade could or should have been met – but that he did not receive a co-ordinated and considered package of care. The possible elements of such a care package are addressed below.

### **Personality disorder, mental health needs, substance misuse and the national policy framework**

11. It was recognised at the time that Stephen Soans-Wade had complex mental health symptoms that varied in form, intensity and consistency. Such a presentation is not uncommon, and for at least two decades it has been recognised that a considerable proportion of patients will meet diagnostic criteria for more than one type of condition at a time.
12. As a recent confirmation of this view, Weaver et al (2003) measured the prevalence of comorbidity among patients of community mental health teams and substance misuse services – the areas sampled were the London Boroughs of Brent and Hammersmith and Fulham and inner-city Nottingham and Sheffield. Of CMHT patients, 44% reported past-year problem drug use and/or harmful alcohol use; 75% of drug service and 85% of alcohol service patients had a past-year psychiatric disorder. Among the London CMHT patients the substances of misuse ranged from cannabis (36%), alcohol (27%), sedatives (17%), crack cocaine (10%) and heroin (6%). Among the London drug-service patients, 58% showed a personality disorder and 11% showed a non-substance induced psychotic disorder.
13. Patients with problems that do not fit neatly into service expectations often fall between “psychological stools”. As Weaver et al (2003) observed, “Psychiatric teams and substance misuse services fail to identify significant proportions of patients with such comorbidity on their case-loads. Most patients with substance misuse problems on psychiatric case-loads receive no substance misuse interventions, and a third of substance misuse patients with mental health problems do not receive any mental health”. The net effect is that most comorbid patients appear ineligible for cross-referral between services, and yet these are often patients with severe needs and high risks.

14. In 2003, the Department of Health published information for Trusts about the Government's intentions for the delivery of personality disorder services within general mental health and forensic settings (N1MHE 2003).

15. The National Service Framework for adult mental health sets out responsibilities to provide evidence-based, effective services for all those with severe mental illness, including people with personality disorder who experience significant distress or difficulty. The guidance aims to build on standards four and five in the National Service Framework and sets out specific guidance on development of services for people with personality disorder. The guidance states that:-

“all Trusts delivering mental health services need to consider how to meet the needs of patients with a personality disorder who experience significant distress or difficulty as a result of their disorder.”

16. It is noted that –

Many general mental health services struggle to provide an adequate service for people with personality disorder. In many services people with personality disorder are treated at the margins – through A&E, through inappropriate admissions to inpatient wards, on caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them. They have become the new revolving door patients, with multiple admissions, inadequate care planning and infrequent follow-up. Many clinicians are reluctant to work with people with personality disorder because they believe that they have neither the skills, training, or resources to provide an adequate service. Clinicians may find the nature of interactions with personality disordered patients so difficult that they are reluctant to get involved.

Many clinicians are sceptical about the effectiveness of treatment interventions for personality disorder, and hence often reluctant to accept people with a primary diagnosis of personality disorder for treatment. However, a range of treatment interventions are available for personality disorder, including psychological treatments and drug therapy, and there is a growing body of literature available on the efficacy of varying treatment approaches..... In general, a combination of psychological treatments reinforced by drug therapy at critical times is the consensus view of treatment in personality disorder.

The key guiding principles of effective therapy for personality disorder are that therapy should:



- be well structured
- devote effort to achieving adherence
- have a clear focus
- be theoretically coherent to both therapist and patient
- be relatively long term
- be well integrated with other services available to the patient
- involve a clear treatment alliance between therapist and patient

Trusts may also wish to consider the development of a specialist personality disorder team to meet the needs of those with personality disorder who experience significant distress or difficulty. Such a team would provide the hub within a hub and spoke approach to service delivery, and should target those with significant distress or difficulty who present with complex problems. The specialist team would provide consultation and support for staff working in a range of settings in accordance with agreed protocols:

- within the adult mental health service ( e.g., in patient ward, community teams)
- across the Trust (to CAMHS, A&E, and drug & alcohol teams etc)
- to external agencies (social services, probation, housing, primary care).

17. The guidance states that staff working with personality disordered individuals will require careful selection, training and support.
18. The guidance states that funding has been made available which has enabled some Trusts to develop personality disorder services over the three-year period from 2003-2006. However, currently this has occurred in only two Trusts in the London area, one of which is the East London and The City Mental Health NHS Trust i.e. the Forensic Personality Disorder Services (Millfield Unit) at the John Howard forensic unit in Hackney.
19. The Dual Diagnosis Good Practice Guide (DH 2002) summarises current policy and good practice in the provision of mental health services for people with severe mental health problems and problematic substance misuse.

## References

Dual Diagnosis Good Practice Guide (DH 2002). (London, Department of Health).

National Institute for Mental Health in England. (2003). **Personality disorder: no longer a diagnosis of exclusion.** (London, Department of Health).

WEAVER T, MADDEN P, CHARLES V, et al (2003) **Comorbidity of substance misuse and mental illness in community mental health and substance misuse services.** Br. J. Psychiatry; 183: 304 - 313.

## Chapter 7 Discussion

1. The Trust serves the London boroughs of Tower Hamlets, Newham, Hackney and The City of London. Its forensic services are also provided to the boroughs of Barking & Dagenham and Havering. It is operating within an area of London which comprises many different ethnic communities, including a significant number of asylum seekers, refugees and homeless people. A wide variety of languages is spoken. Using the DETR's Index of Multiple Deprivation, Tower Hamlets is fourth on the IMD, Hackney is fifth and Newham is eleventh (where one is the most deprived area). A clear correlation exists between adverse social, economic and health conditions and substance misuse.
2. The Trust, Tower Hamlets Council and Tower Hamlets PCT therefore face the challenge of how to offer accessible, co-ordinated, efficient and effective mental health and social care services to a diverse population. Many members of the community are socially deprived, discrimination and stigma may often be encountered when dealing with mental health issues and substance misuse may often appear as a feature of diagnosis. All are fully aware that they have to implement appropriate policies and procedures to meet this challenge. In particular, the Trust is also aware that it was the subject of rigorous criticism in February 2003 when the Commission for Health Improvement published its Clinical Governance Review of East London and The City Mental Health Trust and that its practice and procedures have been investigated extensively over the past six years following a number of homicides and other serious untoward incidents dating back to the 1990s by psychiatric patients under its care.
3. The Panel has concluded from the written and oral evidence that much has been learned, not only from looking at past incidents, but also by the development of the Trust's executive team and leadership skills, the fostering of better relationships between clinical staff, the building of capable teams at all levels who understand the need to support patients, and by the consideration and adoption of good practice from external sources. All of this has contributed

to the Trust having moved forwards in terms of understanding the changes it needs to make and starting to put those changes into practice.

4. Nonetheless, the Trust's draft Clinical Strategy 2005-2008 accepts that there is more work to be done to provide a more integrated and cohesive system of health and social care than is presently available. Of particular relevance to this Inquiry is the acknowledgement in the Clinical Strategy that adequate services are not yet being provided to those patients who present with personality disorders, to those who have dual diagnoses and to those who potentially represent a considerable risk to themselves or others. These areas of deficit were similarly identified by various witnesses to the Inquiry both in relation to 2002 and now. As one witness observed when talking about Stephen, he was "one of those people who fell through the gap". Another witness was clear in her assessment that the Trust had failed him. Whilst we accept that there have been many positive changes to date, we are not satisfied that the systems in place at present would yet fully identify and meet the health and social care needs of a patient presenting now as Stephen Soans-Wade did in 2002.

### **Personality disorder**

5. *Personality disorder: no longer a diagnosis of exclusion* describes how such patients all too frequently receive a patchy or inadequate response from mental health services. Trusts are urged to consider the development of a specialist personality disorder team - such a team would provide the hub within a hub and spoke approach to service delivery, and should target those with significant distress or difficulty who present with complex problems. The specialist team would provide consultation and support for staff working in a range of settings in accordance with agreed protocols: • within the adult mental health service (e.g. inpatient ward, community teams), • across the Trust (to CAMHS, A&E, and drug and alcohol teams etc), • to external agencies (social services, probation services, housing, primary care).<sup>5</sup>

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<sup>5</sup> National Institute for Mental Health in England (2003). **Personality disorder: no longer a diagnosis of exclusion** (London, Department of Health).

6. The East London and The City Mental Health NHS Trust has established a residential unit for detained patients i.e. the Forensic Personality Disorder Services (Millfield Unit) at the John Howard forensic unit in Hackney. The documentation available to the Inquiry does not demonstrate how the Trust wishes to develop services for personality disordered patients in community and other general psychiatric settings.

### **Dual-diagnosis patients**

7. This term is generally applied to those patients with a substance misuse problem in addition to a mental illness, but should also include those with clinically significant personality disorder.
  8. It is apparent that the Trust and its partners are continuing to develop their work on dual diagnoses. In the Inquiry Panel's view, commissioners need to take a lead in ensuring that Models of Care (i.e. the National Service Framework for Drug Services) is implemented effectively so that services are clear about where they fit into the network of services. In addition to this, service level agreements should be written with clarity, not just about cost and volume of services, but also the interdependencies of various services.
  9. Further progress needs to take place on a range of levels:-
    - staff need to be developed and given further training,
    - policies need to be clear,
    - operational arrangements need to be tight, with clear protocols for escalation.
  10. To a large extent, the Trust has made progress on all of these, but operational arrangements are still reportedly fragile. The oral evidence we heard indicated that it would still be possible for someone with the pathology presented by
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Stephen to 'slip through the net'. In the Panel's view, communication needs to be strengthened so that it is not left to individual preference. Criteria that determine who will be responsible need to be reviewed and tested to ensure that they are clear to all involved, and that arrangements are in place for those not fitting neatly into any given category.

### **In-patient detoxification and rehabilitation**

11. The setting-up of an inpatient unit with detoxification and rehabilitation beds is in the early stages of planning in East London. The Panel considers there is a real need for such a unit which would probably be over-subscribed. There are clear benefits to be gained from having locally run inpatient detoxification and rehabilitation beds. Additional services do however create additional interfaces. The experience locally had been that managing across service boundaries increased the risk of confusion and poor communication. Although this is not a good reason not to develop services that benefit patients, the Trust and its partners must anticipate and manage these risks so that services are clear about respective responsibilities and clinicians are confident about the scope and limits of their roles.

### **Day Centre**

12. Many patients who present with dual diagnoses have poorly developed social networks and can be left feeling isolated and vulnerable when they are unwell. In our view, the provision of effective and useful day services as part of their care package can help to combat those problems. The Care Services Improvement Partnership (incorporating the National Institute for Mental Health in England) has developed useful guidance on creating modern day services. We were told that a day centre may now be incorporated into the new Mile End Hospital complex and this would be a useful step forward. With citizenship firmly in mind, day services should not necessarily be considered as building based 'centres', but should facilitate people's personal growth and integration into society. Again, the issue of multiple interfaces is relevant here and the

Care Programme Approach will need to be operating at optimum levels to avoid duplication and confusion.

### **Joint assessment**

13. The Trust's policies need to be explicit about the need for clear planning meetings that include input from all those involved in the care and treatment of a patient. In order for joint assessments to work effectively, systems need to be in place for meetings to be scheduled in good time and, where care co-ordinators or keyworkers are unable to attend, for representatives to attend in their place or for written information to be submitted as a minimum. It is important that GPs are able to play a full role in care delivery, but not solely through reliance on their attendance at CPA meetings. Full use should be made of telephone communications and routine summaries and care plans, with the potential contribution of primary care being taken into account where possible.
14. Busy services often struggle with obtaining all the relevant information at the point of developing or reviewing care plans and because of the pace at which they work, some information is never gathered, not even at a later date. More stringent performance management and auditing needs to be implemented so that joint assessments are taking place where these are indicated in initial assessments. Audits should also ensure, firstly, that all parties connected with care and treatment are identified and, secondly, that relevant information is gathered so that comprehensive pictures may be formed. It is essential that information sharing protocols are explicit and workable and that staff are enabled to use these as well as their judgment. Staff should feel confident and supported in their decision-making.

### **Risk assessment**

15. As a result of a number of recent Independent Inquiries arising out of homicides involving patients of the Trust and also as practice has developed, the Trust has instituted key changes in its approach to risk management. These changes include the development of a healthcare governance framework that

establishes a structure for learning from adverse incidents. The Trust updates North East London Strategic Health Authority on progress on investigations on a monthly basis. The Serious Untoward Incident policy has been revised in conjunction with the National Patient Safety Agency (NPSA). The Trust has given increased priority to clinical risk assessment training.

16. All the Independent Inquiries criticized the Trust's approach to CPA – in 2001 the Trust introduced a comprehensive CPA strategy, since updated and ratified in December 2004. An electronic CPA system was introduced in March 2004 – this enables clinicians, practitioners and managers to have access to key patient information 24 hours a day. The Trust has a comprehensive training programme in place for all new and existing staff that addresses CPA policy. Team leaders and Ward Managers have had targeted training implementing a team-based approach to CPA documentation. All patients on enhanced level of CPA are expected to have a crisis plan, a care plan and a risk-based contingency plan, and completion rates for these plans are monitored. The Trust is also an early implementer of the Electronic Care Records system (CRS). In February 2004 a standard format for integrated clinical notes was introduced. The Trust has demonstrated a good theoretical knowledge of risk assessment, which has built upon the learning from this and other serious incidents.
17. All of the above are positive steps forward. Nonetheless, it was apparent that, in practice, risk assessment forms and other documentation are not always being utilised as they should be. Bearing in mind that the best predictor of future behaviour is previous behaviour, the Trust must emphasize the fundamental importance of good information gathering and sharing as highlighted above. Audits need to ensure that compliance is achieved across the system and that information is regularly summarized so that it is accessible to people new to the case. The section below discusses audits in more detail.
18. The introduction of balanced scorecards needs to be further embedded into clinical settings. It is not uncommon for organizations to develop systems for performance monitoring without equally robust systems for performance



management. Recruitment challenges and heavy workloads in mental health and substance misuse services can conspire to create a culture where performance management is uni-dimensional, i.e. purely through feedback and reflection. Although it is right that managers should nurture and develop the workforce, it is also important that they manage improvements in performance, drawing on all the techniques and measures available to them.

### **Adult social services**

19. Governance structures need to be strengthened so that there are routine arrangements for dialogue about areas of strength and areas for development. Arrangements need to include Board and elected councillor levels, as well as chief officers and their teams. The Council needs to be clear about its strategy for mental health and substance misuse services, as it still remains accountable for these delegated functions. In stating its strategy, the Council must then hold the Trust to account for delivering against key objectives, including compliance with reporting on indicators. For example the Performance Assessment Framework (PAF) and Referral, Assessment and Packages of Care (RAP) requirements should be delivered within mental health and substance misuse services. The Council should agree with the Trust the expected level of performance on the various indicator sets and reporting mechanisms must be well established. Councillors should receive reports of the contribution that the Trust is making to its overall strategies, including those for specific service areas. Councillors should be interested specifically in how the Trust contributes to its performance on key indicators and therefore its impact on the Comprehensive Performance Assessment for the Council.

### **Performance Management and Audits**

20. Mental health services have been moving towards health and social care integration for over a decade. In 1999, the National Service Framework for Mental Health made it a specific requirement that mental health services should be delivered in fully integrated systems. This ideal of health and social care

integration has been undermined by an inability for central government to deliver single unified inspections or ongoing performance management.

21. Health and social services departments are constitutionally and fundamentally different in terms of local accountability and funding. The NHS has a direct line of accountability to central government. Social services are delivered through Councils and these are local democracies.
22. Even in integrated mental health settings, Councils still remain accountable for social services. This is clearly true in partnerships born of historical joint working. Further to this, the National Health Service and Social Care Act 1999 introduced new powers in Section 31 for the NHS and Councils to delegate responsibilities to each other and introduce joint commissioning arrangements and pooled budgets. This has led most social services departments to delegate their mental health delivery functions to the local NHS trust, whilst remaining accountable for these services. This accountability means that Councils still need to give an account for their mental health performance through data returns and reports e.g. to the Department of Health. The inspectorate for social care was part of the Department of Health until March 2004. At that time, the function of social care inspection moved from the Social Services Inspectorate (SSI) to the Commission for Social Care Inspection (CSCI), an arms length body.

## **National**

23. There are a range of performance management systems that hold mental health services to account through the NHS route. The only integrated performance management system in mental health is the Autumn Review also known as the LIT Assessment (LIT being the multi-agency Local Implementation Team that has overall responsibility for commissioning and developing services). This has been in operation since 2001. Attempts by inspectorate bodies to develop a single integrated performance management system and inspection are just coming to fruition in a joint inspection approach being pioneered by the Commission for Social Care inspection and the

Healthcare Commission (which superseded the Commission for Health Improvement in April 2003). The first wave of the joint inspection is currently being piloted.

### Differences since September 2002

<b>Mental Health Inspection and Performance Management</b>	
<b>Sept 2002</b>	<b>Oct 2005</b>
1. NHS data returns on key performance indicators, monthly and quarterly submissions to DH – monitored by NHS ROs	Same but monitored and performance managed by SHAs
2. Social Services data returns on key performance indicators, monthly and quarterly submissions to DH – monitored by SSI	Same but monitored by CSCI
3. CHI Clinical Governance Inspections (including of mental health trusts)	Joint Healthcare Commission and SCIE mental health assessment
4. SSI Inspections of mental health. These involved health colleagues. Policy was clear that the NHS is the lead agency in mental health	Joint Healthcare Commission and SCIE mental health assessment
5. SSI Position Statements (generic with data and narrative on mental health and drugs and alcohol)	SCIE Delivery and Improvement Statement (generic with data and narrative on mental health and drugs and alcohol)
6. SSI Annual Review Meeting (generic comprehensive review of performance, with mental health component)	Same but led by SCIE
7. LIT Autumn Review of NSF implementation (around forty indicators including CPA, dual diagnosis and personality disorder)	Same but with change to focused themed review. Over the years since 2001 the indicator set has changed slightly but still includes DD
8. Collation of indicators and allocation of NHS Star Rating	Healthcare Commission Annual Health check - at October 31 <sup>st</sup> trusts are required to make a declaration in relation to a set of standards. The Annual Health Check (against which the declaration is made) will attract a

	rating for the full preceding year. Declarations will be made again at 31 <sup>st</sup> March and some trusts will be inspected to ensure validity.
9. Collation of indicators and allocation of Social Services Star Rating	Same
10. Various personnel schemes such as Investors in People (IIP) and Improving Working Lives (IWL)	Same plus the new consultant contract and Agenda for Change, which standardises pay according to the job (not the people) across the NHS

### **Local**

24. In the NHS, a major turning point was the publication of *A First Class Service: Quality in the New NHS* (July 1998) which heralded the current arrangements around clinical governance in NHS Trusts. This marked a shift from previous arrangements where Chief Executives and Boards were accountable for corporate governance and clinicians were accountable only to themselves and their professional bodies.
25. A number of processes are in place which were also in place in 2002. Though guidance has strengthened arrangements, the basic frameworks have remained consistent over time.

### **Clinical Governance**

26. Trusts are required to have arrangements in place for clinical governance. This usually manifests itself in the form of a clinical governance committee with input from the Medical Director and Nursing Director, often chaired by the Chief Executive.
27. Clinical governance is defined in *A First Class Service* as “A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

28. Four strands are identified: -

- Clear lines of accountability for the overall quality of clinical care
- A comprehensive programme of quality improvement activities
- Clear policies aimed at managing clinical risk
- Procedures for all professional groups to identify and remedy poor performance

### **Serious Untoward Incidents**

29. Each trust will have a mechanism for reviewing serious untoward incidents. It was a requirement under DH guidance HSG 94(27) May 1994 that trusts review serious incidents internally and in certain cases (homicides) an independent inquiry was required. Paragraphs 33 – 36 were revised in June 2005. Specific timescales for the internal initial investigation were recommended and suggestions were made about the funding for independent investigations.

### **Health Scrutiny in Councils**

30. Councils reorganised into cabinet style leadership as a result of the Local Government Act 2000. Overview and Scrutiny Committees have a role similar to a Select Committee. They carry out scrutiny of functions and make recommendations, for example in relation to drugs services or mental health services. Councils have a specific statutory power to require all major service changes within the NHS in their area to be brought before them.

### **Best Value**

31. Best Value was introduced by the Government in 2000 as a means of promoting efficiency and effectiveness. Councils have used this approach to

identify the extent to which benefits may be made from doing things differently, with a gain not necessarily being financial savings, but greater efficiency and improvement. Though mental health services may be delegated to a trust, Councils retain the right and responsibility (in partnership with the NHS) to carry out Best Value reviews.

### Organisational Changes

<b>Organisation in 2002</b>	<b>Organisation In Oct 2005, With Date Of Change</b>
1. Social Services Inspectorate	April 2004 Commission for Social Care Inspection
2. NHS Regional Office (aka London Regional Office)	Strategic Health Authority (28 nationally, 5 in London)
3. Commission for Health Improvement	April 2004, Healthcare Commission though legally called Commission for Health Audit and Inspection
4. National Institute for Excellence 5. (NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health)	April 2005, joined with the Health Development Agency and is now National Institute for Health and Excellence (still called NICE)
6. Social Services Departments	Between now and 2008 Councils will have created Directors of Children's Services (Under Children's Act 2004). Adult Social Care will typically join with another directorate e.g. housing. Social Services Departments as we know them will no longer exist.

32. The Trust has a number of action plans from serious incidents which it has to deliver. It will therefore need to develop sophisticated streamlined performance management arrangements to ensure that monitoring is not unwieldy and therefore ineffective. It will also need to be in a position to demonstrate progress against each of the recommendations / action points. Significant progress has been made with comprehensive reporting and a balanced scorecard approach. However, we are of the opinion that this work needs to be

strengthened if the maximum learning and benefit are to be gained from serious untoward incidents.

## **Chapter 8 Recommendations**

**There is widespread acceptance within the Trust and by its partners that, whilst improvements have been made to their services, they still need to develop the scope and quality of the care available to patients with substance misuse problems, personality disordered patients, including those co-morbid for other psychiatric conditions, and to those patients who potentially represent a considerable risk to themselves or others. To this end, we are aware that the issues we raise in our recommendations are already under discussion and/or implementation at the Trust and elsewhere. However, many mental health services are finding it hard to provide an adequate level of care for people with severe mental health problems and/or personality disorders and substance misuse issues. Hence, each of the Inquiry Panel members is of the view that it is important to continue to concentrate on such patients' needs and to seek to bring about advancements in their management and treatment. We are fully aware that this will have significant resource implications, but it is our hope and intention that the contents of this report together with our recommendations will maintain that focus in East London and The City of London.**

### **Patients with Dual Diagnoses**

1. The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and Tower Hamlets Primary Care Trust should review their strategy and operational policy for the provision of services to those with a dual diagnosis, i.e. a substance misuse problem co-morbid with mental illness or a clinically significant personality disorder.

In particular, the Trust needs to define and develop a coherent approach to services for people with dual diagnoses in conjunction with the London Borough of Tower Hamlets and the Tower Hamlets Primary Care Trust, thereby seeking to ensure that its dual diagnosis service is fully integrated within mainstream



mental health services. Whilst not wishing to limit the scope of the review, the Panel recommends that it should include consideration of the following:-

- The extent to which the National Service Framework for Drug Services has been implemented, and still needs to be implemented, and the adequacy of existing service level agreements;
- The feasibility of establishing a local detoxification and rehabilitation unit in East London;
- The existence and implementation of clearly defined care pathways;
- The extent to which the existing dual diagnosis service is integrated with, for example, the forensic psychiatric services, the CMHTs and primary care and the measures necessary to improve that integration;
- The extent to which advocacy is available to relevant service users whilst they are undergoing psychiatric assessment in Accident & Emergency Departments;
- An assessment of the skills and experience of staff presently caring for patients with dual diagnoses and the provision of further training and development of skills on a continuing basis, where appropriate.
- The appointment in every relevant case of a care co-ordinator and the unequivocal communication to the patient of the name and contact details of his/her care co-ordinator.

### **Personality Disorders**

2. Within the review recommended at (1) above, East London and The City Mental Health NHS Trust should also give consideration to the development of a specialist personality disorder team to provide consultation and support to staff working:-

- Within its adult mental health teams;
- More widely across the Trust (e.g. to Child and Adolescent Mental Health Services and Accident & Emergency Departments);
- To external agencies (e.g. to social services, primary care and the National Offender Management Service).

The Trust should look at developing skills and resources in those of its staff who work with personality disordered people and at the range of treatment interventions available.

### **Day Services**

3. The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and Tower Hamlets Primary Care Trust should conduct a comprehensive review of the adequacy of day services they make available to patients with multiple morbidities as part of their care package. That review should not be limited to considering the provision of facilities at the proposed day centre at Mile End Hospital. As part of the review, the Trust should assess the services available on a trust-wide basis from both statutory and non-statutory agencies and their efficacy at, for example, building better social networks for patients and achieving a return to employment.
4. Upon completion of the strategy review recommended at (1) above, the London Borough of Tower Hamlets should seek to ensure that the Trust is held accountable for delivering against their key objectives and reporting mechanisms between the two must be well established. For example, the Performance Assessment Framework and Referral, Assessment and Packages of Care Requirements should be delivered within mental health and substance misuse services.
5. As part of their reporting mechanisms, the London Borough of Tower Hamlets should establish formal quarterly reviews with East London and The City Mental

Health NHS Trust. Those reviews should monitor the Trust's progress and achievements in the delivery of mental health and substance misuse services which have been delegated to it pursuant to the National Health Service and Social Care Act 1999. Those reviews should examine qualitative matters such as carer and service user experience and progress on findings from serious incidents, and enable the Council to assess the Trust's impact on the Council's Comprehensive Performance Assessment.

## **Assessments of Patients**

### **(a) Risk Assessments**

6. As has been recommended by earlier Independent Inquiries, East London and The City Mental Health NHS Trust ought to address its training for risk assessment and management and emphasize the importance of good information gathering and sharing. All members of psychiatric teams, of whatever discipline, should constantly remind themselves and be reminded that the proper assessment of the risk of harm must:-
  - Be exhaustive and thorough;
  - Embody the observations of all staff involved in the care and treatment of a patient;
  - Include a detailed independent account of the patient's mental state and behaviour from a member of his family or friend, if at all possible;
  - Study the documentation describing past personal and psychiatric history, noting any reported or threatened violence;
  - Study social work and probation records where such records are available;
  - Include records of previous convictions, if at all possible.

## **(b) Diagnostic Discipline**

It is essential that the communication between professionals of the diagnosis for a patient is clear and unambiguous in order that all those involved in the care of the patient know what conclusions have been reached about that patient and to inform the proposed care package. Different diagnoses obviously have different and specific meanings and there should be no room for confusion as to the diagnosis reached in a particular case.

7. There should be a clear record in a patient's medical notes of the diagnosis for that patient once it has been made, and the reasons why that particular diagnosis has been reached for that patient. That diagnosis should inform the treatment plan for the patient.

## **(c) Joint Assessments**

8. East London and The City Mental Health NHS Trust should develop, and adhere to, clear policies on joint assessments for patients which are aimed at achieving effective discharge planning including contingency and crisis planning and a designated care co-ordinator. Those policies should seek to ensure that all agencies or services involved in a patient's care and treatment participate in the joint assessments and are fully aware of the outcome of the assessments.

## **(d) Discharge Summaries**

9. East London and The City Mental Health NHS Trust must ensure that a patient's GP and any other agency providing care to him is informed promptly of his discharge from inpatient care and is given full details of the contingency and crisis plans formulated for that patient.

## **Governance and Risk Management**

10. East London and The City Mental Health NHS Trust must establish a governance and risk assurance structure which distributes expertise across its senior staff and makes use of Non-Executive Directors.

## **Performance Management**

11. East London and The City Mental Health NHS Trust, in partnership with the London Borough of Tower Hamlets and Tower Hamlets Primary Care Trust, should review the Trust's performance management systems to satisfy themselves that those systems are sufficiently robust to ensure compliance with the Care Programme Approach and its requirements. Learning and changes in practice and in culture should be acknowledged and reflected at all levels within the organization.

## **Serious Untoward Incidents**

12. East London and The City Mental Health NHS Trust should carry out a review of the recommendations of all of the Independent Inquiries in which it has been involved and which have reported since 2001, and of the resulting action plans, to monitor its progress since then. An audit programme should be in place to manage the changes implemented by the Trust in a coherent and consistent manner. Key areas of weakness that need constant monitoring are assessments (including risk assessments), care planning and record-keeping.

## Appendix

### Chronology

Date	Event
7.7.67	Date of birth.
1990	Overdose of vodka and some medication.
20.11.92 – 24.11.92	Admission to Kingsway Hospital, Derby.
27.4.93 – 11.5.93	Admission to Winterton Hospital, Sedgefield.
23.6.97	Registers at Great Chapel Street Medical Centre, London: presenting problem – “substance misuse and depression”.
10.11.98	Threats to kill Dr Philip Reid. Banned for life from Great Chapel Street Medical Centre.
03.00	Approaches Tower Hamlets CDT for help with drug use.
29.9.00	Referred to Dr Cobb, Consultant Psychiatrist.
16.11.00	Sees Dr Cobb who writes: “Drug use is a problem. ... I found no evidence of mental illness during this first appointment.”
20.9.01	Attends A&E Department at Royal London Hospital complaining of depression and anxiety.
20.9.01 - 25.9.01	Admission to Lansbury Ward, St Clement’s Hospital.
15.10.01	Does not attend appointment with Dr Cohen at Drug Dependency Unit: subsequent phone call to say he was ill and would like another appointment.
19.11.01	Attends appointment at DDU with Dr Cohen.
25.2.02	Attends appointment at DDU with Dr Cohen: <u>Recorded impression:</u> (1) continuing psychosis (2) Seems connection with drug-induced aggravation but not clear (↓→ abnormal

	<p>mental state)</p> <p>(3) needs occupation</p> <p><u>Plan:</u> (1) take over → needs kw (keyworker)</p> <p>→ needs transfer of methadone script</p> <p>(2) needs ↑ DX work wrt [with regard to]drugs</p> <p>(3) slowly support return to college</p> <p>(4) needs antipsychotic</p>
4.3.02	Attends appointment at DDU with Dr Cohen.
11.3.02	Does not attend appointment with Dr Cohen
13.5.02	Attends appointment at DDU with Dr Cohen.
20.6.02	Attends without appointment requesting appointment with Dr Cohen.
26.6.02	Does not attend appointment with Dr Cohen.
1.8.02	<p>Attends appointment at DDU with Dr Cohen.</p> <p>Letter from Dr Cohen to duty psychiatrist at A&amp;E:</p> <p>It appears that he is experiencing a deterioration of his psychotic illness and that he is only just containing his feeling from acting out. Although his drug use is probably aggravating his mental state, I feel he would benefit from an admission in which the drugs could leave his system and he could be establish (sic) on a regular neuroleptic....”</p>
1.8.02	Attends A&E department at Royal London Hospital. Prescribed Olanzapine, diazepam declined and agrees to contact community drugs team the next day. Discharged home.
1.8.02	<p>Telephones GP out of hours co-operative from outside A&amp;E complaining of anxiety, depression and opiate dependency.</p> <p>Spends night sleeping in park.</p>
2.8.02	<p>Sees Dr Robson at Chrisp Street Health Centre. Tells Dr Robson repeatedly that he will harm himself or someone else and wants to be “sectioned”. Dr Robson speaks to duty psychiatrist.</p> <p>Attends A&amp;E Department at Royal London Hospital. Sees Dr Read, Consultant Psychiatrist.</p> <p><u>Recorded impression</u></p> <p>Dual diagnosis: opiate addict – probable psychotic symptoms worsening leading to increased risk of self neglect or harm to self or others. Dr Cohen is concerned about deteriorating mental state and recommends admission.</p> <p><u>Plan</u></p>

	Admit informally; PRN antipsychotics only and methadone 15ml tds. He understands that the purpose of admission is to assess and treat psychotic illness and that he will be discharged eventually to his accommodation.
2.8.02	Admission to Monro Ward, St Clement's Hospital.
22.8.02	Discharge from Monro Ward. DDU to be notified of discharge. Diagnosis of drug induced psychosis; no psychotic symptoms
23.8.02	Returns to Monro Ward "demanding to be admitted". "Became aggressive, throwing things around the office..." Is now threatening self harm in order to secure re-admission."
23.8.02	Attends A&E department at the Royal London Hospital and subsequently leaves without being assessed. Subsequently police take him back to A&E using their powers under section 136 Mental Health Act 1983. Seen by on-call psychiatric SHO – throws table across room and threatens assault when told he will not be admitted. Police called to remove him.
25.8.02	Attends A&E Department at King's College Hospital at 0513 hours. Requests hospital admission to prevent self-harm; states he will walk under a car. <u>Risk</u> Already complied with a search; no weapon. Not suicidal "at the moment" but threats to self or harm others if needs not met. History of violence but no history of following through self harm threats ...." <u>Recorded impression</u> Dissocial personality disorder (or borderline). Substance misuse (opiates). <u>Plan</u> Discharge. To self present to DDU for methadone. Not for meds."
26.8.02	Attends A&E Department at the Royal London Hospital. Whilst there, threatens to kidnap/assault Dr Robson.
27.8.02	Visits Dr Boomla at Chrisp Street Health Centre. Says he is agitated and upset, does not feel safe in the community and needs to be admitted. Dr Boomla agrees and sends him to A&E for reassessment.
27.8.02	Attends A&E at the Royal London Hospital. Whilst there, is recorded as saying:- "I just don't feel safe"



	<p>“I feel like I’m going to do something”  “I’m going to push somebody under a bus or a train unless I get help. I’m not safe.”</p> <p><u>Recorded impression</u>  Well known patient with drug problems, has been becoming ↑ingly violent. Claiming to be depressed and homicidal.</p> <p><u>Plan</u>  Discussed with Dr Briggs who explained pt would not benefit form I/P admission, is threatening and no illness</p> <p><u>But</u>  Due to threats of causing harm to others <u>agrees</u> to crisis admission for few days.</p> <p><u>Plan</u>  - Informal admission  - <u>No leave</u> from ward  - Drug testing  - Needs forensic assessment  - prn medication  + methadone</p>
27.8.02 – 5.9.02	Admission to Monro Ward, St Clement’s Hospital.
5.9.02	Attends A&E Department at the Royal London Hospital having taken an overdose of 24x 500mg Paracetamol. Referred to psychiatric liaison service.
5.9.02- 9.9.02	Admission to Monro Ward, St Clement’s Hospital. <u>Plan</u> - admit informally - regular drug urine screens - no leave for time being - methadone 60mls/day - Haloperidol 5mg im/po. PRN - Procyclidine 5mg im/po. PRN - Discussed with him that a lengthy hospital admission will not be beneficial for him and that he has to regain independence. ...

	The admission is on grounds of his suicide risk and ideas of harming others. A regular antipsychotic and antidepressive medication should be considered. Before discharge the possibility of day centre/community groups ... should be explored as he lacks any social support.”
9.9.02	Attends Dr Boomla at Chrisp Street Health Centre.
13.9.02	Taken to St Clement’s Hospital by police at 08.10 hours: he is complaining of hearing voices and asking for help. Then, taken to Royal London Hospital by police. Does not wait to be seen. 1610 hours: Goes to Mile End Underground Station. 17.09 hours: pushes Christophe Duclos from platform.

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF STEPHEN SOANS-WADE  
JOINT ACTION PLAN

Recommendation	Action Taken To Date	Further Action	Responsible	Date
<p>The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and Tower Hamlets Primary Care Trust should review their strategy and operational policy for the provision of services to those with a dual diagnosis i.e. a substance misuse problem co-morbid with mental illness or a clinically significant personality disorder</p>	<p>Within the East London and The City Mental Health Trust, the Tower Hamlets Directorate has implemented Phase One of the Trust Dual Diagnosis Plan, and currently has in place: a Lead Nurse for Dual Diagnosis who oversees practice development and provides a range of training programmes for staff, a dual diagnosis worker based in two CMHTs and a dual diagnosis worker in Assertive Outreach. The Directorate is also participating in a London Development Centre pilot project to develop standards for assessment and care planning for people with a dual diagnosis in in-patient settings. The Directorate has an identified lead for dual diagnosis within the Senior Management Team and the Lead is currently working with a group of professionals to develop a dual diagnosis "operational policy" for adult mental health services in the borough in line with Phase Two of the Trust Dual Diagnosis Plan. The plan has been considered by both the Adult Mental Health Partnership Board and the Drug Action Team.</p>	<p>The Drug Action team will co-ordinate the development of a system wide strategy for the provision of services to people with a dual diagnosis. Operational policies to support the delivery of this strategy will build on the work already undertaken within ELCMHT.</p> <p>To complete Phase Two of the Trust Dual Diagnosis Action Plan and to develop plans for implementation of Phase Three which is to put in place support structures specifically for people with a personality disorder and substance misuse problem.</p>	<p>DAT</p> <p>ELCMHT</p>	<p>Strategy completed by April 07</p> <p>Oct 06</p>

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<p>East London and The City Mental Health NHS Trust should give consideration to the development of a specialist personality disorder team to provide consultation and support to staff working</p> <ul style="list-style-type: none"> <li>• Within adult mental health teams</li> <li>• More widely across the Trust</li> <li>• To external agencies</li> </ul>	<p>ELCMHT has established a Personality Disorder Steering Group which has developed a Personality Disorder Strategy. The Trust has developed services for people with Dangerous Severe personality Disorder (DSPD) at the John Howard Centre. ELCMHT recognises that there is now a need to consider with partner agencies how best to support people with personality disorder who do not meet a DSPD threshold. The Tower Hamlets Partnership has identified services for people with a personality disorder as one of its Top Ten priorities for 2006/7 and is in the process of forming a sub-group to the Local Implementation Team to oversee this work, jointly chaired by the locality Clinical Director and the Trust Director of Therapies.</p>	<p>To agree and complete the LIT work programme on services for people with a personality disorder for 06/07.</p> <p>To consider outcomes of the work plan as part of the commissioning round for 07/08.</p>	<p>LIT sub group</p> <p>Joint Commissioning Executive</p>	<p>Oct 06</p> <p>Nov 06</p>

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<p>The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and Tower Hamlets Primary Care Trust should conduct a comprehensive review of the adequacy of day services they make available to patients with multiple morbidities as part of their care package. That review should not be limited to considering the provision of facilities at the proposed day centre at Mile End Hospital. That review should assess the services already available on a trust-wide basis from both statutory and non-statutory agencies and their efficacy at, for example, building better social networks for patients and achieving a return to employment.</p>	<p>A review of social day care was completed by the Adult Mental Health Partnership Board in 2003. Subsequently, day services have been refocused with an emphasis on promoting social inclusion, integration with wider community networks, and access to employment and training. There has been additional investment in these services. However, current day services do not have a specific focus on patients with multiple morbidities, and the development of such services would require either new or redirected investment.</p> <p>ELCMHT is remodelling its Rehabilitation Services to focus on a recovery model. The Trust is working with partners in developing 'Routes to Employment', a programme to promote the employment of people with mental health problems, in conjunction with statutory and non statutory partners and local businesses.</p>	<p>Commissioners should consider whether further day services of the kind proposed should be commissioned, and if so what priority should be afforded to them in considering future investment plans.</p>	<p>Joint Commissioning Executive.</p>	<p>Consider in 2007/8 commissioning round</p>

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<p>Upon completion of the strategy review recommended above, the London Borough of Tower Hamlets should seek to ensure that the Trust is held accountable for delivering against their key objectives and reporting mechanisms between the two must be well established. For example, the Performance Assessment Framework and Referral, Assessment and Package of Care Requirements should be delivered within mental health and substance misuse services.</p>	<p>The mechanisms described have been established under the existing Section 31 Partnership Agreement. The Joint Management Board meets monthly, and there is a six weekly tripartite performance management meeting between ELCMHT, LBTH and THPCT. ELCMHT has a responsibility, under the Section 31 agreement, to provide LBTH with all required performance management information, including all information required for Performance Assessment Framework / Referrals Assessments and Packages of Care purposes. There have, however, been ongoing difficulties with obtaining this information from the Trust's information systems, which have had to be overcome by manual data collection. It is expected that these difficulties will be resolved either via the deployment of Sepia Phase 2 or by the implementation of the Rio system, although there is uncertainty at this point about the timescale for those developments.</p> <p>Work is already underway by the ELCMHT performance department to streamline the collection and presentation of both health and social care performance data, including the LIT performance schedule which includes a measure for meaningful occupation.</p>	<p>Resolve and implement the next phase of mental health information system development.</p> <p>Future governance arrangements of integrated health and social care mental health services are under review between ELCMHT and LBTH, and both parties have signalled their intention to move to a robust joint management model, rather than the current delegation of functions model, by 31.12.06. This will strengthen direct accountability to LBTH for delivery of its statutory functions</p>	<p>ELCMHT</p> <p>ELCMHT / LBTH</p>	<p>October 2006</p> <p>Implement new arrangements by 01.01.07.</p>

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Recommendation	Action Taken To date	Further Action	Responsible	Date
<p>As part of their reporting mechanisms, the London Borough of Tower Hamlets should establish formal quarterly reviews with East London and The City Mental Health NHS Trust. Those reviews should monitor the Trust's progress and achievements in the delivery of mental health and substance misuse services which have been delegated to it pursuant to the Health and Social Care Act 1999. Those reviews should examine qualitative matters such as carer and service user experience and progress on findings from serious incidents and enable the Council to assess the Trust's impact on the Council's Comprehensive Performance Assessment.</p>	<p>The existing governance and performance management arrangements are described above.</p>	<p>As described above, the delegation of functions referred to will cease by 31.12.06.</p>	<p>ELCMHT / LBTH</p>	<p>Revised management and governance arrangements in place by 01.01.07</p>

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Recommendation	Action Taken To Date	Further Action	Responsible	Date
<p>As has been recommended by earlier Independent Inquiries, East London and The City Mental Health NHS Trust ought to address its training for risk assessment and management and emphasize the importance of good information gathering and sharing.</p>	<p>ELCMHT has undertaken a review of the risk management training and implemented a number of changes including</p> <ul style="list-style-type: none"> <li>• Clinical Risk Assessment and Management training programme for clinical staff, which is mandatory with a refresher every 3 years.</li> <li>• An audit of clinical risk assessment was carried out in Tower Hamlets in 2005.</li> <li>• The Trust achieved Level 1 Clinical Negligence Scheme for Trusts (CNST) in March 2006.</li> <li>• Clinical Risk Management Policy reviewed and updated during 2006.</li> </ul>	<p>Achieve CNST level 2</p> <p>Achieve CNST level 3</p>	<p>ELCMHT</p> <p>ELCMHT</p>	<p>By 31.03.07</p> <p>By 31.03.08</p>



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<p>East London and The City Mental Health NHS Trust should develop, and adhere to, clear policies on joint assessments for patients which are aimed at achieving effective discharge planning including contingency and crisis planning and a designated care co-ordinator. Those policies should seek to ensure that all agencies or services involved in a patient's care and treatment participate in the joint assessments and are fully aware of the outcome of the assessments</p>	<p>The Trust has developed a robust and clear CPA Policy which is supported by a defined training programme. CPA policy, guidance and documentation have been reviewed, and the revised documentation is currently subject to final consultation with partners. Users have been actively involved in the review.</p>	<p>Completion of Trust wide review of CPA policy and processes.</p>	<p>ELCMHT</p>	<p>Revised CPA policy to be agreed by Trust Board Oct 2006</p>
	<p>Compliance against key targets is subject to ongoing performance monitoring as part of the Annual Health check. Monthly reports are submitted to the Trust Board.</p>	<p>100% compliance and adherence for patients on CPA including contingency planning and crisis planning and allocation of dedicated care co-ordinator.</p> <p>On going Audit and patient survey and rolling programme of training for staff.</p>	<p>ELCMHT</p>	<p>By 31.3.07</p>
	<p>The locality has piloted an inpatient care pathway, developed as part of the National Management Development Initiative that needs to be rolled out to all wards. There has been active user involvement in the review of CPA process within ELCMHT.</p>	<p>Roll out inpatient care pathway to all inpatient areas with in built evaluation.</p>	<p>ELCMHT</p>	<p>March 07</p>

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<p>East London and The City Mental Health NHS Trust should ensure that a patient's GP and any other agency providing care to him is informed promptly of his discharge from inpatient care and is given full details of the contingency and crisis plans formulated for that patient.</p>	<p>Discharge policies covering all these issues are now in place.</p>	<p>Audit to ensure that policies are being fully complied with.</p>	<p>ELCMHT</p>	<p>Complete audit by March 07</p>
<p>East London and The City Mental Health NHS Trust must establish a governance and risk assurance structure which distributes expertise across its senior staff and makes use of Non-Executive Directors</p>	<p>The Trust has established an integrated healthcare governance framework which sets out the governance arrangements through committee structures accountable to the Trust board. Members include clinicians, managers executive and non exec directors and service users.</p> <p>The framework is subject to regular internal audit and is consistent with good practice guidance for board assurance.</p>	<p>The Governance arrangements are under review as part of the process for our application for Foundation Trust status.</p>	<p>ELCMHT</p>	<p>Complete review as part of Foundation Trust application Nov 06</p>

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Recommendation	Action Taken To date	Further Action	Responsible	Date
<p>East London and The City Mental Health NHS Trust, in partnership with Tower Hamlets Primary Care Trust, should review the Trust's performance management systems to satisfy themselves that those systems are sufficiently robust to ensure compliance with the Care Programme Approach and its requirements. Learning and changes in practice and in culture should be acknowledged and reflected at all levels within the organisation.</p>	<p>The performance management systems now in place have been described above. Both CPA compliance and Serious Untoward Incidents are a standing item at performance management meetings</p> <p>CPA has been identified as a LIT Top Ten priority for 2006/07. Primary care representatives are now involved in overseeing the operation of CPA through the locality CPA implementation group. The group oversees local implementation of Trust CPA policy and manages a rolling quarterly audit of CPA implementation across community and inpatient areas.</p>	<p>Ensure 100% compliance with requirements of CPA for all service users placed on CPA by 31.3.07.</p> <p>Lead GP to attend CPA implementation group.</p>	<p>ELCMHT</p> <p>ELCMHT</p> <p>ELCMHT</p>	<p>March 07</p> <p>July 06</p> <p>Immediate</p>
<p>East London and The City Mental Health NHS Trust should carry out a review of the recommendations of all Independent Inquiries in which it has been involved and which have reported since 2001 and the resulting action plans to monitor its progress since then. An audit programme should be in place to manage the changes implemented by the Trust in a coherent and consistent manner. Key areas of weakness that need constant monitoring are assessments (including risk assessments), care planning and record-keeping.</p>	<p>The Trust Healthcare Governance Committee is currently reviewing all previous Reviews since its inception. Audit forms part of this review and key learning points will be disseminated for action through to Borough services. Need to review progress against all action plans. Progress updates to be requested from each Directorate where the Independent Inquiries have arisen. Assurance Department to map progress. Key areas of weakness have been incorporated into priority workstreams e.g. policy development, training audit. The Trust has made significant steps to strengthen SUI reviews and responsiveness.</p>	<p>Any areas where action identified as outstanding through current review process to be addressed.</p>	<p>ELCMHT</p>	<p>All required actions completed by 31.3.07</p>